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Advocates' FORUM

2007

ADVOCATES' FORUM 2007 STUDENTS OF THE SCHOOL OF SOCIAL SERVICE ADMINISTRATION THE UNIVERSITY OF CHICAGO

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MISSION STATEMENT

Advocates' Forum is an academic journal that explores clinical implications, social issues, administration, and public policies linked to the social work profession. The journal is written, edited, and created by students of the School of Social Service Administration, and its readership includes current students, alumni, faculty, fieldwork supervisors, and other professionals in the field. The editors of *Advocates' Forum* seek to provide a medium through which SSA students can contribute to the continuing discourse on social welfare and policy.

EDITORIAL POLICY

Advocates' Forum is published by the students of the School of Social Service Administration (SSA) at the University of Chicago. Submissions to the journal are selected by the editorial board from works submitted by SSA students and edited in an extensive revision process with the authors' permission. Responsibility for the accuracy of information contained in written submissions rests solely with the author. Views expressed within each article belong to the author and do not necessarily reflect the views of the editorial board, the School of Social Service Administration, or the University of Chicago. All inquiries and submissions should be directed to:

Advocates' Forum
School of Social Service Administration
The University of Chicago
969 East 60th Street
Chicago, IL 60637

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ESSAYS AND ARTICLES

ON THE COVER

GROWTH by C. Marks
School of Social Service Administration, The University of Chicago
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The history of social work is one of continually expanding awareness of the implications of environmental stress as well as a commitment to addressing problems in living that arise from such stress. Social workers recognize the importance of the social environment to clients' daily functioning and well-being. As they collaborate with clients to improve well-being, social workers identify both intrapersonal and interpersonal sources of vulnerability and strength. All of the articles in the 2007 issue of *Advocates' Forum* reflect this abiding dedication to understanding the interplay between the social environment and clients' well-being.

Christina James and Katherine Gregg draw from their experiences in working with individuals experiencing acute stress. In "Psychological Effects of Disasters on Children: Hurricane Katrina and Child Survivors in New Orleans," Christina James documents psychological distress experienced by child survivors of Hurricane Katrina and assesses the viability of one particular treatment approach. In "A Treatment Plan for Incarcerated Male Juveniles Who Experience Posttraumatic Stress Disorder (PTSD)," Katherine Gregg examines stress observed at clinical levels among incarcerated male juveniles. Using principles of evidence-based practice, she proposes a treatment plan for addressing posttraumatic stress and restoring well-being.

Abigail Coppock and Amy Proger explore the impact of chronic environmental stress on the daily functioning of individuals who are connected to the welfare and foster care systems, respectively. In "Transitional Jobs: Overcoming Barriers to Employment," Abigail Coppock proposes a strategy for reducing unemployment among current and former welfare recipients. The strategy attempts to addresses such barriers to employment as discrimination, lack of job preparation, and employer expectation. In "The Educational Experiences of Youth in Foster Care: The Current State of Knowledge and Directions for Future Research," Amy Proger reviews the large body of literature on the relationship between foster care placement and educational outcomes among foster youth.

Finally, Steve McMillin's article shifts our focus from the social environment of our clients to our own practice environments. In "Practice Prohibitions in Religious Child Welfare Agencies: The Case of Lesbian and Gay Adoption," he explores the implications of a practice environment in which organizational policies are at odds with social work ethics and values. His assessment of the legal history of practice prohibitions touches upon factors of decision-making and ideology that are relevant to many sectors of social work.

The articles in the 2007 issue of *Advocates' Forum* reveal the variety of ways in which social environments shape the well-being and relational experiences of clients and social workers alike. Whether it is acute stress stemming from a natural disaster or incarceration, or the daily stress related to unemployment or foster care placement, social workers must attend to the factors in the social environment that both contribute to and mitigate stress. Further, social workers must be aware that factors in their practice environments can limit their ability to practice social work in a manner true to the profession's values. It is our hope that these perspectives on well-being will inspire questions, reflections, and discussion in response to the current state of affairs in social work and the social world.

April Kopp
Amy Proger
COEDITORS IN CHIEF

ABOUT THE EDITORIAL BOARD

AMY PROGER is a second-year social administration student at the School of Social Service Administration. She received her B.S. in education and social policy from Northwestern University. Amy is interested in minority adolescent development and urban education. Currently, she is completing her field work practicum at the Chicago Public Schools Department of Postsecondary Education and Student Development, where she is creating programming to facilitate a successful transition to high school. Amy plans to pursue a career in research in education policy, focusing on the educational experiences of at-risk youth.

APRIL KOPP is a first-year clinical student at the School of Social Service Administration. She received an A.B. in English from the University of Chicago in 2004 and an M.F.A. in poetry writing from the Iowa Writers' Workshop in 2006. Her field placement is at North Kenwood/Oakland Charter School. April works at Teen Living Programs on the Southside. The agency serves youth who are homeless. She also codirects The Patient Voice Project, which offers expressive writing classes to individuals with mental and chronic illness and disadvantaged youth. Her combined interests in writing and child welfare policy led her to SSA to study narrative intervention with children.

BOARD MEMBERS

VANESSA ASKOT is a second-year joint degree student at the School of Social Service Administration and the Graduate School of Business. Before moving to Chicago, Vanessa worked in Washington, DC, providing case management services and antiviolent education to survivors of domestic abuse and teen dating violence. During this time, Vanessa started thinking about efficient resource allocation, effective management strategies, and strategic program growth. Upon graduation, Vanessa hopes to work as an administrator in an agency that provides direct services to children.

PAUL BROWN is a first-year social administration student at the School of Social Service Administration. He plans to specialize in community organizing, planning, and development as well as the Community Schools program. His research interests include social work and its global response to HIV/AIDS, antiracist social work education, and international social work. Paul aspires to pursue a career that would integrate his social work values and ethics with the business world, supporting and developing corporate social responsibility programs and initiatives.

JESSICA FALK is a second-year evening student at the School of Social Service Administration with a concentration in social administration. She holds a J.D. from the University of Michigan School of Law and a B.A. in political science from the University of Illinois. Her current field placement is with the Chicago Coalition for the Homeless. After graduation, she hopes to work in social welfare policy and as an advocate for social change. As a law student, Jessica worked on the editorial board of the University of Michigan *Journal of Law Reform*.

SAM FITZGERALD is a first-year administration student at the School of Social Service Administration. Prior to attending SSA, she served as a Peace Corps volunteer in Costa Rica, supporting children, youth, and families affected by illegal emigration to the United States. Additionally she served as editor of *La Cadena*, the Peace Corps Costa Rica newsletter. She graduated from Dartmouth College with a B.A. in English and theater.

CHRISTINA JAMES is a third-year joint degree student at the School of Social Service Administration and the Harris School of Public Policy Studies. Prior to coming to SSA, she worked for a nonprofit organization serving low-income children and families in New Orleans, LA, and for the U.S. Department of Justice in Washington, DC. For her second-year field placement with SSA, Chrissie returned to New Orleans to do therapy with child and family survivors of Hurricane Katrina. She is eternally grateful for her experience there, both to the families with whom she worked and to the agency that supported her internship.

STEPHEN E. MCMILLIN is a graduate student at the School of Social Service Administration. He holds a master's degree in public policy and administration from Northwestern University. His research interests include adoption, foster care, and non-traditional parenting.

LIZ SCHNITZ is a second-year clinical student at the School of Social Service Administration. She graduated from St. Mary's College of California in 2003 with a B.A. in religious studies. During her two years at SSA, Liz has become interested in working with people with dual disorders. She is working as an intern this year at Heartland Health Outreach Mental Health and Addiction Services as an outreach worker and as a group and individual counselor. She also assists the Resource and Community Development office with agency projects. Liz is particularly interested in applying a harm reduction approach to her work with clients with dual disorders.

SARAH SCHUTZ is a first-year student at the School of Social Service Administration, interested in preventative healthcare and community revitalization programs. Growing up in the Chicagoland area, she has enjoyed living in different neighborhoods throughout the city but looks forward to moving to a warmer climate and traveling internationally. She likes to read, watch movies, and see live music in her very minimal spare time.

MARION (MIMI) SCOTCHMER is a second-year clinical student at the School of Social Service Administration. She has strong interests in mental health, family interventions, and cultural diversity. She currently interns in the adult inpatient psychiatry unit at a community hospital. Before graduate school, Marion worked in Washington, DC, with American Institutes for Research, a nonprofit organization providing social science and behavioral research. Marion received a B.A. from the University of Virginia, double majoring in socio/cultural anthropology and Asian studies. After graduation, she hopes to pursue a career in mental health, working directly with adults and their families, and also to find ways to contribute to social work research.

SARAH WURZBURG is a first-year social administration student at the School of Social Service Administration, concentrating on policy analysis. As an undergraduate, Sarah majored in English writing. She has enjoyed the opportunity to work on this journal.

Psychological Effects of Disasters on Children: Hurricane Katrina and Child Survivors in New Orleans

By Christina James

In August 2005, Hurricane Katrina fell on the Gulf Coast, resulting in unprecedented, long-term mental health needs of hurricane survivors. Child survivors are especially vulnerable following a disaster; it is therefore crucial that mental health providers understand and utilize effective interventions to address the psychological impacts of disasters on children. This article examines the psychological impacts of disasters on child survivors, exploring factors that increase a child's vulnerability to psychological distress and presenting an evidence-based intervention for child survivors of Hurricane Katrina. The author uses case examples from a New Orleans agency that serves survivors of Hurricane Katrina.

On August 29, 2005, Hurricane Katrina fell on the Gulf Coast, resulting in unprecedented physical destruction, thousands of deaths, and the displacement of hundreds of thousands of individuals (Voelker, 2005). Experts note that the effects of Hurricane Katrina have created unprecedented mental health needs among the storm's survivors, particularly among child survivors (Voelker, 2005). Rebecca Voelker (2005) notes that many of these children experienced multiple traumas during and immediately following the hurricane. Some of these children continue to experience trauma associated with the transition back to life in a recovering city. Indeed, Hurricane Katrina's effects on children show how devastating storms can be on this population; however, it is important to note that not all storms have the same impact.

This article has four goals. First, it examines the literature on the psychological impact of disasters on child survivors, devoting special attention to the association between disasters and posttraumatic stress disorder (PTSD). Second, it discusses several factors that may contribute to a child's experience of PTSD symptoms following a disaster. Third, it presents the experiences of several child survivors of Hurricane Katrina who are living in New Orleans.

Finally, it presents the Project LAST's (Lost and Survival Team) Elementary-Age Grief and Trauma Intervention, a unique, evidence-based intervention for individuals as well as groups. The intervention has been used with children who experienced various traumas, including those experienced as a result of Hurricane Katrina in New Orleans. The article concludes with several policy recommendations.

The article also presents relevant case assessments of and interviews with child survivors of Hurricane Katrina. These are drawn from the author's fieldwork in New Orleans during the months following the hurricane.[1] Fieldwork was conducted through a New Orleans organization that primarily provides mental health counseling to low-income African American children and families. The children and families discussed in this study have experienced multiple traumas as a result of their experiences during and after the hurricane. Although many along the Gulf Coast region experienced similar traumas, this article focuses on child survivors in New Orleans.

It is first important to note that although the tragedy in New Orleans has been generally discussed as the result of Hurricane Katrina, the reality is that the majority of devastation there was caused not directly by the hurricane itself but by the flooding that occurred due to multiple breeches in the levee system. Therefore, the discussion of Hurricane Katrina as it affected New Orleans will not be described as a natural disaster but simply as a disaster. This is done in order to convey the fact that the disaster in New Orleans was the result of both a natural phenomenon and man-made error (e.g., a levee system that was unprepared to withhold the hurricane storm surges).

HURRICANE KATRINA AND NEW ORLEANS CHILDREN

Results of the 2000 U.S. Census reveal that there were 70,629 children ages 9 years and younger living in New Orleans; in addition, 36,769 were between the ages of 10 and 14 years old (U.S. Census, 2000). Children living in New Orleans during Hurricane Katrina were affected by the storm in different ways, whether it was because they lost their homes, their parents lost their jobs, they were forced to change schools, or they lost family members or friends.

Although Hurricane Katrina and the subsequent levee breeches affected most children and families in New Orleans, obstacles to evacuation and subsequent problems in finding shelter made the disaster much more difficult for low-income children and families. In 2000, 43.0 percent of children under age 6 in Orleans Parish were living in poverty; the rate was 42.4 percent among Orleans Parish children between the ages of 6 and 11 (Greater New

Orleans Community Data Center).[2] Understanding the extent of poverty among children living in New Orleans before Katrina is important because the socioeconomic status of these children and their families is likely to have greatly affected their experiences both during and after the hurricane. As Olivia Golden (2006) notes, for children whose families struggled economically before Katrina, the impact of the hurricane may have been that much more damaging.

As the organization Save the Children (2006, p. 1) notes, "Now, a year after the storm, children still face enormous challenges. Many still live in temporary and often unwelcoming situations. They have lost their communities and schools, disrupting [sic] social networks and learning. And studies have found high rates of depression, anxiety, and behavioral problems among many children trying to make their way in a post-Katrina world." The child survivors of Hurricane Katrina may be vulnerable to these and other traumas for many years to come.

DATA

Data for this study were collected during the author's fieldwork with a New Orleans-based agency. The author was part of a staff that provided mental health services in the aftermath of Hurricane Katrina. Services included grief and trauma counseling for children and families affected by the hurricane, the subsequent flooding, and violent crimes. Many of the children experienced multiple traumas during and after the hurricane. Clients seeking services at the agency come on a voluntary basis. The majority of clients are low-income African American children and families. All of the clients discussed in this study reported that they lived in New Orleans at the time of the hurricane.

The case examples included in this article come from the author's work with the agency between the months of June and September, 2006, almost a year after Hurricane Katrina. The article's content results from an assessment of approximately 14 children who ranged in age from 4 years to 12 years old. The majority of the cases were elementary-age children at the time of assessment. Most of the assessments come from the author's family therapy work with four families, three of which were seen by the author and supervisor in the community (i.e., either in their home or at another location in the community). The author saw one family alone in the office. Parents of the children were included in the family sessions. The number of sessions in which each family participated varied from 4 sessions to 10. In addition, the article also presents the case of a 9-year-old child who was assessed by the author and was considered for participation in the Project LAST Intervention school-based group treatment. The author conducted the assessment under the supervision of an agency employee in the child's school.

The cases included in this article were chosen for their relevance to the topics covered in the article and thus may serve as illustrative examples. The cases included were also ones of which the author had first-hand knowledge. It is important to note that although the included cases may serve as examples of the experiences of some families after the hurricane, their experiences cannot necessarily be generalized to the larger population of New Orleans families. Each family's experience was unique.

Many of the clients seeking services at the agency experienced multiple traumas during the hurricane. One child reported to the author during an assessment (as part of a family session) that he had seen a dead body at the Ernest Morial Convention Center and that he and his mother were eventually taken in a plane without being told where they were going. The mother of this child reported to the author that they were thusly transported to Texas, where they stayed in a shelter for several weeks. The child reported being scared during his time at the shelter and described an incident in which he was separated from his mother at one point. According to staff reports, other children reported witnessing acts of violence, hearing about a relative dying in horrific conditions, being separated from a parent during the evacuation, and being air-rescued. Whether the child experienced these events as traumas depends on several factors that will be described later in the article. However, unpublished data from the agency under study show that 30 percent of the children seeking services have experienced two or more traumas as a result of Hurricane Katrina, and 10 percent have experienced three or more traumas. These findings suggest that children in New Orleans need effective and appropriate coping strategies to help them work through these traumas.

PSYCHOLOGICAL EFFECTS ON CHILDREN WHO HAVE SURVIVED A DISASTER

Background

In recent years, there has been an increase in research on the psychological consequences of man-made and natural disasters (Williams, 2006). Some of this work focuses specifically on the consequences that those events have for children. Juliet Vogel and Eric Vernberg (1993) find that researchers in the 1970s and 1980s became increasingly aware of the enduring and severe effects that disasters can have on child survivors. This shift reflected a recognition that the effects were greater than research previously acknowledged. Nonetheless, current research continues to suggest that the psychological and emotional needs of children (both man-made and natural) are still often neglected after disasters. Annette La Greca and associates (2002) note several reasons for this

neglect. First, a disaster may compel parents and caregivers to deal with their own traumas, making it difficult for them to address the needs of their children. Second, parents and caretakers may not be fully aware of the extent to which their children are in distress. Finally, as La Greca and associates (2002, p. 4) observe, because of the stage of their developmental process, children may lack the ability to recognize their own distress or to seek help.

Both immediately following a disaster and in the long-run, neglecting the emotional and psychological needs of children may have detrimental consequences. Such neglect may impede the long-term growth and development of children (La Greca et al., 2002). Joy Osofsky (2004, pp. 6–7) notes, "The psychological outcomes of … trauma on children include threats to their sense of basic trust and secure attachment…. Thus it is crucial that parents and other caregivers be able to listen to their children and hear their concerns."[3]

DISASTER-SPECIFIC PTSD IN CHILDREN

Posttraumatic stress disorder (PTSD; see American Psychiatric Association, 2000) occurs as the result of the experience a traumatic event. Among children, PTSD manifests itself through disorganized or agitated behavior (American Psychiatric Association, 2000). Children may continue to reexperience the trauma through intrusive thoughts, and such thoughts may manifest themselves in repetitive play that depicts the traumatic event. Children may also reexperience trauma through recurrent dreams that come in the form of nightmares in which the content is unrecognizable to the child. Children with PTSD may resist discussion of the traumatic event or may give a flat, seemingly unemotional description of the event (Kronenberger and Meyer, 2000). Research shows that children's symptoms of PTSD are more likely to be behavioral than cognitive (Kronenberger and Meyer, 2000). Examples of this behavioral manifestation include aggressive behavior, throwing tantrums, and "escape behavior" (Kronenberger and Meyer, 2000, p. 251).

