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When Children Hurt You: Examining the Experiences of Clinicians Who Work with Aggressive Young Children

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WHEN CHILDREN HURT YOU: EXAMINING THE EXPERIENCES OF CLINICIANS
WHO WORK WITH AGGRESSIVE YOUNG CHILDREN

by
Melisa S. Madsen

A Dissertation Submitted in
Partial Fulfillment of the
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ABSTRACT

WHEN CHILDREN HURT YOU: EXAMINING THE EXPERIENCES OF CLINICIANS WHO WORK WITH AGGRESSIVE YOUNG CHILDREN

by

Melisa S. Madsen

The University of Wisconsin-Milwaukee, 2019
Under the Supervision of Professor Marty Sapp

This grounded theory qualitative research study examined the experiences of mental health staff who work with aggressive young children under the age of 9. Through the use of semi-structured interviews, participants were asked about individual and organizational aspects that affect the care they provide to young children and their decision to stay with the organization. 14 mental health professionals from five different intensive outpatient programs for youth with behavioral concerns were interviewed. Data were analyzed using Strauss and Corbin's (1998) three-step data analysis process of open coding, axial coding, and selective coding. In answer to the question "What experiences do mental health professionals have that help or hinder them from providing daily care to aggressive young children?" the themes of "Ability to Conceptualize and Treatment Plan Effectively" and "Our Savior Complex" were found. Themes found to answer the question, "How do organizational aspects affect a mental health professional's ability to provide quality care to aggressive young children?" include "Logistics," "Career Opportunities," "Effective Multidisciplinary Teams," and "The Role of Management." The research and conclusions are presented in the form of a novella.

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Chapter I

Every day hundreds of thousands of mental health professionals prepare to go into work with no idea what to expect during their shift. The frequent change in clients coupled with frequently changing client personalities combine to create the perfect storm of unpredictability within the mental health profession. Some of those individuals work specifically with young children. Based on this author's experience, many mental health concerns can be difficult to identify in young children, leaving the majority of these referrals to children whose internal struggles cause them to become aggressive. Due to a less developed ability of formal decision making, these children can be impulsive in their aggression, causing it to be unpredictable for the children and clinicians alike.

Yet, these clinicians continue this routine day after day. Some days they come home with bruises and scratches, aches and pains. Every day they go into work prepared for that possibility. Some individuals enter into the field with an idyllic view of working with young children. This fantasy can be quickly shattered the first time a child's fist makes solid contact with their body. Eventually they return, but this is only temporary. It's only a short matter of time before they submit their resignation and move onto another area of focus; perhaps geriatric psychology, as a friend of the author's did. Still others find themselves enthralled with the constant unpredictability. They savor the rare moments of peace and quiet, and shine in the moments of crisis intervention. Some of the individuals who work in the field for years until their bodies, their doctors, or their dreams of freedom lead them to retire.

Those working in the field of child psychology are likely to agree that many children struggling with mental health concerns and aggressive behaviors are more likely to come from chaotic or unstable home and/or school environments. This instability has resulted in difficulties regulating emotions, leading to the frequent behavioral outbursts. Thus, an ideal treatment plan

for these children would include consistency and stability, which starts with consistent caregivers.

For this reason, it is vital to understand the experiences of individuals that work with aggressive young children. It's important to examine how individuals experience working with aggressive children, what makes their job easier, and what makes their job more stressful. This