One's reaction to a traumatic event depends, however, on the type of trauma that one experiences. Anait Azarian and Vitali Skriptchenko-Gregorian (1998) find that the trauma experienced as a result of a disaster differs from such other traumas as physical abuse or rape. They point, for example, to the fact that disasters often involve multiple stressors, which affect survivors in a variety of ways. "As a result of such interwoven stressors and such an overwhelming life experience, the survivors manifest a wide range of cognitive, emotional, and behavioral problems" (Azarian and Skriptchenko-Gregorian, 1998, p. 81). Azarian and Skriptchenko-Gregorian (1998) study 839 child survivors of the 1988 Armenian earthquake, conducting personal interviews

and questionnaires 1 year after the earthquake. They find that these children showed many common PTSD symptoms, including reenactment and avoidance. The most common forms of reenactment were nightmares and drawings, but the authors also note, "Certain places, smells, sounds, memories, feelings, thoughts, even people who reminded them of the original traumatic events, were energetically avoided" (Azarian and Skriptchenko-Gregorian, 1998, p. 103). Azarian and Skriptchenko-Gregorian report, for example, that many children refused to go to school because this may have been where they were when the earthquake occurred. Ricky Greenwald (2005, p. 16) discusses similar phenomena and presents the idea of "survival orientation," an aspect of avoidance, or "the wish to keep any more bad things from happening. For example, a traumatized child might avoid walking down a certain street where she was hit by a car, both to avoid a recurrence of the accident and to avoid being reminded of the memory" (2005, p. 16).

Azarian and Skriptchenko-Gregorian (1998) also report that expressions of guilt were common among the child survivors they studied. For example, some adolescents reported feeling guilty that they hadn't been able to say goodbye to a parent who was later killed. Other children reported feeling guilty that they had done something to cause the earthquake (Azarian and Skriptchenko-Gregorian, 1998, p. 96).

In recent years, a fair amount of research has connected disasters and PTSD (Shaw et al., 1995; Azarian and Skriptchenko-Gregorian, 1998; Thienkrua et al., 2006; Williams, 2006). In fact, of all the symptoms that a child might experience after a disaster, PTSD symptoms are the most frequently studied (Silverman and La Greca, 2002). La Greca and Mitchell Prinstein (2002, p. 120) observe that "the most common psychological reactions to hurricanes and earthquakes are consistent with current formulations of PTSD." Evidence on postdisaster PTSD among children suggests that if these symptoms emerge, they usually do so weeks or months after the disaster (Silverman and La Greca, 2002). Vogel and Vernberg (1993) note that children's PTSD symptoms typically decrease quickly after a disaster. Children usually recover fully between 18 months and 3 years afterwards. They note, however, that symptoms may be prolonged for children whose disaster experience involves a severe threat to life or "long-term family and community disruption" (Vogel and Vernberg, 1994, p. 464).

Reviewing the situation 1 year after the disaster, Amy Liu, Matt Fellows, and Mia Mabanta (2006, p. 2) observe, "New Orleans has rebounded unevenly, leaving entire neighborhoods mostly out of the recovery effort and many key pieces of the city's infrastructure – from childcare centers to affordable housing to utility service – lagging" (Liu et al., 2006, p. 2).

Such conditions can affect the emotional and psychological healing of the city's children.

Reminders of the disaster represent recurring challenges for children in New Orleans. Many children seeking services at the agency in this study reported avoidance symptoms. For example, one 9-year-old survivor of Hurricane Katrina reported that he avoided walking past certain houses in his neighborhood because he remembered seeing the wind knock the doors of theses houses down during the hurricane. Another child reported that he and his mother did not talk about Hurricane Katrina because it was "too sad" to think about.

Along with symptoms of avoidance, child survivors of Hurricane Katrina may have also experienced guilt similar to that described by Azarian and Skriptchenko-Gregorian (1998). In order to be rescued, some of the children in this study were forced to leave behind their family pets. This may have caused them to experience guilt. For example, a 9-year-old male who sought services at the agency in this study reported that he had to leave his dog at the house when he and his mother were rescued by boat. Leaving his dog was something that this boy brought up multiple times in sessions, despite the fact that he and his mother endured other harrowing experiences. Although he did not outwardly express guilt about having to leave his dog, educating children about things that are out of their control is one way to alleviate any guilt they might be experiencing after a disaster.

FACTORS THAT CONTRIBUTE TO CHILDREN'S EXPERIENCE OF PTSD SYMPTOMS

Child survivors of a disaster are vulnerable to experience PTSD symptoms, but not all children who have been exposed to a disaster will have a traumatic reaction or display clinical levels of PTSD symptoms. What makes some children more likely than others to be vulnerable to PTSD symptoms? Philip Lazarus, Shane Jimerson, and Stephen Brock (2003, p. 2) note that children who experience a disaster may have a variety of PTSD symptoms and that the severity of these symptoms depends on several factors, including, "personal injury or loss of a loved one, level of parental support, dislocation from their home or community, [and] the level of physical destruction." Vogel and Vernberg (1993) add that whether the child was separated from others during the disaster, whether a child lost someone to the disaster, the characteristics of the child's family and community, and the severity of the exposure to the disaster can all contribute to a child's experience of PTSD symptoms.

Child survivors of Hurricane Katrina reported varying levels of exposure to the hurricane and subsequent flooding. For example, some children were able to evacuate with their parents before the hurricane hit, but other children were still in their houses when the levees broke. One 9-year-old male seeking services at the agency reported seeing the water rush into his home after the levees breeched. The rising water forced him to sleep in the attic with his mother. However, he did not display clinical levels of PTSD. Although the factors mentioned above may contribute to a child's experience of PTSD symptoms, each factor alone is not necessarily a predictor of PTSD.

Child survivors of Hurricane Katrina also reported separation from others during the hurricane. For example, one 6-year-old reported that, of all of the things that he endured during Katrina, the most difficult thing for him to talk about was how scared he had been that his aunt, who was not able to evacuate with the rest of his family, was going to die alone in her house during the hurricane. His aunt survived, but over a year after the hurricane, the child still found it still extremely difficult to talk about the separation from his aunt during the evacuation.

Several authors report that threats to life, or perceived threats to life, can be another factor that contributes to children's experience of PTSD symptoms after a disaster. Wendy Silverman and La Greca (2002, p. 24) note, "The more children perceive their lives or the lives of loved ones to be threatened, the higher are their reports of PTSD symptoms." Preexisting risks, such as a previous traumatic experience, represent a final (and crucial) factor that may contribute to children's experience of PTSD symptoms after a disaster (Lazarus et al., 2003, p. 2). Carol Garrison and associates (1993, as cited in La Greca and Prinstein, 2002, p. 123) find that "adolescents who have a history of experiencing other traumatic or violent events have reported more severe PTSD symptoms after hurricanes than those without prior trauma exposure." This gets back to the idea, mentioned previously in the article, about multiple layering of traumas. If a child has had previous unresolved traumas, this lack of resolution will affect his or her experience of a current trauma.

For example, one family in this study survived Katrina and endured multiple traumas in the year after the hurricane. Several months after the hurricane, the oldest son in the family (who was also a father-figure to the younger children) was murdered. One month later, a close cousin (a teenager) was killed in a drunk-driving accident. The author and other agency staff worked with the family to address the family's multiple traumas. Each family member's experience of each event was unique, and family members were at different stages of healing. The goals in the work with this family were thus to build on their

many strengths as a family, to further develop their coping strategies, and to build on the family unit as a support system.

PROJECT LAST: AN ELEMENTARY-AGE GRIEF AND TRAUMA INTERVENTION

Project LAST's (Loss and Survival Team) Elementary-Age Grief and Trauma Intervention (hereafter, Project LAST Intervention) is a unique evidence-based effort created by Alison Salloum (2006) through her work with a New Orleans-based agency that addresses the mental health needs of predominantly low-income, African American children and families. The intervention was originally developed as part of the agency's work on Project LAST, a program created in 1990 to respond to the needs of children and families who witnessed, or been a victim of violence, including having a loved one murdered (Salloum, 2006). The intervention was expanded after Hurricane Katrina to address the needs of children who, because of the hurricane or to the death of someone close to them, experienced grief, loss, and moderate symptoms of posttraumatic stress. The Project LAST Intervention is being used in several New Orleans public schools to engage child survivors of Hurricane Katrina. Children who meet the intervention criteria participate in the Project LAST Intervention group model with other child survivors. Children who do not meet the criteria for the group intervention (e.g., children who are suicidal or whose identified trauma occurred less than a month before the beginning of the intervention) are given the option of participating in the individual intervention that is to be conducted by clinicians trained in the Project LAST Intervention (Salloum, 2006).

The Project LAST Intervention is unique because it was developed in New Orleans by a clinician familiar with the population (Salloum, 2006). The program was piloted in New Orleans both before and after Hurricane Katrina. It has been modified to meet the specific cultural and emotional needs of the post-Katrina New Orleans population. However, it was originally developed and continues to be a model intervention for children and families who experienced other types of traumas unrelated to Hurricane Katrina.

According to Salloum (2006), the three main goals of the Project LAST Intervention are to help the child: (1) learn more about grief and traumatic reactions through psychoeducation; (2) express his or her thoughts and feelings about the event that brought the child to the intervention, for example, through the creation of a coherent narrative; and (3) reduce traumatic reactions, as measured by the *UCLA PTSD Index for DSM-IV* (Pynoos et al., 1998). In the group intervention model, children attend 10 sessions, including a closing session in which children celebrate the work that they have completed. The

individual intervention model is also based on a 10-session schedule but can be modified to fit the needs of the child.

The Project LAST Intervention is to be used under the general framework of an ecological perspective (Salloum, 2006). This framework is preserved by maintaining an awareness of each child's environment and individual cultural practices. The Project LAST Intervention was created using theories of cognitive-behavioral therapy and narrative therapy. Some of the intervention's elements are based in cognitive-behavioral theory. These include imaginative exposure; creating a coherent narrative through the creation of My Story (described below); making connections among thoughts, feelings, and behaviors; relaxation exercise; and the use of psychoeducation (Salloum, 2006).

The use of cognitive-behavioral strategies is reflected in the intervention's focus on anger management. In several of the sessions, children are asked to list their physical anger signs (e.g., racing heart, flushed face) so that they can recognize their body's reaction to anger. Therapists then ask children to identify the feelings, thoughts, and behaviors that are associated with their physical anger signs. The process is intended to enable the child to understand how all four (body reactions, feelings, thoughts, and behaviors) are connected. Children are also taught relaxation strategies, both physical and thought-based (e.g., children tell themselves they are relaxed), so that they can use these strategies when they become aware of their physical anger signs. These strategies are reinforced during each session, and children are encouraged to practice on their own (Salloum, 2006).

Some of the narrative therapy strategies used in the Project LAST Intervention include: telling of the trauma story with the focus on the meaning to the child; telling of stories with rich descriptions; exploring alternative stories and unique outcomes; retelling of the story with a different outlook; recognizing that the problem did not occur within the child but rather is external; highlighting the child's strengths; using the child's language; and working collaboratively (Salloum, 2006). One crucial element of the narrative therapy strategy is that each child creates My Story, a compilation of the work that he or she does throughout the intervention. During each session, children complete worksheets related to different aspects of their experienced trauma (or traumas). The worksheet activities are done in three parts: drawing; explaining the drawing to the clinician; and writing about the drawing. The last of these can be done either by the child or the clinician. Finally, the child is encouraged to share the drawing or written story with an outside witness, usually a parent or other caring adult, to include the witness in the process of the intervention and to increase support. At the completion of the intervention, all of the drawings and written stories that the child completed throughout the sessions are compiled into the personal My Story narrative (Salloum, 2006).

Other unique aspects of the Project LAST Intervention include the use of cofacilitators in the group intervention; strong parent involvement, including frequent meetings with clinicians and involvement in their child's My Story narrative; a focus on clinicians' self-care and awareness of vicarious traumatization; and the fact that the intervention has been effective both in the group and individual setting (Salloum, 2006). Two pilot tests with random assignment have been performed on this intervention. In both tests, the intervention was shown to be effective in reducing PTSD and depressive symptoms in the child (Salloum, 2006). The most recent pilot test was performed with 56 children who were experiencing grief, loss, and moderate symptoms of posttraumatic stress. Children's experiences were due to Hurricane Katrina or to the death of someone close to them. The pilot intervention was conducted between January and May 2006 in New Orleans schools. Children ranged in age from 7 to 12 years old, and the majority (90 percent) were African American (Salloum, 2006).

Using a quasi-experimental design, a pilot test was performed on the Project LAST Intervention between 1997 and 2001. The sample includes 102 children who participated in the school-based form of the group intervention. The quasi-experimental design was employed using secondary data analysis from participant case records and the child posttraumatic stress reaction index (Nader, 1996) was used to measure posttraumatic stress (Salloum, 2006).

Results of the pilot test show that there was a statistically significant decrease in mean posttraumatic stress scores over time (Salloum, 2006). There was also a statistically significant decrease in mean depression scores over time. The results suggest that the Project LAST Intervention helped to decrease the PTSD and depression symptoms in the children who participated. This intervention continues to be used in New Orleans with child survivors of Hurricane Katrina in a culturally sensitive manner by clinicians who know the population well. The intervention can be used with children and families in future disasters. It is also being used with children and families who have experienced other traumas unrelated to disasters (Salloum, 2006).

CONCLUSION

Hurricane Katrina brought to light the crucial need to invest in research on the psychological effects of disasters on survivors and specifically on children. It prompts researchers to identify the ways that social workers can address the effects of disasters on children through practice and policy. Although research interest has increased in recent years, many gaps remain. There are a few reasons for this, including lack of funding and difficulties in deploying research teams to communities that have been affected by a disaster (La Greca et al., 2002).

In order to ensure that the psychological needs of children are met following a disaster, several improvements need to be made. First, there is a need for increased funding for research on the psychological effects of disasters on children. Research should also be expanded to include long-term studies on the effects of disasters, as current research tends to focus on a short period of time following a disaster. Long-term research is especially important for children who have experienced multiple traumas. Second, more research is needed on protective factors for child survivors of a disaster. Current research tends to focus on the factors that make children more vulnerable to the negative psychological effects of disasters. Although this focus is crucial (and central to this article), it is also critical to understand why certain children fare better than others after a disaster.

Third, there needs to be further exploration of posttraumatic growth in children who have experienced a trauma. Although there is a growing research interest in posttraumatic growth (i.e., positive change as a result of a trauma) among adults, research has largely ignored such growth among children. Understanding protective factors and the dynamics of posttraumatic growth in children may increase social workers' ability to facilitate such growth among vulnerable children.

Finally, social workers should use interventions, such as the one developed by Project LAST, that employ culturally sensitive practice to enable children to create a narrative of the traumas they have experienced. The Project LAST Intervention has helped New Orleans children who experienced multiple traumas to develop coping strategies that they can use throughout their lives.

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NOTES

[1] In order to preserve the confidentiality of subjects in this study, this article does not disclose the names of the agency and clients or the specific interview dates.

[2] The Incorporated city limits of New Orleans are the same as the boundaries of Orleans Parish.

[3] It should be noted, however, that not all children who survive a disaster are necessarily traumatized. This idea will be explored later in the article.

ABOUT THE AUTHOR

CHRISSIE JAMES is a third-year joint degree student at the School of Social Service Administration and the Harris School of Public Policy Studies. Prior to coming to SSA, she worked for a nonprofit organization serving low-income children and families in New Orleans, LA, and for the U.S. Department of Justice in Washington, DC. For her second year field placement with SSA, Chrissie returned to New Orleans to do therapy with child and family survivors of Hurricane Katrina. She is eternally grateful for her experience there, both to the families with whom she worked and to the agency that supported her internship.

Practice Prohibitions in Religious Child Welfare Agencies: The Case of Lesbian and Gay Adoption

By Stephen E. McMillin

On March 10, 2006, Catholic Charities of the Archdiocese of Boston announced that it would cease all adoption work following orders from the Vatican ambassador to stop allowing children to be adopted by lesbian and gay parents. This article reviews the current legal and social policy environment in the area of adoption to lesbian and gay parents. It also examines research on gay parenting, devoting particular attention to some of the work that opposes allowing gays and lesbians to adopt. The article makes recommendations for related aspects of policy and practice.

On March 10, 2006, Catholic Charities of the Archdiocese of Boston announced that it would cease all adoption work following orders from the Vatican nuncio (ambassador) to stop allowing children to be adopted by lesbian and gay parents.[1] Discrimination on the basis of sexual orientation has been illegal in Massachusetts since 1989 (Mass. Gen. Laws Ann. chap. 151B, secs. 3–4 [2007]), and since that time, Catholic Charities had complied with the law, adopting 13 of 720 children to gay parents (Colbert, 2006). At present, Catholic Charities of Boston has transitioned adoption services to the Massachusetts state department of children and families. On the level of federal law, the question of whether the First Amendment protects a right to privacy for gay adoption is complicated by the fact that Catholic Charities of Boston also claims a First Amendment right to exercise religious freedom by discriminating against gays.

Catholic Charities organizations in such communities as San Francisco have announced intentions to reconsider their adoption practice with gays in

light of the Boston experience (Buchanan, 2006). Because Catholic Charities plays a substantial role in many public adoption programs throughout the United States, problems of significant scope and severity will follow the implementation of new practice prohibitions that impede the work of adoption professionals in religious child welfare agencies. This article reviews recent legal and policy activity in the area of adoption by gays. It also examines clinical research on gay parenting and recent journal articles that call the findings of available research into question. The article concludes by presenting recommendations for advocacy, practice, and future research in the area of gay adoption.

THE LAW, SOCIAL POLICY, AND GAY ADOPTION

In the absence of antidiscrimination laws that directly protect prospective lesbian and gay adopters, discrimination against them is generally legal. On January 11, 2005, the U.S. Supreme Court denied certiorari in the case of *Lofton v. Secretary, Florida Department of Children and Families* (543 U.S. 1081), the most recent challenge to Florida's law against gay adoption.[2] Recent Supreme Court decisions that upheld privacy rights for gay couples have not yet had a direct impact on the issue of gay adoption.[3] As Alison Smith (2003) notes, the *Lofton* case unsuccessfully argued that a ban on gay adoption violated First Amendment rights of intimate association and privacy, as well as Fourteenth Amendment rights to due process and equal protection. The *Lofton* decision also held that as there is no fundamental right to adopt, to be adopted, or to apply for adoption (*Lofton v. Secretary, Florida Department of Children and Families* 358 F.3d 804 [11th Cir. 2004]). Gay adopters therefore cannot be deprived of due process if they have no fundamental right to what is denied them.

There are also difficulties in applying equal protection arguments to lesbian and gay adoption. In *Romer v. Evans* (517 U.S. 620 [1996]), the High Court ruled that homosexuals do not constitute either a "suspect" or "quasi-suspect" class and thus are not especially vulnerable to discrimination. Although individual gays have a right to equal protection, the courts have not yet recognized them as a class or group for purposes of reviewing equal protection. Courts have held that such a categorized class must have a history of experiencing discrimination, have characteristics that make them identifiable as a discrete group, and be either politically powerless or at risk for violations of fundamental rights (Massaro, 1996).

Laws that affect a suspect class are held to strict scrutiny and must be narrowly tailored to achieve a compelling state interest (Harvard Law Review, 1985). The law also provides protections for members of quasi-suspect classes. Quasi-suspect classes are groups of individuals, such as women and illegitimate

children, who have long experienced violations of rights. Laws affecting quasi-suspect classes are held to heightened scrutiny and must be considerably related to an important state interest (Harvard Law Review, 1985). All other laws are merely subject to the rational basis test, the principle that the law in question achieves a legitimate state interest. Different classes and groups that hope to achieve judicial recognition as classes typically seek to claim the strictest standard (suspect class) or to demonstrate that the state has no legitimate interest in restricting the group involved. In the *Lofton* case, the Eleventh Circuit Court interpreted an earlier decision (*Lawrence v. Texas*, 539 U.S. 558 [2003]) as merely prohibiting criminalization of homosexual conduct; the court held that it did not create a fundamental right to sexual privacy. Under this ruling, the *Lofton* case was thus subject to the rational basis test because the plaintiff could not be considered a member of a suspect or quasi-suspect class, and the court concluded that it was rational for Florida to forbid gay adoption due to concerns about gender roles and social stigma (*Lofton v. Secretary of the Department of Children and Family Services*, 377 F.3d 1275 [11th Cir. 2005]). As Nicole Shkedi (2005) notes, even under a rational basis test, these concerns are subject to a great deal of challenge and disagreement.

Since the late 1970s, research on gay parenting has revealed few significant differences between heterosexual and homosexual parents, and no parenting or child outcome deficits are associated with parenting by gays. Some of this work investigates social work's role in adoption by gays. A review of literature elucidates ongoing discrimination and may assist child welfare workers in formulating a response to religiously motivated adoption practice prohibitions.

RESEARCH ON GAY PARENTING

During the so-called Gayby Boom of the 1980s, gay and lesbian childrearing gained a high cultural profile. This development prompted research to consider the social phenomenon of gay families. In 1987, the National Association of Social Workers recommended that gays be recruited as both foster and adoptive parents. By the end of the decade, Sharon Huggins (1989) found in a comparative study that daughters of lesbians had generally high self-esteem, and their self-esteem was increased when their mothers had live-in lesbian partners. James Rosenthal and Victor Groze (1992) soon recommended that adoption agencies explicitly market special needs adoptions to gays, arguing that the gay community has "well-developed resources and organization capability" (1992, p. 207). Rosenthal and Groze especially noted the gay community's successful track record in organizing to deal with the AIDS epidemic.

Throughout the 1990s, research failed to find evidence that children raised by gays had personal, social, or sexual adjustment outcomes that differed from their counterparts in heterosexual households (Golombok and Tasker, 1994). A longitudinal study by Susan Golombok and Fiona Tasker (1994) tracks these children in gay adoptive families from infancy, comparing them to those of heterosexual and single parents. Golombok and Tasker find no significant differences that could be attributed to family structure. Children from gay families are no more likely to exhibit symptoms of depression or to utilize psychotherapeutic treatment. Although they are somewhat more likely to have considered the possibility of having a homosexual orientation, they are not significantly more likely to define themselves as gay when questioned by researchers (Golombek, Tasker, and Murray, 1997). Another study considers children who were born to both lesbians and heterosexual women as a result of donor insemination. It measures children's psychosocial adjustment from birth, finding that neither parental sexual orientation nor family structure influences adjustment (Chan, Raboy, and Patterson, 2000). Identified variables that did affect children's psychosocial development include parenting stress, parental conflict, and partner relationship dissatisfaction. These variables clearly could affect families regardless of parents' sexual orientation.

Ongoing research continues to investigate aspects of family life that improve outcomes across parental sexual orientations, as well as areas in which gay parents could have an advantage in meeting adopted children's best interests. Ruth McRoy (1999) notes that many gays adopted special-needs children who otherwise might have been considered unadoptable. McRoy (1999) surveys disrupted special-needs adoptions and notes that parent factors related to disruption include financial problems, abusive behavior, marital problems, and poor parenting skills. Examples of parental skill deficits include inability to cope with the challenges of raising children who were sexually abused or who sexually act out. McRoy (1999) reports that some parents in her sample held religious beliefs that the acting-out behavior was sinful. Some also are reported to believe that psychotherapy and psychotropic medication for the children were also problematic for religious reasons.

Morag Owen (1999) notes that some children's individual therapeutic needs may make it desirable to target or select the gender of the adoptive parents. It may be in the best interest of sexual abuse victims to have a parent or parents of the opposite sex of the abuser. In such cases, adoptions by single parents of either sexual orientation or gay couples would have advantages in achieving recommended family structures that traditional married couple adoptions do not. Owen (1999) also suggests that the needs of some adopted children are best met if all of the children in the family have the same adopted status and none

are the biological children of the parents. Membership in an intentionally and visibly diverse created family may better meet some children's needs. Gay adoptions clearly have an advantage here over heterosexual married couples, who may have later biological children and thereby change the recommended family structure.

In the *Lofton* case, judges used the fear of stigmatization and bullying of children of gay parents as a rationale to refuse to allow adoptions by gays. Vignette studies in which a hypothetical problem is presented as affecting diverse individuals are often an effective way of detecting bias against certain types of individuals if the individual is described by study subjects as having a worse problem than the one actually assigned in the vignette. Beverly King and Kathryn Black (1999) use vignette studies to show that this perceptual stigmatization of children of gay parents can be a function of unconscious bias; in vignettes of children with the same presenting problems, children of gay parents were perceived to have more severe issues even though the same presenting problem was assigned to children of heterosexual parents in otherwise identical vignettes. This raises a question of whether the belief that children of gay parents face stigmatization may itself indicate ongoing stigmatization of gay families.

Findings from the Toronto Lesbian Family Study (Dundas and Kaufman, 2000) suggest that children of gay parents may not experience stigma at all. The findings also suggest that parents' perceptions of stigma and homophobia may be positively correlated with being closeted and negatively associated with the extent to which the parent's gay identity is public (Dundas and Kaufman, 2000). In tracking stressors unique to gay families, Charlotte Patterson (2000) finds that these stressors include disputes over how public a family's gay identity should be; she points out that such stress may be related to the fact that American laws generally do not protect gay members from discrimination on the basis of sexual orientation.

Kyle Weir (2003) notes that homosexual adoptions almost automatically face social disclosure of adoptive status; it is generally obvious that both members of a same-sex parenting dyad are not biologically related to all of their children. He also notes that gay parents may face other negative social perceptions that make it very difficult to create a control group for analysis. In most social situations, it can be almost impossible to ascertain whether negative social perception is due to the sexual orientation of the parent or parents, public adoptive status of the family, or marital status and perceived legitimacy of the family unit. Families created through adoption and foster care may be subject to unique forms of social scrutiny that are unrelated to the sexual orientation of the parents.

Judith Stacey and Timothy Biblarz (2001) suggest that social science research must avoid an excessively negative perspective that searches for potential deficits in gay parenting and focuses on benchmarking clinical indicators for the children involved. They instead favor a genuinely pluralistic approach that examines differences between heterosexual and homosexual parents with confidence in the repeatedly documented, demonstrated benefits of family diversity. They note that research investigating genuine differences between heterosexual and homosexual parenting of families can be comparative without being competitive or focused on declaring one better than the other. Their review of 21 studies of gay parenting and child outcomes suggests that gay parenting may free children "from a broad but uneven range of gender prescriptions" (Stacey and Biblarz, 2001, pp. 168–70), which might be desirable outcomes worthy of further study.

OPPOSITION TO GAY ADOPTION

Very little research questions that gays can be effective adoptive parents. Paul Cameron and Kirk Cameron (1996) suggest that a contagion theory of sexual orientation, in which contact with homosexuals is believed to cause homosexuality, is the traditional psychological opinion and common sense position for researchers. This study examined self-reports of homosexuality culled from large random samples. Cameron and Cameron (1996) note that 5 of 17 respondents who reported being raised by homosexual parents also reported having sexual relations with their parents.

In another study, Paul Cameron (2003b) seeks to review "molestations by homosexual foster parents," but uses a sample based on newspaper records and combines several distinct populations of persons who molested both boys and girls into one category. Cameron counted child molesters of both boys and girls as homosexual, so that a man who molested more girls than boys would still be counted as a homosexual molester. Cameron (2003b) also counts married heterosexual couples as homosexuals if both spouses molested the same child; the spouse who molested the same-sex child would be counted as a homosexual in this study. In the 33 news articles Cameron reviewed, only 24 of the reported cases involved actual sexual abuse. Cameron (2003b, 797) notes only one case involving an "openly homosexual" perpetrator. Cameron assigned sexual orientation in all other cases because he thought that the subject's "sexual preference could be determined based on the sex of the child molested" (2003b, p. 799). If a perpetrator molested children of both sexes, Cameron classified that individual as homosexual.

In a later article, Cameron (2005a) defends his use of the term "homosexual" instead of "pedophile" by noting that the Centers for Disease Control's 1996

national sexuality survey used the term "homosexual" without regard for the age of sexual partner. This defense does not explain why Cameron uses "homosexual" to describe child abusers who molest both boys and girls. Cameron suggests that the term pedophile "is not particularly useful" (2005a, p. 228) and should be applied only to those who engage in sexual contact exclusively with children or are who incapable of any other sexual contact. In fact, pedophilia is diagnostically considered a broader category that includes individuals over age 16 "who have a pedophilic arousal pattern and act on these fantasies or urges with a child" (American Psychiatric Association, 2000, p. 571).

The same study examines child abuse records from the Illinois Department of Children and Family Services for the period between 1997 and 2002 (Cameron 2005a). Cameron finds that 1 percent of foster children were sexually abused by a foster parent; he describes approximately one-third of those cases as homosexual. Cameron points out that this estimated proportion is much higher than the estimated proportion (1–3 percent) of homosexuals in the general population (2005a, p. 229). Defining "pedophile" in the way that Cameron does, as someone exclusively attracted to children or incapable of any other form of sexual contact, leaves out the majority of actual child molesters. If Cameron's (2005a) categorization is used, child molesters among Illinois foster parents are twice as likely to be heterosexual as they are to be homosexual. In contrast to Cameron's (2005a) work, a study by Devon Brooks and Sheryl Goldberg (2001) provides a comprehensive review of the literature from the 1960s to the 1990s, examining the lack of correlation between homosexuality and child molestation. They note that the vast majority of child molesters are adult males seeking juvenile females. In a 2005 interview, Cameron reiterated his view that those who commit same-sex child abuse are homosexual, regardless of whether they self-identify as homosexual (Bialik, 2005).

A recent article by Walter Schumm asserts that decreased rates of homosexual orientation and questioning among children of homosexuals is a "socially valuable outcome" (Schumm, 2004, p. 423). In a response to Schumm (2004), Martha Kirkpatrick (2004) questions why this would be so, noting that sexual experimentation has not succeeded historically in converting homosexuals to heterosexuality and conversion is unlikely to move orientation in the opposite direction. Kirkpatrick (2004) also references an earlier study of lesbian mothers (Kirkpatrick, Smith, and Roy, 1981), noting that she expected to find associations between lesbian parenting and negative outcomes but that such expectations were never supported by the findings. Paul Cameron later responded by asserting that Kirkpatrick's initial negative expectations

were actually "the 'collective common sense' that has informed society over the course of history" (2005b, p. 400).

Opponents of gay adoption seem to rely on a vague and erroneous definition of homosexuality that includes many who would otherwise self-assess and be identified by others as heterosexuals. This definition inevitably results in an overcount of homosexuals, assigning orientation to subjects without interviewing them about their own sexual orientations. The assertion of vague common sense and social value arguments about homosexuality simply cloud the issue without clarifying how generalizations about homosexuality can be drawn from people who may not be homosexual at all.

DISCUSSION

Religiously motivated practice prohibitions on gay adoption raise several concerns for child welfare agencies and workers. Culturally competent social work practice easily recognizes gays as a minority culture without the need of meeting suspect or quasi-suspect judicial classifications. Competent child welfare workers trained in adoption matching will assess potential parents and adoptees but will not categorically rule out any group of prospective parents on such grounds as sexual orientation. Although courts have not yet affirmed a fundamental right to be adopted, child welfare practice naturally focuses on a child's rights to permanency and to connection with at least one caring adult. Highly motivated gay adopters can easily be helpful to children with special needs, as Catholic Charities of Boston itself (Wen, 2005) has conceded. All 13 of the gay adoptions completed by this agency were placements of foster children with special needs.

In reviewing assertions of religious freedom, the U.S. Supreme Court has ruled that neither religious sponsorship nor church ownership exempts agencies from otherwise general laws (*Employment Division v. Smith*, 494 U.S. 872 [1990]). Furthermore, a legal prescription that requires an agency to provide a specific service is significantly and obviously different from a legal proscription that forbids an agency to discriminate against a certain subgroup or class. Antidiscrimination laws are specifically intended to be general laws; it is obvious that antidiscrimination laws would be powerless if those agencies most likely to engage in discriminatory practice were exempted from them. In the many states where antigay discrimination remains legal, social work professional ethics forbidding unjust discrimination are not suspended, and social workers engaging in even legal discrimination would still be guilty of a gross ethical violation. Adoption practitioners should consider their professional ethical principles and training when they encounter organizational discrimination against gays.

Justice and equity are especially important in the area of gay adoption, both for the parents and for the children involved. The depiction of justice as blind presumes that justice acts equitably without preferring or sanctioning one group over another. Agencies that offer services to the public are therefore obligated by justice and equity to offer services to the public as it truly is, without preferring or sanctioning a specific group within the general population.

Currently, all 50 states recognize the best interests of the child as the standard for child custody determinations (Artis, 2004). The children involved are often dependent on adoptive parents to meet their needs. If agencies reduce the pool of potential adopters by discriminating against whole categories of potential parents, the organizations injure the children in their care by reducing the opportunities for those children to be adopted.

Perhaps it would be helpful to draw a distinction between legal prescriptions and the proscriptions to which agencies might be subject. Legal prescriptions require agencies to provide a particular service. Legal proscriptions prohibit agencies from undertaking a specific activity or offering a particular service. Massachusetts antidiscrimination law (Mass. Gen. Laws Ann. chap. 151B, secs. 3–4 [2007]) does not burden Catholic Charities with a prescription requiring the agency to provide new services; it merely proscribes Catholic Charities from discriminating in offering the services it freely chooses to offer.

Barbara Melosh (2002) notes that although many more agencies are welcoming gays as prospective parents, adoption in the United States is reverting to a pre-World War II market model. Adopters with means increasingly choose to avoid adoption agencies with "long waits and discouraging prospects" (p. 288) in favor of private and international adoptions. Traditional adoption agencies largely serve only special-needs children and already face a significant shortfall of prospective parents for this population.

RECOMMENDATIONS

As shifting events in Massachusetts suggest, adoption practitioners facing the dilemma of practice prohibitions by discriminatory religious child welfare agencies should remain informed about the legal, policy, and clinical issues. Such preparation will help them to advocate on behalf of clients facing this discrimination. Social workers may face an unfamiliar challenge in developing the legal and policy competencies necessary to confront the illogical and inequitable environment that confronts gay adopters.

Adoption practitioners should remember that discrimination against gay adopters is generally legal unless state antidiscrimination laws provide direct protection. As the Romer decision shows, federal law does not protect gays from discrimination based on sexual orientation. The Court refused to grant such protection, asserting that gays have not faced a history of discrimination and thus are not entitled to recognition as a suspect class. Moreover, gays face additional discrimination because of their decision to adopt. As Timothy Lin (1999) points out, gays historically have been excluded even by other excluded groups. One might also suggest that it is a legal fiction to imply that gays do not face regular violations of their fundamental rights; it would seem that just such a fiction keeps them, as a class, in an intentional legal limbo.

In terms of social policy, adoption practitioners should note that no adoption agency can regulate the lives of adoptive parents after the process is legally complete. The concept of an ideal family structure can be illusory. Some married heterosexual couples that adopt children also go through divorces and separations. Some adoptive heterosexual parents who are single and divorced will date and cohabit with partners who have enormous influence in the lives of the adopted children. Even outlawing adoption by single heterosexuals would do nothing to prevent married heterosexual adopters from divorcing. Agencies should evaluate the quality of adoption applicants according to nonsectarian principles that allow for the possibility of divorce and separation and do not stigmatize or sanction families shaped by these realities. As Paula Pfeffer (2002) notes, Catholic Charities' adoption organizations have submitted to nonsectarian oversight since the early 1930s. In Boston, Catholic Charities followed the antidiscrimination law for almost 20 years; the shift came only after the appointment of a new Vatican ambassador (Colbert, 2006). Policy changes at the Vatican should not be allowed to interfere with U.S. social policy. If Catholic Charities and other religious child welfare agencies are no longer able to follow longstanding antidiscrimination laws, it is likely better for both the agencies and the general public that the agencies cease performing adoption work.

In examining the reality of gay adoption, adoption practitioners should remember the recommendation by Stacey and Biblarz (2001) to avoid an excessively defensive stance. Study after study confirms that children of gay parents experience no special deficits or negative outcomes (Huggins, 1989; Golombok and Tasker, 1994; Chan et al., 2000; Brooks and Goldberg, 2001). Clinical research should focus on exploring the positive benefits and outcomes of the new family forms and relationships that are becoming increasingly common.

Studies that are methodologically flawed and critical of gay parenting, especially those that designate child molesters of both boys and girls as homosexuals and those that fail to study noncloseted gays, are unconvincing at best. These efforts demonstrate the vital importance of objective, empirical and evidence-based research on gay parenting and adoption practice. Future research will increasingly center on gays who have never known the closet, and today, many new adoption practitioners themselves are younger than the first encouraging studies of gay parenting from the late 1970s and early 1980s.

Adoption professionals should continue to be vigilant in guarding against the spread of ideology in child welfare agencies. Proactive steps, such as union organizing, civil and human rights training, whistleblowing, and watchdog activity, may be helpful in securing the protection that adoption practitioners need to do their work with the ethics and professionalism it requires. As Rita Simon and Howard Altstein (2000, p. 147) note, "Social work was, at its birth, an 'unconventional' profession that many times supported unpopular causes. Social workers took these positions because in their estimation they were correct." Research suggests that the best interests of some children are served in their adoption by gays, but such adoptions are sometimes met with fierce opposition. The faithful track record of social workers provides reassurance that religious ideology will not succeed in trumping the best interests of these children. Social workers and child welfare practitioners working in the area of adoption face enormous challenges in day-to-day practice. They do not need and should not bear the incredible burden of being asked by their employers and colleagues to discriminate and violate their professional ethics.

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NOTES

[1]In this article, for the sake of brevity "gay" is used to refer to both lesbian women and gay men.

[2]Lofton v. Secretary of the Department of Children and Family Services, 93 F. Supp. 2d. 1343 (S.D. Fla. 2000); 157 F. Supp. 2d 1372 (S.D. Fla. 2001), aff'd., 358 F.3d 804 (11th Cir. 2004), reh'g en banc denied, 377 F.3d 1275 (11th Cir. 2005), cert. denied, 543 U.S. 1081 (2005).

[3]For a recent High Court decision, see Lawrence v. Texas, (539 U.S. 558 [2003]), in which the Court held that private homosexual conduct is protected under the Fourteenth Amendment and cannot be criminalized.

ABOUT THE AUTHOR

STEPHEN E. MCMILLIN is a graduate student at the School of Social Service Administration. He holds a master's degree in public policy and administration from Northwestern University. His research interests include adoption, foster care, and non-traditional parenting.

Transitional Jobs: Overcoming Barriers to Employment

By Abigail Coppock

Despite declining rates of U.S. unemployment, employment remains difficult for subsets of the American population, particularly among current and former welfare recipients, people with criminal records, and youth. Although past policy has tried to help these individuals into the labor market, largely through various programs addressing supply-side factors, barriers to employment still persist. The transitional jobs strategy is an effective solution that works with employers on the supply and demand sides to bridge the gap and transition individuals into the labor market.

Despite declining rates of U.S. unemployment (Sok, 2006), employment remains difficult for subsets of the American population, particularly for current and former recipients of Temporary Assistance for Needy Families (TANF), individuals with criminal histories, and youth (Lower-Basch, 2000; Holzer et al., 2003; U.S. Census Bureau, 2006). In the United States, hundreds of thousands of people are unemployed due to a variety of barriers that prevent them from finding and keeping a job (Bouman and Antolin, 2006). One approach that addresses specific barriers to employment for these populations is transitional jobs (TJ). This study examines the barriers to employment for these populations and whether the TJ strategy is an effective solution.

Unemployment rates for current and former TANF recipients, individuals with criminal histories, and youth are well above that of the general population (Lower-Basch, 2000; Holzer et al., 2003; U.S. Census Bureau, 2006). Welfare reform reduced the numbers of TANF recipients, but unemployment rates remain high among current and former TANF recipients (Lower-Basch, 2000; Zedlewski, 2003). One study finds that unemployment rates among former

Illinois TANF recipients range from 48 to 62 percent, depending on location (Lower-Basch, 2000). The requirements of TANF recently intensified with passage of the Deficit Reduction Act of 2006 (DRA; U.S. Public Law 109-171), which increased work requirements and limited the number of activities that fulfill work requirements. Strict work requirements and time limits have forced many TANF recipients to look for jobs and participate in work activities, even if they are unable to obtain or keep a job (Bartik, 2001; Baider and Frank, 2006). Such requirements also erode the safety net of supportive services, which assist recipients in making successful transitions to work (Ewen, Lower-Basch, and Turetsky, 2007).

Individuals reentering communities from incarceration also face significantly higher unemployment rates than those faced by the general population (Holzer, 1996). Over 670,000 people were released from state prisons in 2004 (Harrison and Beck, 2006). According to Harry Holzer and associates (2003, p. 2), "Among the most challenging situations they face is that of reentry into the labor market." Data on the employment status of this population is limited, but researchers such as Richard Freeman (1992) use the 1979 cohort of the National Longitudinal Survey of Youth (NLSY) to estimate that employment rates averaged around 60 percent during the 1980s for all men who had previously been incarcerated (Freeman 1992; Holzer et al., 2003). These estimates are approximately 20–25 percentage points lower than those for men in the general NLSY data (Holzer et al., 2003). Research clearly documents the link between employment and reduced recidivism (Hirsch et al., 2002; Holzer et al. 2003; Kachnowski, 2005). It also establishes that the majority of individuals being released are hopeful that they will obtain employment (Kachnowski, 2005), but unemployment for individuals with criminal histories continues to be high (Holzer et al., 2003).

The youth population is another segment of society with increasingly high unemployment rates. Using data from the U.S. Bureau of Labor Statistics, the Association of Career and Technical Education (ACTE) reports that "the employment level for teens is at its lowest in 57 years" (ACTE, 2005). The unemployment rate for youth ages 18 to 24 who are actively looking for work is three times that for the adult population (6.1 percent versus 2.6 percent; U.S. Census Bureau, 2006). According to Andrew Sum (2003), rising youth unemployment is significant because of the link between early experience in paid work and future labor market success. This link is particularly important for youth who do not enroll in college (Sum, 2003). Many youth need work to meet their economic needs and those of their family (Sum, 2003). Youth who work are less likely to become teen parents

and use illegal drugs (Bouman and Antolin, 2006). They are more likely to graduate from high school, and their academic performance is better than that of those who do not work (ACTE, 2005). Due to their specific needs (e.g., lack of prior work experience and few workplace connections), youth often need extra support finding and maintaining jobs (Bouman and Antolin, 2006). This is particularly true of youth from low-income communities.

Multiple and compounding barriers impede the successful employment of current and former welfare recipients, reentry populations, and youth (Zedlewski, 1999; Hirsch et al., 2002; Wald and Martinez, 2003). These barriers exist on both the supply and the demand sides of the labor market (Bartik, 2001; Holzer et al., 2003).

SUPPLY-SIDE BARRIERS LIMIT READINESS TO EMPLOYMENT

Supply-side barriers are impediments that affect the quality and the supply of labor. The supply side of labor includes everything that individuals bring to prospective employers (e.g. strengths, weaknesses, and personal circumstances; Holzer et al., 2003). Supply-side employment barriers for welfare recipients, individuals with criminal histories, and youth often include lack of work experience, lack of education, lack of skills, lack of transportation, lack of available child care, limited English proficiency, substance abuse, and physical and mental health needs (Freeman, 1992; Fleischer, 2001; Burchfield and Yatsko, 2002; Derr, Pavetti, and Ramani, 2002; Hirsch et al., 2002; Kirby et al., 2002; Holzer et al., 2003; Norris and Speiglman, 2003; Wald and Martinez, 2003; Pavetti and Kauff, 2006).

Supply-side barriers limit welfare recipients' ability to obtain employment. A study of data from the 2002 National Survey of America's Families (NSAF) identifies six variables that expose significant obstacles for welfare recipients (Zedlewski, 2003). These variables include low education level (defined as less than a high school degree), no recent work experience (defined as no work within the 3 years prior to the survey), caring for an infant, caring for a child on Supplemental Security Income (SSI), a Spanish-language interview (which is used as a proxy for lack of English language proficiency), and indicators that the individual has poor mental health or physical health problems that limit work (Zedlewski, 2003). One study of TANF recipients in Minnesota finds that 34 percent of recipients nearing the 5-year time limit for receipt of welfare benefits were identified as having low levels of cognitive functioning, and 65 percent of recipients in the study were granted extensions on their TANF grant due to extenuating physical or mental needs (Pavetti and Kauff, 2006). Another study identifies low education levels and lack of work skills as the

most significant factors keeping TANF recipients from work (Norris and Speiglman, 2003). Research indicates that as the number of barriers to employment increases, the likelihood of working decreases (Norris and Speiglman, 2003). A study by Sheila Zedlewski (2003) reports that 51 percent of welfare recipients with no barriers to employment are working; by contrast, only 14 percent of recipients with two or more barriers are working (Zedlewski, 2003). Long-term recipients of TANF (i.e., those receiving for over 2 years) and those who cycle on and off reported multiple barriers to employment (Zedlewski, 2003). Since many of these barriers still exist for individuals after they stop receiving TANF (Lower-Basch, 2000), addressing barriers to employment is an important consideration for any employment program that works with current or former TANF recipients.

Similarly, supply-side barriers limit the employment ability of individuals with criminal histories. Research shows that time spent in incarceration depreciates an individual's work skills, prevents work experience, and severs interpersonal and employer contacts (Western, Kling, and Weiman, 2001). After release, individuals commonly face drug and alcohol use, posttraumatic stress disorder, and lack of housing (Kachnowski, 2005). All of these can lead to general life instability, which affects employment. It is estimated that 75 percent of people with criminal histories have substance abuse problems, 70 percent have not graduated from high school (Freeman, 1992; Travis, Solomon, and Waul, 2001), and about half are functionally illiterate (Hirsch et al., 2002). The family and community support systems available to newly released individuals are only minimal (Center for Employment Opportunities, 2006). These characteristics pose barriers to employment.

Supply-side barriers also restrict the employment prospects of youth. Researchers repeatedly note the link between obtaining a high school education and the likelihood of future employment (Sum, 2003; Wald and Martinez, 2003; Edelman, Holzer, and Offner, 2006). Christopher Swanson (2004) reports that the national graduation rate for the United States in 2001 was only 68 percent; nearly one-third of all public high school students failed to graduate. Graduation rates for students who attend school in high poverty, racially segregated, and urban school districts lag 15 to 18 percent behind those of their peers in other districts (Swanson, 2004). Research also indicates that youth are likely to be disconnected from school or employment if they have limited formal schooling, untreated mental illness, substance abuse, and other disabilities, a history of behavioral problems, experience with the juvenile justice or child welfare system, or grow up in high poverty neighborhoods (Wald and Martinez, 2003). These barriers prevent successful connection to the labor market (Wald and Martinez, 2003).

Supply-side barriers limit the stability and preparedness of future workers (Holzer et al., 2003); stability and preparedness are often labeled "job readiness" characteristics (Gibson, 2000, p. 29; Holzer et al., 2003, p. 5). Employment programs often include job readiness components, yet such programs often ignore issues stemming from employers' needs (Gibson, 2000). Employer concerns fall into the demand side of the labor market. Thus, employment programs should address both supply- and demand-side barriers to employment.

DEMAND-SIDE BARRIERS FURTHER REDUCE THE LIKELIHOOD OF EMPLOYMENT

Employment barriers on the demand side of the labor market are driven by employer hiring practices. One barrier to employment for welfare recipients, individuals with criminal histories, and youth is that their skills and experiences are seen by employers as being mismatched to the requirements of the jobs (Gibson, 2000; Holzer et al., 2003). As the U.S. economy becomes increasingly knowledge-based, industries will require employees to have better skills (U.S. General Accounting Office, 2004). In urban labor markets, 95 percent of unskilled jobs that do not require formal training or a college diploma still require a high school diploma, work experience, or other relevant skills (Holzer, 1996). Despite the need for employees with these qualifications, the short tenure of today's workers leaves many employers unwilling to spend large amounts of money for on-the-job training (U.S. General Accounting Office, 2004). As a result, employers expect employees to already possess a set of transferable baseline skills (e.g., verbal communication, problem-solving, and customer service skills) by the time they are hired (Fleischer, 2001; Holzer et al., 2003). A basic skill requirement thus poses a demand-side barrier to employment for individuals lacking those skills, regardless of whether the individual is able to actually perform the duties of the job.

Employers also expect their employees to possess baseline "soft skills" (Fleischer, 2001, p. 15). Soft skills include attributes like the willingness to work hard, habits like good attendance and dressing well, and abilities like conflict resolution (Bartik, 2001; Fleischer, 2001; American Society for Training and Development, 2003). According to employers, these skills are difficult to measure but are sometimes more important than job-specific skills, which are easier to teach (Gibson, 2000; Bartik, 2001; Fleischer, 2001; American Society for Training and Development, 2003). A 2001 study by the National Association of Manufacturers (as cited in American Society for Training and Development, 2003) finds that four out of five companies reported moderate to serious skill shortages among current employees and job

applicants. Employers indicated that their top problem in filling openings is the shortage of such "basic employability skills" as good attendance, punctuality, and work ethic (American Society for Training and Development, 2003, p. 9). Soft skills are usually learned through prior work experience (Bartik, 2001). If employers demand these skills from their employees, such unspoken expectations can become points of miscommunication and confusion for individuals who have limited work history (Bartik, 2001). Thus, these skills are barriers both to getting employed and to staying employed.

Racial discrimination by employers is another demand-side barrier to employment. Devah Pager (2003) conducted an audit study of roughly 200 employers in Milwaukee, WI. She sent out matched pairs of white and black males to apply for jobs, giving them credentials that were identical with respect to education and experience. She found that black men obtained approximately half as many job offers as white men (17 percent vs. 34 percent; Pager, 2003). This finding has serious implications for the employment prospects of welfare recipients and individuals with criminal histories, in particular, due to the high prevalence of minority representation in those populations. Nearly one-half of formerly incarcerated individuals are African American and nearly one-fifth are Latino or Asian (Holzer et al., 2003). Statistics from the U.S. Department of Health and Human Services (USDHHS, 1999) reveal that three out of five TANF recipients are minorities. Statistical discrimination occurs when racial stereotypes are attributed to individual job applicants and systematically affect hiring decisions (Holzer, 1996). Racial discrimination by employers is a demand-side barrier that needs to be recognized by employment programs working with minority populations (Holzer, 1996).

In addition to racial discrimination, employer bias against individuals with criminal records is another demand-side barrier to employment. Over 3,000 employers in large metropolitan areas were surveyed in 2001 (Holzer et al., 2003). Findings indicate that only 40 percent of employers report that they would consider filling their most recent job vacancy with a worker who had a criminal history, yet 90 percent were willing to consider employing a welfare recipient (Holzer et al., 2003). Although this study shows that employers have less bias towards welfare status than towards a criminal record, it nonetheless identifies a significant barrier for those with a criminal history. Pager's (2003) study of employer hiring practices also included pairs of black and white job applicants who listed a period of incarceration for a nonviolent drug sale on their job applications. In each racial combination (one white male, one black male), applicants with criminal records faired worse than those without criminal records (Pager, 2003). Black applicants with criminal histories received two-thirds fewer job offers than did white applicants with criminal

histories (5 percent vs. 14 percent; Pager, 2003). These studies indicate how race and criminal history can combine to act as a double-edged sword and to pose serious barriers to employment.

Barriers to employment on both the supply and demand sides of the labor market are often viewed by both social service agencies and employers as directly impinging upon an individual's ability for successful employment (Fleischer, 2001). According to Bouman and Antolin (2006), employment barriers are related to a variety of complex factors that are embedded within larger problems and issues. Strategies that rely on removing barriers prior to employment are "extremely difficult and involve exact guesswork about how various problems actually interfere with the ability to work and how best to cope with them" (Bouman and Antolin, 2006, p. 107). Although it is necessary to address the specific issues that function as barriers to employment, it is also necessary for employment strategies to start with the desired outcome of employment and to address any additional issues within a supportive employment context (Bouman and Antolin, 2006). Unfortunately, that has not been the traditional approach used to address employment barriers.

PREVIOUS EFFORTS

Past attempts to address unemployment among these populations largely focused on supply-side factors. According to Timothy Bartik (2001), programs offering job readiness classes, skills training, and work supports (e.g., transportation and child care vouchers) seek to increase employment by improving the quantity and quality of the labor supply. Supply-side approaches can be seen in TANF policies and prisoner reentry programs that place high priority on the training and job readiness services of workforce intermediaries like OneStop centers (Bartik, 2001). A supply-side approach is also evident in the Earned Income Tax Credit (EITC), which seeks to entice workers into the labor force (Bartik, 2001). Supply-side solutions, however, can only go so far.

Supply-side strategies have produced low long-term returns on investment. James Heckman and Lance Lochner (2000) examine various welfare training programs. One of these is the National Supported Work program, which provided intensive training and job search assistance at a cost of about $16,550 per participant. The estimated rate of return in increasing participants' earnings and employment was only 3.5 percent. Training programs do show a positive effect, but the gain is modest. Because of the high cost, training programs alone are an unlikely solution. The programs that are somewhat successful are those with direct ties to the local labor market (Heckman and Lochner, 2000).

Similarly, wage supplements, such as the EITC, help working Americans out of poverty but have had only small effects on rates of employment (Bartik, 2001). It is estimated that, at most, the EITC has only increased employment by 500,000 persons (Bartik, 2001).

One explanation for the marginal effects of supply-side strategies is that the demand for low-level employees is not equal to the supply. Training and incentives may encourage people into the labor market, but finding and keeping a job is still difficult. One argument is that the existing labor pool does not have the skills or experience required by employers (U.S. General Accounting Office, 2004). This argument notes that, "it is not capital equipment or technology that differentiates organizations, it is their workforce" (American Society for Training and Development, 2003, p. 5). This implies that organizations want the best and the brightest of the labor pool for their employees, so a low-level workforce is not in demand. Eileen Appelbaum, Annette Bernhardt, and Richard Murnane (2003), however, document employer responses to economic globalization, industry deregulation, and advances in technology. They find that new opportunities exist and employers still have choices in how they respond to economic pressure (Appelbaum et al., 2003). Some employers in the telecommunications industry, for example, compete on the basis of service quality rather than low prices (Batt, Hunter, and Wilk, 2003). These employers choose to hire low-skilled employees and provide specialized internal training; the strategy ultimately reduces the employers' turnover (Batt et al., 2003). Thus, employer demands do not necessitate exclusion of low-level workers.

These examples illustrate is the need for employment strategies that incorporate the demand-side requirements of individual employers. Employment programs have an opportunity to work with employers to redefine entry-level requirements and expand applicant pools to include participants from disadvantaged populations (Gibson, 2000). The TJ strategy is one approach that incorporates both the supply-side and the demand-side factors.

TRANSITIONAL JOBS AS A POSSIBLE SOLUTION

The transitional jobs (TJ) strategy works with participants and employers to address both the supply and demand sides of employment. It is "a workforce strategy designed to overcome employment obstacles by using time-limited, wage-paying jobs and combining real work, skill development, and supportive services to transition participants successfully into the labor market" (National Transitional Jobs Network, 2006, p. 1). The TJ model can be

adapted to fit different target populations and contexts, yet it maintains common design elements.

In the TJ strategy, community and social service agencies partner with participating public and private employers to help participants gain skills and experience through paid on-the-job learning in subsidized transitional jobs, which typically last 2 to 6 months. Participants earn a wage, usually between $5.15 and $8.00 per hour, and work between 20 and 35 hours per week (National Transitional Jobs Network, 2006). The job is supplemented by additional vocational training, soft skills training, case management, and other supportive services (Baider and Frank, 2006). The goal is to provide the participant with experiential learning and training from an actual employer (National Transitional Jobs Network, 2006). At the end of the transitional period, the program works to find a permanent unsubsidized job for the participant, whether with the same employer or with a different one (National Transitional Jobs Network, 2006).

On the supply side, the goal of the TJ strategy is to provide participants with a range of tangible skills and training in a real work environment. According to the National Transitional Jobs Network (2006), the transitional job provides participants with an opportunity to learn the skills and routines of work while building a work history in a supportive atmosphere. Supportive services are an important element in the TJ model, providing participants with assistance during times of transition (National Transitional Jobs Network, 2006). The TJ strategy is able to reinforce learning while providing needed financial stability (Baider and Frank, 2006). By being an employee, participants learn what is expected by employers and how to navigate the world of work (National Transitional Jobs Network, 2006).

On the demand side, employers are a key element in the TJ strategy, ensuring that TJ participants are trained in the skills that are useful to their organizations and to the general labor market (Baider and Frank, 2006). The TJ program also works with participants to address skills gaps and the transitions to the work environment; for example, the program helps participants to adhere to workplace rules and culture (Baider and Frank, 2006). The program acts as a mediator between the employer and the participant, resolving potential problems that may arise as a result of skill deficits or miscommunication (Gibson, 2000). For example, employers may not be aware of the life circumstances and barriers facing low-level employees. One company representative notes that "People don't get to work because of basic things like they can't get daycare. All employers see is that the employee isn't there so they fire the people for being late or not showing up, when much of it is just a

breakdown in communication" (Gibson, 2000, p. 25). On a structural level, workforce development programs such as TJ may challenge employer hiring practices and "help employers discern whether biases are rooted in blatantly discriminatory attitudes or are simply the result of hiring policies that unintentionally keep low-income or minority workers out of jobs" (Gibson, 2000, p. 25). Thus, the TJ strategy attempts to address the employer's need for competent employees as well as the participant's need to overcome barriers that might otherwise impede successful employment.

TRANSITIONAL JOBS WORK

Research suggests that the TJ approach is an effective workforce strategy (Burchfield and Yatsko, 2002; Derr et al., 2002; Kirby et al., 2002; Rynell and Beachy-Quick, 2003). For many hard-to-employ individuals, obtaining a job is a first step towards self-sufficiency and positive life changes (Baider and Frank, 2006). Washington State's Community Jobs (CJ) program places 50 to 75 percent of participants into unsubsidized jobs within 6 to 9 months of enrollment (Burchfield and Yatsko, 2002). This placement rate is approximately one-third higher than that among less-intensive employment programs serving similar populations (Burchfield and Yatsko, 2002). Income of post-CJ participants also increases by an average of 60 percent during their first 2 years in the workforce. That income is 148 percent higher than their average pre-CJ income (Burchfield and Yatsko, 2002). Georgia's GoodWorks! program works with TANF recipients who are at the 5-year limit on receipt of benefits (Derr et al., 2002). Program officials report that 73 percent of participants find jobs after completing the TJ program (Derr et al., 2002). A study of six TJ programs finds that 81–94 percent of participants who completed the TJ program were placed into unsubsidized employment (Kirby et al., 2002). In a study of a bridge program operated by the Marriott Foundation for youth with disabilities, Ellen Fabian (2007) found that 68 percent of participants secured jobs above the minimum wage (Fabian, 2007). The TJ strategy not only helps participants obtain jobs, it also helps them keep jobs.

For some participants, keeping a job is a greater challenge to long-term stability than getting a job is. In a study that compares a Workfirst program in Chicago with a TJ program, participants in the TJ program are found to have better retention outcomes than the Workfirst participants, who received job readiness and employment assistance services (Rynell and Beachy-Quick, 2003). Three months after completing their respective programs, 71 percent

of TJ participants were still employed, but the same was true for only 49 percent of Workfirst participants. Six months after the program, 65 percent of TJ participants were employed, but the rate was only 47 percent among Workfirst participants (Rynell and Beachy-Quick, 2003). Six months after the program, the earnings of TJ participants were also 32 percent higher than those of participants in the Workfirst group. More importantly, TJ participants maintained their gains in earnings. By contrast, the Workfirst group's average earnings began to diminish over time (Rynell and Beachy-Quick, 2003).

THE NEED FOR NATIONAL SUPPORT OF TRANSITIONAL JOBS

Although the TJ strategy has been proven as an effective program model, to date, there is only fledging national support and no dedicated funding stream for TJ programs. According to John Bouman and Joe Antolin (2006, p. 108), existing TJ programs have pieced together enough funding from private and public sources "to operate pilot programs and a handful of statewide programs, but there has not been enough to make the strategy as available as it needs to be." Existing funding streams, such as those through TANF, the Workforce Investment Act (U.S. Public Law 105-220 [1998]), Community Development Block Grants, and the McKinney-Vento Grant, are all potential sources that can and do support TJ programs (Kass, 2003). Because these funding streams contain ambiguous language and do not specifically mention that TJ is an allowable use of the funds, policy makers have hesitated to fund TJ programs, particularly wages for TJ participants (Bouman and Antolin, 2006). National support would increase the availability of funds for TJ. It also could increase funds designated for employment and training.

CONCLUSION

Numerous barriers impede the employment of such disadvantaged populations as TANF recipients, individuals with criminal histories, and youth. Employment strategies cannot be limited to improving supply-side characteristics of employees. Rather, effective solutions must also address the demand-side factors facing employers. The TJ strategy incorporates both supply- and demand-side factors. It has been proven to successfully assist thousands of individuals with significant barriers to employment.

Although the TJ strategy has produced successful outcomes, helping participants find and keep jobs, issues of job design, working conditions, and long-term poverty reduction are not directly addressed in the TJ strategy.

For many TJ participants, permanent job placements do not offer living wages, benefits, or opportunities for advancement. The absence of these features may undermine the original intent of employment as a means to self-sufficiency. Researchers assert, for example, that jobs remain personally demoralizing and ineffective in reducing poverty if wages remain low (Appelbaum et al., 2003). It must be noted, however, that the TJ strategy is intended for individuals who are the hardest to employ. The strategy emphasizes work supports and supportive services to participants for that very reason. The average wages paid by TJ are higher than those paid in other employment strategies. Some might argue, however, that the wages are not high enough. Over time, with proven success and strengthened ties to employers, TJ programs and policy may garner opportunities to challenge employer practices and job structure, just as they are beginning to challenge hiring practices. However, outcome measurements are currently based on job placement rates, and employee retention is viewed as the employee's responsibility rather than the employer's. In this environment, the TJ strategy offers little leverage for structural change.

In order to continue strengthening communities that face TANF's time limits and work requirements, growing reentry populations, and low high-school completion rates, policy decisions must account for significant barriers to employment among these and other populations. Policy decisions at the state and federal levels must include practical, programmatic solutions for assisting these populations with successful entry and retention in the labor market. With broader state and national support, the TJ strategy could effectively strengthen communities and build the workforce of the future by addressing both supply- and demand-side factors.

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ABOUT THE AUTHOR

ABIGAIL COPPOCK is a second-year master's student at the School of Social Service Administration at the University of Chicago. She has previous experience working with substance abuse populations and teaching vocational skills. Abigail holds bachelor of arts degrees in business/economics and communications from Wheaton College.

The Educational Experiences of Foster Youth: The Current State of Knowledge and Directions for Future Research

By Amy Proger

There is ample evidence that foster youth fare exceptionally poorly in school. This article describes the current state of knowledge on the educational experiences of foster youth, examining research that focuses on five outcomes: academic achievement, special education, grade retention, behavior problems and disciplinary incidents, and educational attainment. This article discusses what is known about the pathways that lead to each outcome. It concludes by suggesting both substantive and methodological directions for future research into the educational experiences of foster youth.

Prior to the 1970s, the literature on abuse, neglect, and foster placement typically centered on the medical consequences of maltreatment. In the 1970s, researchers began to explore the effects of maltreatment on psychosocial development. This article explores one effect of maltreatment, the effect of maltreatment on education. In 1974, Rebecca Canning first documented the educational difficulties experienced by foster youth. Through her interviews with foster youth and their teachers, she found that the youth were often overage for their grade level, had poor attendance records, were inadequately prepared to engage in classroom activities, and had significant behavior problems. Canning's 1974 study opened the door to more rigorous research into the educational problems experienced by foster youth.

A study by P. David Kurtz and associates (1993) aptly observes that the impact of maltreatment does not stop at the school door. In recognition of this reality, research documenting foster youths' educational experiences has expanded rapidly. Ample evidence indicates that foster youth fare exceptionally poorly in school (Canning, 1974; Goerge and van Voorhis, 1992; Eckenrode,

Laird, and Doris, 1993; Kurtz et al., 1993; Sawyer and Dubowitz, 1994; Buehler et al., 2000; Newton, Litrownik, and Landsverk, 2000; Burley and Halpern, 2001; Courtney et al., 2001; Kortenkamp and Ehrle, 2002; Lansford et al., 2002; McMillen et al., 2003; Shin, 2003; Zetlin, Weinberg, and Kimm, 2003; Courtney, Roderick et al., 2004; Courtney, Terao, and Bost, 2004; Smithgall et al., 2004; Zetlin, Weinberg, and Luderer, 2004; Courtney et al., 2005; Smithgall et al., 2005). The following literature review describes the current state of knowledge on these youths' educational experiences and suggests directions for future research.

THE CURRENT STATE OF KNOWLEDGE ON THE EDUCATIONAL EXPERIENCES OF FOSTER YOUTH

The literature on the educational experiences of foster youth examines multiple educational outcomes. This article summarizes research in five domains: academic achievement, special education status, grade retention, behavior problems and disciplinary incidents, and educational attainment. The article pays particular attention to the pathways from foster care placement to each outcome. Although the outcomes are presented separately, they have complex relationships with each other, and some outcomes can serve as pathways to other outcomes. Such relationships are documented elsewhere in education literature and not discussed here, but the educational outcomes are presented in roughly the order in which they occur during a youth's life course. Educational attainment is presented last, as it can be considered a culmination of each of the other outcomes; academic achievement, special education status, grade retention, and behavior problems and disciplinary incidents all predict eventual educational attainment (Grissom and Shepard, 1989; Ensminger and Slusarcick, 1992; Roderick, 1994; Rumberger, 1995; Alexander, Entwisle, and Kabbani, 2001; Allensworth, 2004).

Academic Achievement

Several researchers use standardized test scores to examine the academic achievement of foster youth. They consistently find that foster youth have poorer reading and math achievement than do their peers who are not in foster care. Standardized test score data from several states reveal that the two groups are separated by wide gaps in achievement (Eckenrode, Laird, and Doris, 1993; Burley and Halpern, 2001; Smithgall et al., 2004). In addition, analyses of reading levels reveal that very few foster care youth read at grade level and many read several years below grade level (Courtney et al., 2001; Shin, 2003; Courtney, Terao, and Bost, 2004).

Part but not all of this gap in academic achievement can be explained by demographic (Eckenrode et al., 1993) and school (Smithgall et al., 2004) characteristics. In addition, aspects of foster care placement may explain some portion of the gap. Richard Sawyer and Howard Dubowitz (1994) find that youth who are placed in foster care between the ages of 18 months and 5 years, or who live in foster homes with more than five children, are most at risk for poor academic achievement. Sonny Shin (2003) determined that placement in relative foster care is an important predictor of reading ability, but he acknowledges that youth with the fewest difficulties are the most likely to be placed in relative foster care.

Special Education

Foster youth are more likely than similarly aged children in the general population to be placed in special education, and in particular, to be classified as emotionally disturbed (ED; Goerge and van Voorhis, 1992; Smithgall et al., 2005). In Chicago, the rates of youth who were classified as ED but who were not victims of substantiated abuse remained stable between 1995 and 2004 (at about 1.5 percent); by contrast, the percentage of foster youth who had an ED classification increased rapidly (from 6.3 to 17.3 percent; Smithgall et al., 2005). Cheryl Smithgall and associates (2005) attribute this trend to the fact that foster youth with an ED classification are much less likely to transition to permanent homes; over time, these youth comprise a growing proportion of the foster care population. Further, the authors' interviews with caseworkers reveal that caseworkers often refer youth for special education evaluations out of frustration or because they do not know how else to help. This misclassification is particularly troublesome because the classification is seldom removed (Smithgall et al., 2005).

Grade Retention

There is evidence that foster youth repeat grades at higher rates than do youth who are not in foster care. John Eckenrode and colleagues (1993) find that maltreated youth are 2.5 times more likely to repeat a grade than are nonmaltreated youth. The finding persists even after Eckenrode and colleagues (1993) control for public assistance status, age, and gender. Controlling for demographic characteristics and school characteristics, Smithgall and associates (2004) find that foster youth in Chicago are 1.8 times as likely as other students to be overage for grade (i.e., older than one's same-grade peers). They are 1.2 times as likely as other students to have been retained (i.e., held back). Frequent

changes in foster placement provide another possible explanation for high rates of retention among foster youth; frequent changes in foster placement are typically accompanied by frequent changes in school placement. As children change schools, their academic and social development can be adversely affected. Adverse effects are particularly pronounced if children change schools during the school year, because changing schools disrupts educational instruction and social relationships (Courtney, Roderick et al., 2004). Thus, multiple placement changes are associated with grade retention and with being overage for grade. They are also associated with an array of emotional and behavioral difficulties. Many foster parents have trouble managing such difficulties and often give up, asking that the child be moved to a new home (Newton et al., 2000). These same emotional and behavioral difficulties are associated with additional negative outcomes (described below) for foster youth.

Behavior Problems and Disciplinary Incidents

Behavior problems among foster youth often begin early and escalate in a dynamic process as youth progress through school. Eckenrode and associates (1993) suggest that educational difficulties represent a continuation of disadvantage for maltreated children, who exhibit early developmental difficulties, such as insecure attachment to their mothers. Indeed, many youth enter foster care with behavioral difficulties that stem from child characteristics associated with maltreatment (e.g., difficult temperament). Maltreatment and aspects of foster care placement may contribute to additional behavioral difficulties. For instance, foster youth with behavior problems are more likely to experience placement disruptions than foster youth without behavior problems, but placement disruptions strongly predict increased behavior problems (Newton et al., 2000). In addition, length of time in foster care is significantly related to behavior problems. Bonnie Zima and associates (2000) find that each additional year in foster care corresponds to a 118 percent increase in the likelihood of being suspended (Zima et al., 2000).

Other correlates of foster care placement may contribute to behavioral difficulties. Smithgall and associates (2005) document the high rate of ED classification among foster youth. They contend that the rate is only partially explained by behavioral disorders. Regardless of whether they are in foster care, students who are classified as ED are the most likely to violate the disciplinary code. Thus, ED classification may have important ramifications for foster youth (Smithgall et al., 2005). In addition, socioeconomic risk and family structure may explain behavioral problems to some extent. Katherine Kortenkamp

and Jennifer Erhle (2002) find that foster youth are significantly more likely to be suspended or expelled form school than are youth who are not in foster care. They also observe, however, that foster youth are only marginally more likely to be suspended or expelled than are youth in socioeconomically disadvantaged, single-parent homes. This may be because many foster youth come from socioeconomically disadvantaged, single-parent homes (Coulton et al., 1995; Ernst, 2000), and given the child welfare system's reliance on kinship foster placements, many foster youth may also be placed in socioeconomically disadvantaged foster homes headed by single parents.

Finally, behavior problems tend to compound; in foster care, a single behavior problem can lead to additional problems. For example, Zima and associates (2000) find that 14 percent of a sample of foster youth were suspended from school at least once, but 55 percent of those who had been suspended were suspended two or more times. Jennifer Lansford and colleagues (2002) examine the number of adjustment problems experienced by adolescents. Problems include: aggression (if observed at clinical levels), anxiety or depression (if observed at clinical levels), school suspension, trouble with the police, pregnancy or impregnating someone, running away from home, and gang membership. Lansford and associates (2002) find that 74 percent of adolescents who reported that they were maltreated also reported at least one adjustment problem. By contrast, at least one adjustment problem was reported by 43 percent of adolescents who never reported maltreatment. In addition, 21 percent of maltreated adolescents reported experiencing three or more adjustment problems; three or more adjustment problems were reported by only 7 percent of adolescents never reported maltreatment (Lansford et al., 2002).

Educational Attainment

In tandem with the dramatic rise in educational aspirations over the past several decades, foster youth have expressed a strong desire to attend college (Courtney et al., 2001; McMillen et al., 2003; Courtney, Terao, and Bost, 2004). Yet, many foster youth do not complete high school education, and few of those who do go on to earn a postsecondary degree. Both the 2005 study by Mark Courtney and colleagues and another 2001 work by Courtney and associates estimate that only about 33 percent of foster youth earn a high school diploma or general equivalency diploma (GED). These low rates are partly due to higher than average dropout and incarceration among foster youth (Smithgall et al., 2004).

In light of the many educational difficulties faced by foster youth, it is no wonder that their educational attainment is so low. According to Karl Alexander

and colleagues (2001), dropping out of high school is a long process of disengagement from school. This process may be fueled, in part, by the low academic achievement, increased special education placement, high rates of grade retention, high rates of behavior problems, and high rates of disciplinary incidents. Further, just as there appears to be an association between foster placement change and retention, there appears to be an association between foster placement change and educational attainment. Research conducted by Russell Rumberger and Katherine Larson (1998) documents the strong positive relationship between school change and educational attainment. The authors find that even one change in school between the eighth grade and twelfth grade doubles the likelihood that students will not complete a high school education. Therefore, a change in foster placement that results in a school change puts foster youth at a higher risk of dropping out.

Due to high rates of dropout, foster youth may be prevented from gaining postsecondary education. Further, among foster youth who do complete high school, opportunities to attend a postsecondary institution may be limited by scarce resources and by inadequate support from adults in navigating the postsecondary admission and enrollment processes. Some states have begun to allow youth to remain in foster care beyond the age of 18. Early research by Courtney and associates (2001) suggests that such policies may have positive effects on youth with high educational aspirations. Compared to youth who leave foster care at the age of 18, youth who remain in foster care beyond the age of 18 are more than twice as likely to receive a high school diploma or GED and more than three times as likely to attend a 2-year or 4-year college (Courtney et al., 2001).

It is possible that youth who stay in foster care beyond the age of 18 are even better off than youth who have similar background characteristics but never entered foster care. Cheryl Buehler and associates (2000) find that adults formerly in foster care are unlikely to complete any education beyond high school, but they are no less likely seek postsecondary education than are adults who never entered foster care but have similar socioeconomic backgrounds. This finding suggests that foster youth are prevented from pursuing postsecondary education by socioeconomic disadvantage, not foster care. Thus, staying in foster care beyond the age of 18 may provide the stable living arrangements and resources that disadvantaged youth need to pursue postsecondary education. Courtney and Amy Dworsky of the Chapin Hall Center for Children at the University of Chicago are currently evaluating the impact of a new policy that allows foster youth in Illinois to remain in care beyond the age of 18. Their results may provide greater insight into the benefits of this policy and may guide other states considering similar policies.

THE EDUCATIONAL EXPERIENCES OF FOSTER YOUTH: DIRECTIONS FOR FUTURE RESEARCH

Research clearly documents poor educational outcomes among foster youth, but little is known about the many correlates that predict these poor educational outcomes, and causal directions are not yet understood. Future research on the educational outcomes of foster youth should attempt to untangle the complex relationships among child characteristics, placement characteristics, demographic background, and educational outcomes. Many researchers have undertaken the task. For example, Zima and associates (2000) examine the relationships among behavior problems, academic skill delays, school failure, and placement characteristics. They find that children living in group homes are 3 times more likely to repeat at least one grade than are children living in relative foster care or traditional foster care. However, the cross-sectional design of the study makes this finding difficult to interpret. Is living in a group home a cause or consequence of poor educational outcomes? Is it both? In order to isolate cause from effect, longitudinal research should follow successive cohorts of youth over many years.

State child welfare agencies have already begun to respond to the large body of research that documents the poor educational outcomes of foster youth. The author's experience in Illinois, for example, indicates that educational liaisons assist caseworkers in monitoring educational progress and advocating for the educational needs of foster children. Similar efforts are underway in other states, including California (Zetlin et al., 2003; Zetlin et al., 2004). Evaluative research is necessary to determine the effectiveness of particular interventions.

It is also important to understand the factors that facilitate or hinder successful implementation of an intervention. Two potential difficulties face child welfare caseworkers tasked with implementing educational interventions. First, although school records contain important information about a child's educational history, they are often hard to find or nonexistent (Zetlin et al., 2004). Second, caseworkers lack knowledge of school procedures, educational resources, and students' rights (Zetlin et al., 2003). Mixed methods research that includes interviews with caseworkers can help shed light on the challenges faced by caseworkers as they attempt to meet a child's educational needs. Such research can also assist child welfare agencies in crafting interventions that address such challenges.

Finally, there has been a remarkable increase in research, policy, and philanthropic attention to postsecondary education over the past decade. Specific attention to the postsecondary education experiences of foster youth is

also necessary. It is not sufficient to know how many foster youth enroll in postsecondary education; it is also important to know what types of postsecondary institutions they attend, how they fare while there, and whether they ultimately graduate. Longitudinal research is particularly well-suited to these inquiries, but a central challenge will be constructing a sample of adequate size. To address this issue, researchers should follow successive cohorts of youth. Attrition will be another important concern, and extra efforts must be made to retain members of the original sample. Finally, researchers should conduct qualitative interviews with youth who left foster care by successfully transitioning to postsecondary education. Results may shed light on the internal and external resources that enable such positive outcomes. In order to craft effective policies and programs for foster youth, it is important to understand why some foster youth are successful in school and go on to complete postsecondary education while others struggle so profoundly.

CONCLUSION

The U.S. Department of Health and Human Services (n.d.) estimates that 513,000 youth currently reside in foster homes. Many more youth may continue to reside in abusive or neglectful homes. Research has begun to elucidate the educational outcomes of foster youth and to reveal the processes that contribute to these outcomes. Child welfare agencies across the country have begun to respond to this research, formulating and implementing policies and programs to support the educational needs of these youth. In order to ensure that these policies and programs improve the educational experiences of foster youth, further research, particularly longitudinal quantitative and qualitative research, is necessary. Finally, in this era of rising educational aspirations and "college-for-all" norms (Rosenbaum, Miller, and Krei, 1996, p. 267; Rosenbaum, 1997) further research into the college-going experiences and career outcomes of foster youth in particular is crucial.

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ABOUT THE AUTHOR

AMY PROGER is a second-year social administration student at the School of Social Service Administration. She received her B.S. in education and social policy from Northwestern University. Amy is interested in minority adolescent development and urban education. Currently, she is completing her field work practicum at the Chicago Public Schools Department of Postsecondary Education and Student Development, where she is creating programming to facilitate a successful transition to high school. Amy plans to pursue a career in research in education policy, focusing on the educational experiences of at-risk youth.

A Proposed Treatment Plan for Incarcerated Male Juveniles Who Experience Posttraumatic Stress Disorder

By Katherine Gregg

This article details a plan for treating youth offenders who suffer from posttraumatic stress disorder (PTSD). Developed through work with youth offenders at the Cook County Juvenile Temporary Detention Center in 2005 and 2006, the proposed model incorporates evidence-based practice to develop a group treatment for adolescents. The plan demonstrates that creative interventions engage youth and may enable them to address symptoms of PTSD.

Posttraumatic stress disorder (PTSD) is one possible response to a traumatic experience. After a traumatic experience, an individual may be anxious, become depressed, and feel unable to deal with daily responsibilities. Over a brief period that can range from a few weeks to a few months, most who have experienced trauma find that their ability to function improves. However, someone who continues to be affected by the experience may suffer from PTSD (Martin and Pear, 2005). Evidence suggests that incarcerated male juveniles suffer these symptoms at higher rates than those observed among other adolescent communities (De Arellano et al., 2005). A reason for this disparity is that community violence is a contributor to symptoms of PTSD. A study by David Foy and Carole Goguen (1998) reveals that living in poor, inner-city areas and being a minority increases the risk for exposure to community violence. Gang affiliation and gender are other risk factors for exposure. Males witness more community violence and are at higher risk for physical assault than are females of a similar age (Foy and Goguen, 1998). Jessica Hamblen (n.d.) reports that PTSD emerges in as much as 100 percent of children who

witness a parental homicide or sexual assault. Her review finds that PTSD symptoms are experienced by 77 percent of children exposed to a school shooting. Furthermore, Hamblen notes that 35 percent of urban youth develop PTSD as a result of exposure to community violence. These proportions are substantially higher than those found among adolescent general populations; in general, among adolescents who experience trauma, 3 to 15 percent of adolescent girls experience PTSD; the rate is only 1 to 6 percent among boys (Hamblen, n.d.).

Adolescents' experience of PTSD differs from that of adults. Hamblen's review finds, for example, that adolescents suffering from PTSD are likely to engage in traumatic reenactment; that is, they reenact aspects of the trauma in their daily lives. Also, adolescents suffering from PTSD are more likely than their adult counterparts to exhibit impulsive and aggressive behaviors (Hamblen, n.d.). It is thus important that the mental health community offer effective and client-centered interventions for juveniles, because subjects who are incarcerated and suffer from PTSD are vulnerable to further court involvement.

This article proposes a treatment plan for youth offenders who suffer from PTSD. It examines the research literature, the criteria for assessing PTSD, and the different modes of available treatment. The article thus reviews the empirical foundation for the treatment of a population of adolescent offenders suffering from PTSD. It proposes a treatment approach for youth incarcerated at the Cook County (Illinois) Juvenile Temporary Detention Center. Incarcerated youth were referred through the Cook County (Illinois) Juvenile Court Clinic. The clinic works with the Cook County probation department, juveniles, and the youths' families in order to complete forensic psychological evaluations for the court. In this context a forensic evaluation refers a mental health assessment completed by a state licensed psychologist in order to provide a judge with information about the youth's social and emotional level of functioning. The judge then uses this information to determine sentencing in relation to the youth's offense. Youth referred to Cook County Juvenile Court Clinic for psychological evaluations are disproportionately male and from a minority population. These youths are often affiliated with gangs. The population is therefore likely to have experienced trauma. It is thus an appropriate target population for short-term efforts to assess and treat PTSD.

OVERVIEW

Diagnostic Criteria and Symptom Presentation for PTSD

The definition for the criteria of PTSD gives clinicians leeway in determining whether an event qualifies as a traumatic stressor (American Psychiatric Association, 1994). The practice parameters of the American Academy of Child and Adolescent Psychiatry (AACAP) indicate that a youth's reaction must include intense fear, horror, helplessness, or disorganized or agitated behavior (AACAP, 1998).[1] Some children with PTSD symptoms regress from previously learned skills; they are unable to do things that they were able to do before the trauma (AACAP, 1998). For example, an adolescent may show lack of speech or wet the bed. Also, adolescents who have experienced trauma occasionally engage in magical thinking; a youth imagines, for example, that the trauma will not happen again if he or she behaves well, or that he or she possesses the power to see into the future. Some other symptoms of PTSD in children and adolescents include social withdrawal, separation difficulties, hoarding of possessions, and loss of fantasy or imaginary play (Hillman, 2002).

Commonly Used Treatment Approaches

Published treatment guidelines indicate that, among the methods for treating children with PTSD, cognitive-behavioral therapy (CBT) has the strongest empirical support (Cohen et al., 2000). Recommendations published in the AACAP practice parameters endorse treatment that uses exposure, stress management, relaxation, narrative retelling, and parental participation in treatment sessions.[2] This article will briefly outline main features of several approaches used for work with clients who experience PTSD.[3]

Cognitive-behavioral therapy works to change an individual's emotions, thoughts, and behaviors (Martin and Pear, 2005). Exposure, as part of CBT, uses repeated, detailed images of the trauma in a safe context that helps the survivor face and gain control of the fear that was overwhelming during the trauma. Techniques include flooding and desensitization. Each method confronts the trauma in a way that is specific for the individual. In flooding, the client is helped to confront the full memory of the traumatic event. Desensitization uses relaxation techniques to enable the client to gradually confront the trauma. Cognitive-behavioral therapy may also include developing social skills, learning skills for coping with anxiety, preparing for stress reactions, and discussing how to handle future trauma symptoms (Martin and Pear, 2005).

Another common approach is pharmacotherapy, which involves the treatment of a mental health disease through the administration of drugs by a medical provider. Pharmacotherapy can be used to reduce the anxiety, depression, and insomnia caused by the trauma memories. Medication may be useful for symptom relief while the individual engages in psychotherapy (Hillman, 2002).

A less-common approach to working with clients who experience PTSD is Eye Movement Desensitization and Reprocessing (EMDR). Francine Shapiro (2001) describes EMDR as an information processing therapy that combines CBT with eye movements, hand taps, and sounds that are completed by the client. The client is instructed to focus on the image, negative thought, and body sensations while simultaneously following the therapist's fingers as they move across his or her field of vision for a short period (Shapiro, 2001). The goal is to decrease the individual's negative belief or intense fear associated with the trauma memory. For example, a rape victim may hold the belief that the attack was her fault. However, EMDR focuses on changing the belief so the client may recall the memory without guilt, shame, or fear (Shapiro, 2001). There is some limited evidence that EMDR increases an individual's ability to process the memories of the trauma (Hillman, 2002).

Psychodynamic psychotherapy provides an alternative method for work with emotional conflicts caused by the traumatic event. In brief psychodynamic psychotherapy, the client and therapist examine maladaptive functions developed early in life that contribute to daily problems (AACAP, 1998). The therapist helps the individual to recount the traumatic event and to identify effective ways of coping with his or her emotions. By doing so, the client can replace maladaptive functioning with a healthy substitute. This form of treatment often requires a substantial amount of introspection and reflection from the client.

Group treatment is one setting in which CBT and the other approaches might be delivered to clients who experience PTSD. A group provides an environment where clients can share the memories of and symptoms related to the trauma with group members who may have also experienced a traumatic event. Sharing their own trauma narrative enables individuals to process the event and focus on other aspects of their lives. Whereas individual treatment provides a controlled therapeutic environment, group methods offer validation and help normalize clients' traumatic experiences (Hamblen, n.d.).

JUVENILE OFFENDERS WITH PTSD

Research identifies several useful approaches for working with juvenile offenders who suffer from PTSD. Because research suggests that both group and individual modalities are effective for children and adolescents, the current discussion focuses on the significance of the modality in treatment for juvenile offenders with PTSD symptoms.

The literature shows that treatment for an adolescent should be developmentally appropriate (Davis, 1992). Inger Davis (1992) examines studies of individual and group treatment, reviewing how the differences in therapeutic effects for adolescents differ from those of younger children.[4] The studies in the review include problem adolescents who received treatment as a result of referrals from teachers, parents, social workers, probation officers, or juvenile court judges. Davis criticizes meta-analytical techniques for "superimposing ... statistical computations across studies" (Davis, 1992, p. 49). The review synthesizes similarities in failed treatments and suggests how future interventions may improve treatment. She demonstrates that if a similar intervention is used, children 4 to 12 years have a better outcome in decreased symptoms than do adolescents between 13 and 18 years (Davis, 1992, p. 51). Of the 108 outcome studies examined, the mean age of study subjects was 10.23 years. Ages range from 4 to 18 years; 66 percent of participants were male. Her review suggests that early intervention may be helpful in working with adolescents. Davis (1992) also notes that behavioral therapy is better than nonbehavioral therapy for juvenile offenders who experience PTSD. She concludes that the outcomes of individual therapy do not differ significantly from those of group therapy. The review suggests that outcomes vary by the method of intervention. The findings are meaningful for the intervention proposed in this article, because the majority of those in samples reviewed by Davis are male and involuntary clients.

There is limited evidence that group therapy is more effective than individual treatment for children with PTSD. However, research shows that the treatment modality is not as important as a trauma-focused approach that targets the adolescent's specific symptoms (Friedrich, 1996). Group interventions often provide a timely response to a large number of adolescents.

For treatment of adolescent trauma, cognitive-behavioral interventions enjoy the most empirical support (Ahrens and Rexford, 2002, Cohen et al., 2000, Davis, 1992, Friedrich, 1996, March et al., 1998, Ovaert, Cashel, and Sewell, 2003). Typically, these interventions target the specific symptoms of PTSD by focusing on the thoughts and feelings that the client associates with the traumatic experience. The existing literature finds two cognitive-behavioral

approaches to be effective: trauma-focused cognitive-behavioral therapy (TF-CBT) and cognitive-processing therapy (CPT).

Judith Cohen and associates (2000) review the major components of TF-CBT for children and adolescents. As Cohen and colleagues observe (2000), this approach includes three basic components: educating the client about his or her posttraumatic stress reactions, cognitive therapy, and exposing the client to the memory of the traumatic event by encouraging him or her to recount the traumatic event (Cohen et al. 2000). Much of the empirical evidence that establishes the efficacy of TF-CBT is found in treatment studies with young children. Cohen and associates (2000) reveal that the approach has been adapted to treat clients who are between the ages of 3 and 18 years old and who have experienced a variety of traumas (e.g., physical abuse, sexual abuse, domestic violence, rape, natural disasters, and community violence). A limitation of the review is that it does not identify which populations of children may not benefit from CBT treatment components. Cohen and associates (2000) acknowledge that there is insufficient data to determine which CBT components are most efficacious in treating specific symptoms and specific populations of children, but they find strong empirical support for the use of TF-CBT in treatment of adolescents experiencing symptoms of PTSD. The review also shows that TF-CBT is most effective for treatment of PTSD in a time-limited context. The authors suggest that 8 to 15 sessions are effective. Time sensitive approaches are particularly applicable for work with the specific population examined in this article, because incarcerated juveniles have stays of varying length at the Juvenile Temporary Detention Center.

Julia Ahrens and Lillian Rexford (2002) examine the effect of short-term cognitive-processing therapy on incarcerated adolescents with PTSD. Cognitive-processing therapy is based on Peter Lang's (1977) observation that information is stored in fear networks. When recalled through external stimuli, these networks cause avoidance behavior. Although there may be no actual threat, a person may nonetheless alter his or her behavior because a preexisting thought (caused by the memory of the traumatic experience) is recalled. Ahrens and Rexford (2002) find that CPT is associated with statistically significant declines in clients' reports of symptoms of trauma, including anxiety, depression, intrusion, avoidance, and numbing. The examined procedure was conducted over eight 60-minute sessions. Each adolescent in the study learned about the symptoms of PTSD, participated in exercises to distinguish between thoughts and feelings, examined thoughts associated with the traumatic experience, and wrote a narrative describing the trauma. The youth were also assigned homework (e.g., journaling, worksheets) related to antecedents, beliefs, and consequences of their targeted behavior.[5]

After youth received treatment, PTSD symptoms diminished among participants in the treatment group (Ahrens and Rexford, 2002). The rates of symptom reduction were higher among those who received treatment than among those in a similar group that was not treated. In contrast to the samples in alternative studies, the sample group in this study had many comorbid disorders, such as ADHD, as well as histories of head trauma. Comorbid disorders may have complicated Ahrens and Rexford's (2002) findings, and treatment outcomes may thus be difficult to duplicate with the present study's sample.

In another study, 14 children (ages 10–16) received cognitive-behavioral therapy. Participants were assessed for PTSD before and following treatment. After 18 weeks, 57 percent of the sample did not meet criteria for PTSD; at a 6-month follow-up assessment, 85 percent did not meet the criteria (March et al., 1998). Although the study by John March and associates (1998) is limited by a small sample, it represents another CBT treatment that has been found to effectively decrease symptoms of PTSD in a group setting.

Lynda Ovaert and associates (2003) test a cognitive-behavioral group intervention that included adaptations of CPT techniques (e.g., narrative exposure). The study's sample included 43 incarcerated males between the ages of 13 and 18. Approximately 30 percent were Caucasian, 40 percent were African American, and 25 percent were Hispanic. Ten groups of juveniles completed a 12-session intervention that met twice weekly for 6 weeks. All participants were diagnosed with PTSD. The treatment approach was administered in three phases: rapport building and education about PTSD (sessions 1–5), reexperiencing (sessions 6–11), and resolution (session 12).[6] The results indicate that group participants experienced significant reductions in self-reported PTSD symptoms, as well as reductions in behavioral problems. The reductions of PTSD symptoms were greater for youth who experienced community (e.g., gang) violence than for those who experienced personal violence.

It should be noted that the Ovaert and associates' (2003) approach devotes a disproportionate amount of time to building rapport with the client; it involves a relatively short period (one session) on resolution. The study is limited by a small sample, and the size makes it difficult to project how the effects of this approach might generalize to all juvenile offenders who experience PTSD. A strength of the study is that the diagnostic measurement included an open-question interview, which was used to evaluate the type of trauma exposure that each adolescent participant experienced. Of the 43 participants, 90.3 percent experienced gang-related trauma. Ovaert and associates (2003) also observe that participants reportedly found it helpful to discuss the traumatic

experience with peers. These findings are also valuable because the group treatment was effective for youth who experienced gang and community violence. Effectiveness of a given treatment type (i.e., group or individual treatment) may vary for each adolescent.

Motivational interviewing introduces an added benefit for working with adolescents who may be ambivalent towards changing their targeted behavior. William Miller and Stephen Rollnick (2002, p. 33) explain that, "anything from cash vouchers to cattle prods" has been called motivational interviewing. The clearest definition describes motivational interviewing as a "directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence" (Rollnick and Miller, 1995, p. 326). Motivational interviewing addresses the client wherever he or she is in the change process. In the current article, and for the proposed target population, motivational interviewing will be helpful in determining whether the youth is ready to discuss the traumatic experience, associated behaviors, and their consequences in a group setting. Such information may prevent an adolescent from harming himself and may also protect other group members.

The motivational interviewing approach uses the transtheoretical model as its basis for support. James Prochaska and Carlo DiClemente (2005, p. 148) describe the transtheoretical model as a response to the dilemma that clinicians face daily in "what to do, when, with whom, in what way, with which problem." They argue that no one system of therapy addresses these questions. Motivational interviewing draws upon four dimensions of the transtheoretical approach: the processes of change, the stages of change, the benefits and liabilities of change, and the levels of change (Prochaska and DiClemente, 2005). Miller and Rollnick (2002) rely on the stages of change dimension, which presents five stages: precontemplation, contemplation, preparation, action, and maintenance (Prochaska and Prochaska, 1999). If the client is matched to the correct change process, he or she can address his or her readiness to participate in treatment.

Research indicates that motivational interviewing is effective in work with adolescents (Greenwald, 2002). Two hypotheses suggest reasons for this effectiveness. First, motivational interviewing allows youth to discuss their ambivalence with the therapist. The youth are able to elaborate from their own perspective on why they may not need to change their behaviors. Secondly, youth are often involuntary clients and are accustomed to being told what to do by authority. This, in turn, causes some youth to rebel. By providing informal feedback, educating the adolescent about other youth behavior, and asking what changes the youth is willing to make, the therapist initiates

exchanges in which the therapist and adolescent work together instead of against one another (Greenwald, 2002). This collaboration differs from previous therapeutic approaches, and obstacles identified during motivational interviewing are not failures or resistance from the client but part of the process. Motivational interviewing lends itself to working with adolescents because the method emphasizes consistent feedback and a listening style that provides the youth with a sense of safety, especially when he or she discusses sensitive material. In order to meet the specific needs of juvenile offenders in this article, the proposed treatment plan integrates motivational interviewing techniques to assess if individual or group treatment is best.

Ricky Greenwald (2002) argues that adolescents who experience trauma develop persistent conduct disorder. To assess the effectiveness of motivational interviewing with adolescents, he adapted motivational interviewing, self-control training, and trauma resolution in an open-trial treatment of six adolescents with school and conduct problems (Greenwald, 2002). Greenwald (2002) finds that five out of the six participants had significant reductions in PTSD symptoms, and the number of problem behaviors decreased. Greenwald also reports an unexpected outcome: the school performance of each participant improved. Weaknesses of the study include the relatively small sample size and the lack of a control group. However, Greenwald (2000) presents innovative ideas that could be used in the current therapeutic adaptation. For example, the trial suggests an imaginative way to decrease ambivalence among teens through a motivational interviewing technique called "Future Movies" (Greenwald, 2002, p. 242). This form of motivational interviewing occurs when a client is asked to "fill in the details of a movie of the next 10 years of his life" (Greenwald, 2002, p. 242). In this activity, the therapist is able to highlight personal risk and negative consequences for a client. He or she may also affirm a client's positive choices and projected accomplishments. Future Movies offer a way to address the adolescents' preoccupation with thinking of the traumatic events and instead to focus on how the juvenile visualizes his life. This article will adapt elements of Greenwald's work, including the Future Movies approach, for the proposed treatment plan (Greenwald, 2002).

Cognitive-behavioral therapy delivered in a group setting has been shown to be effective for youth who experienced such traumas as sexual abuse, and it may be used to treat whose who experienced community violence (Foy and Goguen, 1998). In addition, there is no empirical evidence that successful treatment of traumatized children always requires repeated retelling of the details of the traumatic event (Cohen et al., 2000). It is relevant that there is

no such evidence to retell the traumatic experience, because this article proposes a treatment plan that excludes a narrative retelling by the clients. The treatment plan proposed here will follow Trauma Adaptive Recovery Group Education Therapy for Adolescents (TARGET-A; Mahoney, Ford, and Cruz St. Juste, 2005) and will focus on group methods for working with incarcerated males.

The proposed approach attempts to refocus the youth's attention on gaining a sense of control and making sense of traumatic stress reactions. It is most similar to trauma-focused cognitive-behavioral therapy. A current study is following 20 youths in a juvenile justice program that includes the TARGET-A intervention, and those findings have not been published yet. Preliminary findings, however, indicate that the intervention is associated with reductions in PTSD symptoms, posttraumatic cognitions, and maladaptive coping (University of Connecticut Health Center, n.d.). These findings also indicate that TARGET-A is associated with improvements in self-efficacy and psychosocial functioning.

In contrast to exposure therapies, TARGET-A is designed for adolescents and provides a "sequence of specific behavioral skills for processing emotionally-charged somatic and cognitive information" (Mahoney et al., 2005, p. 54). The goal of TARGET-A is not to coach the individual to be desensitized to the fear or other negative thoughts that are triggered by the trauma, but instead to give attention to trauma reminders (extreme vs. normal stressors) and to guide the client to live life in the present. In this way, the plan is most similar to Lang's (1977) aforementioned information processing, yet it differentiates itself by providing a model for recovery and resilience. The plan focuses the client's awareness on external and internal stimuli that provoke a reminder of the traumatic experience. The approach is a strategy for acknowledging and moving beyond a trauma reminder or memory.

GROUP CHARACTERISTICS

In sentencing juvenile offenders, judges in Cook County, Illinois, may base their decisions on the results of forensic evaluations (i.e., in order to return the youth to a normative level of social and emotional functioning, a judge may order psychotherapy services rather than confinement for a youth who is found to exhibit a mental health disorder). These evaluations are administered by the Cook County Juvenile Court Clinic. The clinic has expanded its efforts to provide trauma-focused group therapy for incarcerated male youth. Youth are referred for this therapy by correctional facility staff and probation officers. The period of observation occurred from October 2005 through June 2006.

The population remained stable because youth remain in treatment for the duration of their incarceration. Two staff will participate in this form of treatment for each group session. This article does not use specific youth as a study sample, but rather reports characteristics in order to develop a treatment plan.

Juvenile offenders are characterized as a special subgroup of urban adolescents who are exposed to "high levels of chronic family and community violence" (Ovaert et al., 2003, pp. 294–95). Daniel Coleman (2005, p. 114) proposes that incarcerated youth are at risk of "developing serious sequelae of trauma exposure, given high rates in this population of known risk factors such as lower socioeconomic status (SES), family problems, family substance abuse, and lower [intelligence quotient]." As the literature suggests, juvenile offenders experience PTSD at a higher rate than youth not involved with the juvenile justice system (Ovaert et al., 2003). Numerous studies suggest that PTSD occurs across diverse ethnic backgrounds (Hamblen, n.d.). However, incarcerated youth are more likely than nonincarcerated youth to come from minority families and from socioeconomically deprived backgrounds (Coleman, 2005). In many of the multistressed families that are court-involved, the lack of familial support places the imprisoned adolescents at higher risk for an increase in symptoms associated with PTSD than that for adolescents who are not court-involved (Ovaert et al., 1997). This article expects the targeted group to reflect the outlined characteristics. The group that uses this intervention plan will be limited to those who identify as male and report at least one traumatic experience.

PROBLEM DEFINITION

This article attempts to propose a method for treating incarcerated male adolescents with PTSD symptoms. The presence of such symptoms is suggested by target behaviors; the tasks of accurate assessment and effective treatment are facilitated by documentation of the intensity, frequency, and duration of the target behaviors. Such target behaviors include, for example, learning difficulties (e.g., perceptual distortions; problems with sensory integration), displays of aggression, increased drug use, and risk behavior for HIV, social withdrawal, and feelings of helplessness or fear. Documentation also records the physical setting in which these behaviors occur and who is present. For example, a youth who was referred for group intervention urinated without control during the day and night. The behavior and the setting in which it occurred was recorded. The record was compared to the youth's case file, which showed that he "urinated when he felt pressured by his abuser."[7] Research indicates that this

indicates a possible regression from to a previously learned skill and a diagnosis of PTSD was made (American Psychiatric Association, 2000).

In order to treat PTSD, it is also necessary to document the effects (i.e., consequences) of target behaviors and environmental influences, like medication, medical conditions, sleep, diet, schedule, and social factors, that may affect behaviors. Location is also an environmental influence; youth from high-risk PTSD samples often reside in areas that have high incidences of community violence. Finally, it is important to document indicators of adolescents' resilience. For example, resilience may be evident in a juvenile offender's ability to engage with peers in a positive, constructive manner during a school group exercise.

ASSESSMENT

An intake interview is the initial point of contact in the proposed treatment. During the intake interview, the clinician will assess whether the adolescent should participate in the group intervention or be referred to a community-based agency for individual treatment. The clinician will be encouraged to use motivational interviewing techniques to order to assess the youth's readiness for the intervention process. If the youth is able to discuss the traumatic experience, the clinician may inquire whether he or she would prefer to attend sessions with a group of peers or to receive one-on-one treatment. This discussion will allow the youth to experience the intake interview as part of the intervention process.

The assessment for PTSD in adolescents remains challenging and characteristically requires a comprehensive approach. In the proposed model, assessment will take place in direct clinical interviews and may also include the youth's parents. Because one or both of the parents may be perpetrators of the traumatic experience, it is important that the interview occur with the nonoffending parent. Although the AACAP encourages parental involvement (AACAP, 1998), the organization also notes that youth must feel safe to report information without fearing that it will get back to their guardians. To encourage adolescents to express their opinions and feelings, data will be gathered from information self-reported by the youth, as well as from clinical interviews. Measures that gather self-reported data also enable researchers to efficiently screen large groups and to determine who may need further assessment. Greenwald (2002) cites one study of delinquent adolescents that used the 43-item Los Angeles Symptom checklist. This measure gathers self-reported

data and was tested effectively to measure the presence of child and adolescent PTSD. This checklist will be used to determine appropriate referrals for treatment.

To further determine participant involvement in the proposed treatment, the clinician will examine the client's symptoms and the location of the client's residence. Specific questions on the traumatic experience inquire about the following four symptoms: (1) reexperiencing, or the existence of a mental replay of the trauma and the strong emotional reactions attached to it; these reminders may occur when the adolescent is awake or during sleep (e.g., nightmares); (2) avoidance, exhibited through the youth's effort to escape activities, places, or people that may remind him or her of the trauma; (3) numbing, which involves the loss of emotions, especially positive feelings; and (4) arousal, which involves a heightened sense of awareness and is often experienced as difficulty in sleeping or concentration. The clinician will also document the length and severity of the symptoms. It is equally important that the clinician consider the environmental factors affecting each individual. Some adolescents currently in the Juvenile Temporary Detention Center may experience a heightened sense of anxiety due to their environment. For others who reside in communities with high crime rates and violence, the community environment may affect the targeted behavior.

Youth with PTSD may also suffer from other mental health disorders. The clinical interview, self-report measures, and motivational interviewing allow adequate opportunity for self-disclosure (Greenwald, 2002). Adolescents with a wide range of traumatic experiences may be effectively treated with these cognitive-behavioral techniques, however, individual treatment may be more effective than group therapy for an adolescent with multiple clinical issues (Davis, 1992).

TREATMENT PLAN

The proposed group intervention is consistent with AACAP recommendations for treatment for adolescents diagnosed with PTSD (AACAP, 1998). The proposed treatment method employs a group therapy format. Research supports this modality as an effective method for treatment of incarcerated males whose traumatic experiences are due largely to community violence (March et al., 1998; Ovaert et al., 2003). The choice to participate in group treatment will be discussed for each adolescent during his or her initial assessment with a psychologist. In that meeting, the clinician may discuss the traumatic experience with the adolescent and, with the youth's input, determine whether group or individual treatment is the more promising approach.

The primary treatment model to be discussed in this study, Trauma Adaptive Recovery Group Education and Therapy for Adolescents (TARGET-A), is currently

being used and adapted for specific populations (Ford, 2006). The TARGET-A approach is a strengths-based approach for trauma survivors. The method teaches pyschoeducation, coping skills, and lasting recovery through a seven-step practical approach that can be summarized by the acronym FREEDOM (Ford, 2006). The acronym FREEDOM stands for focus, recognition, emotion, evaluate, define, options and make a contribution (Ford, 2006). The steps center on empowering youth and teaching them to self-regulate, process current traumatic stress reactions, manage emotions, and set goals. In between sessions, adolescents complete worksheets. Through the FREEDOM approach, youth learn strategies to "use their minds to teach their bodies and emotions to be less reactive, and to create new memories that increase their self-esteem and personal control" (Mahoney et al., 2005, p. 12).

This article adapts the TARGET-A treatment plan (Mahoney et al., 2005) for use in a 10-session plan for group therapy with male juvenile offenders. Sessions will be held twice a week and will be 90 minutes long. Because most incarcerated youth are court-involved or currently placed at the detention center (located within the court complex), it is likely that they will be available to attend sessions held at the court complex. The proposed treatment plan is comprised of three elements: psychoeducation, coping skills, and lasting recovery. Sessions are delineated for each element discussed. The seven-step FREEDOM approach will also be integrated into the proposed treatment plan. To reinforce and build on what the adolescents learned previously, each successive session will review the material and handouts from the previous session. At the end of each session, each youth will be asked to assess his level of personal stress, personal control, and extreme stress reaction. Youth will be asked to rate each concern on a scale of 1 (low) to 10 (high).

Psychoeducation

Psychoeducation refers to educating an individual about the problem they experience, about how to treat it, and about how to prevent relapse. Although psychoeducation will occur to some extent in each session, it will be the main focus of the first session. The goal of this session is to provide youth with information about normal stress and to contrast normal stress with extreme stress. This first session will also set ground rules (e.g., attendance, participation, and safety guidelines) for the group's meetings (which will be held twice a week). Members will be asked to attend each session and to notify the facilitator if they cannot attend. Because this is a trauma group, aggressive behavior (i.e., causing physical harm to others) will not be tolerated. Members must feel safe if they are expected to participate in the sessions.

In order to gain an understanding of the difference between the biopyschosocial effects of normal stress and those of extreme stress, youth will be asked to review handouts (Ford, 2006; pp. 4–7). The handout uses a metaphor to show youth that their brains possess something like an alarm system. The same system that wakes them up in the morning also warns them if they are in danger. The activity is designed to illustrate the protective signals that the brain sends each individual. Yet, traumatic events may damage this alarm system. This handout illustrates how the conditions in which the brain signals emotions that may help create options for decision-making or coping are distinct from other situations (e.g., trauma or extreme stress) that may trigger emotions of "survival alarm mode" (Mahoney et al., 2005, p. 4).

The metaphor may be further illustrated by showing youth an alarm clock, letting them know when the alarm is set to sound, and then continuing to speak as the alarm goes off during the session. The observable distraction demonstrates how youth may feel when they cannot concentrate because their brain's alarm continues to signal after a trauma. The metaphor of a nonstop alarm is accessible to the adolescents because they can relate it to feelings of being out of control. Once the point has been made, the facilitator can turn down the alarm to show that this treatment may help the youth to turn down their own stress alarms. The adapted treatment approach described here returns to the alarm metaphor throughout group treatment. A consistent thematic intervention applies a focal (FREEDOM) skill set to cope with and reduce PTSD symptoms. To remind participants of the significance of the alarm metaphor, they are assigned weekly homework in which they must keep track of any time that they feel they are in the alarm mode. The handout and depiction of emotions are designed to help adolescents to conceptualize how their PTSD symptoms are likely to have developed. As a result, youth may be likely to accept treatment for help with this fear response (De Arellano et al., 2005).

Psychoeducation prepares the adolescents for the second session, in which youth are coached to develop coping skills for dealing with extreme stress. The first session concludes with an overview of the FREEDOM steps that will be covered over the next seven sessions. Here, the handout "TARGET Teaches Positive Coping" (Ford, 2006, p. 11) is helpful because it shows that many different actions are possible when the alarm is triggered as a result of extreme stress. Another acronym is used to illustrate a strategy available for coping with such stress: TRAPPED (terror, rage, abandoned, pressured, pain, emptiness, and defeated). The strategy may be discussed through a dialogue in which adolescents describe how they deal with stressful situations and with reactions to their own traumatic experience. Adolescents are not asked to "get in touch and get over"

the trauma, but rather to focus on current posttraumatic reactions and to learn how to "turn down the alarm" (Mahoney et al., 2005, p. 1).

Coping Skills

Because this approach is both strengths-based and present centered, most of the treatment plan involves teaching coping skills through the FREEDOM guidelines. During the second session, the group is taught about the first of the seven FREEDOM steps. This first set encourages a three-part strategy (slow down, orient, and self-check, or SOS) to develop focus as a skill for coping with extreme stress reactions. In response to extreme stress, the youth first slows down by taking a moment during a reaction to a traumatic event and by paying attention to breathing.

In the second phase of the SOS strategy, the youth orients. That is, the youth attempts to see the current time and place, who is around, and what activity is occurring. Orienting thus focuses the youth on being present and recognizing the surroundings. Self-check is the final phase in the SOS strategy. In this phase, the youth is instructed to consider how he feels at that moment. Although some youth may find focusing difficult, the use of diaphragmatic breathing may nonetheless provide the adolescents with a means of relaxing amid stress. Research has shown that controlling breathing reduces arousal in the nervous system, lowers heart rate, and slows the individual's rate of breathing (Friedrich, 1996; Greenwald, 2002; Hillman, 2002). The breathing technique is also useful because the youth can do it on his own. To learn how to control breathing, the individual is instructed to sit on a chair, to plant both feet firmly on the ground, and to close his eyes. The youth then is asked to take a deep breath, to count to six, and then to exhale. If an individual finds this difficult at first, he is encouraged to leave his eyes open and to place an object on his belly. The object rises as he inhales and falls as he exhales. This visual component helps to train the individual to use breathing as a way to focus. The method can also be used to reduce anxiety produced as a result of talking or thinking about the trauma.

Michael de Arellano and colleagues (2005) argue that coping skills are highly effective because they provide youth with ways to address dysfunctional thoughts, label emotions, and confront those emotions. Use of these skills, in turn, increases social functioning and builds problem-solving skills that the teenagers may use in the future.

The third of the 10 group sessions examines the second element in the FREEDOM model: recognition of stress triggers. The goal of this element is to teach the group members what triggers stress and how a trigger can lead to an

extreme stress reaction. To encourage youth to think about triggers, the facilitator might ask, "What are one or two specific triggers that can set off the alarm in your brain?" and, "What can you do to increase your control and happiness when you have a trigger?" These questions encourage youth to recognize triggers and to participate in problem-solving with other group members (Mahoney et al., 2005).

The fourth and fifth group sessions address youths' emotion awareness and encourage them to evaluate central thoughts. These sessions transition from teaching initial coping skills to instruction about the early warning signs that enable adolescents to foresee and avoid extreme stressors. In the discussion of emotion awareness, youth are instructed to differentiate between reactive feelings and a main emotion. For example, the main emotion may be excitement but the adolescent may be feeling impatience. Other main emotions, such as worry, may trigger numerous reactive feelings, like irritation or anger. By considering the different reactive emotions, the youth is encouraged to continue behavioral conceptualization, and he is able to make a connection between feelings and consequent behaviors. In this fourth session, the handouts review the "EED steps," which Julian Ford (2006, p. 16) defines as "Emotion, self-check, evaluate thoughts, define goals." The purpose of this review is to transition the youth from reaction to self-regulation of targeted behavior.

The current model adapts the provisions of the FREEDOM method to incorporate motivational interviewing into the session. This adaptation also presents an opportunity to incorporate a technique that Greenwald (2002) employs in his work with juvenile offenders. The proposed treatment will integrate Greenwald's therapeutic Future Movies technique (Greenwald, 2002). The activity will be introduced at the end of the fifth session, after the group has been instructed on how to recognize triggers, received training on emotion awareness, and learned to evaluate main thoughts. Then, each individual will depict his future movie as homework any in any medium (e.g., music, poetry, narrative, audio recording) he chooses. When the group returns for the sixth session, the adolescents will review the coping skills they learned in the preceding sessions, and each will present his future movie. Although incarcerated youth may have limited resources, the facilitator can provide the youth with access to the juvenile detention center's library so that they can complete the projects prior to the next session. The addition of future movies to the FREEDOM model promotes creativity among the group members and allows each individual to showcase his talent. It is also noteworthy that this treatment adaptation avoids focusing on the youth's retelling of the traumatic event. Rather, the method is consistent with the solution-focused, strengths-based approach.

Lasting Recovery

The seventh, eighth, and ninth sessions emphasize lasting recovery; in these sessions, the youth will begin to terminate involvement in the group treatment and to implement learned skills in daily living. Lasting recovery alludes to the expectation that PTSD symptoms have diminished as a result of participation in treatment. The Future Movies activity prepares group members to project their ideals for the future. In the seventh session, youth begin to address their plans through the fourth element of FREEDOM: defining main personal goals. For adolescents who experience PTSD symptoms, the focus on the future is essential; when individuals are overwhelmed or stressed, they often are not able to think clearly or to decide what they want out of a situation. Youth may describe this as feeling frozen or unable to control what occurs in their life. The youth's task during the seventh session is to define what he needs and then to identify main goals that will enable him to meet those needs. This process again reinforces the process of prioritization and the coping skill that enables a youth to turn down the alarm.

As the youth address their main personal goals, they consider how they might achieve these goals. For example, the goal might be to decrease aggressive behavior in the classroom at the juvenile detention center. Group members provide feedback on tried approaches that succeeded and those that failed. The feedback allows members to problem solve around failed approaches and improve goal setting skills. This record is reviewed during the eighth session, which is devoted to FREEDOM's options. The session identifies good options and has an options exercise that follows up on the records kept by youth between the sessions. It is important to reinforce the successes reported by youth. The options exercise (Ford, 2006; pp. 22–23) presents a stressful situation (typically, a common occurrence) that a youth is likely to experience. The group uses the situation to brainstorm about possible options on how to respond in a situation. This session identifies how a youth may solve problems and reduce behaviors that often occur as a result of symptoms from posttraumatic stress disorder.

The ninth session emphasizes the final element in the FREEDOM approach: making a contribution. This step is included in the treatment plan because individuals who experience stressful situations may have negative feelings about themselves (Mahoney et al., 2005). By recognizing a youth's positive contributions, the facilitator helps him to build upon small successes. Such successes may alter the individual's negative feelings about himself and may help him to react to future stresses in a controlled manner. For example, juveniles often do not give credit to themselves for being role models to younger siblings or protecting

family members. The primary function of this session is to recognize achievements that youths have already made, not to force adolescents to try harder to be a good person. The attention to the youth's small successes is crucial for juvenile offenders who may feel that they have already failed (Coleman, 2005). Session nine concludes with a review of the seven practice elements of FREEDOM: focus, recognition, emotion, evaluate, define, options and making a contribution (Ford, 2006).

The tenth and final session takes the format of a graduation ceremony in which group members review what the group has learned. In addition, the facilitator may inquire about whether the youth would like significant others, such as family members or probation officers, to attend the ceremony. The ceremony acknowledges the youth's acquisition of a new skill set for dealing with stressful situations. This acknowledgement validates the youth's work towards recovery from PTSD symptoms. Also, parental involvement may reduce the risk of future court involvement (Friedrich, 1996). Each individual is encouraged to share how he has begun to make positive changes as a result of the group. The facilitator may ask members what they particularly appreciate and value about the other group members. Members may also be encouraged to identify what they value about their own contribution to the group. The graduation ceremony is a good point to reintroduce the Future Movies activity. As the youth review their creations, they will be able to see how the expressed goals align with plans to make future contributions. Revisiting the activity also integrates the seven elements of FREEDOM into the final session. In this session, adolescents focus on current reconstruction, not on reviving memories of extreme stress experience.

CONCLUSION

Because PTSD in adolescents may manifest itself through deviant behaviors, the criminal acts of those youth may reflect the externalization of traumatic experiences. In these contexts, it is important to identify symptoms early, because reduction of the symptoms may in turn diminish deviant behaviors that cause recidivism. Because juvenile offenders are exposed to community violence at high rates, trauma-focused treatment, provided during probation or detention, may help to end patterns of violence that can persist as offenders return to their community. Most compelling for youth correctional facilities is the fact that treatment is associated with a reduction of behavioral problems (Coleman, 2005). However, juveniles who have not discussed traumatic events prior to assessment may not be prepared for group intervention. One suggestion for these adolescents is that they receive individual therapy prior to participation.

Future research should consider the form of group intervention adapted here, examining its effects on recidivism rates among juveniles with PTSD. Research should also consider the approach's effects on behavioral functioning at school and with the family.

The strength of TARGET-A is that it is flexible. An individual may use the intervention for a 4-session short-term group that addresses only the steps two through five of FREEDOM or for ongoing groups, such as those for anger management. The inclusion of motivational interviewing for the assessment and treatment intervention addresses ambivalence that many youths may feel towards their traumatic experience. The adapted treatment plan presented in this article is beneficial because it is present-centered. Among adolescents who have experienced trauma, it can also improve attachment concerns, emotion regulation, and information processing.

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NOTES

[1] The academy does not differentiate intense fear from horror; rather, the parameters suggest that symptoms vary according to developmental age of the child and fit within three broad categories: reexperiencing, avoidance and numbing, and increased arousal (AACAP, 1998).

[2] Narrative retelling refers to when the client revisits the trauma by relating the events in a narrative, oral or written, form.

[3] Many of the reviewed treatment approaches in this article do not regard the age of the targeted client suggesting that treatment among adolescents who experience PTSD is not as well documented as it is for adults.

[4] Davis (1992) reviews research published in the United States and identified through computer searches.

[5] Here, the goal is to encourage the youth to examine how they have stored memory of the traumatic event. The antecedents and beliefs allow a youth to recognize which external stimuli cause avoidance behavior.

[6] Resolution comprised the final session, in which participants concluded their experience within the group and integrated the learned skills in relation to trauma memories.

[7] In order to protect the confidentiality of the subjects in this study, the article omits the names and other identifying characteristics of subjects.

ABOUT THE AUTHOR

KATHERINE GREGG is a second-year full-time clinical student at the School of Social Service Administration. She also is a participant in the Graduate Program in Health Administration and Policy. Katherine received her B.A. in English from University of Michigan in 2004. Prior to enrollment at SSA, Katherine completed a year of service with AmeriCorps in Chicago as a health educator. Katherine's field placements included resource and intake positions as coordinator at Cook County Juvenile Court Clinic and Behavioral Health counselor at Sullivan High School school-based health center. Through her work with adolescents and health care, Katherine maintains her interest in health and mental health promotion for underserved populations. After graduation, Katherine will work as manager of behavioral health for PCC Community Wellness Center, a federally qualified health center in Chicago.

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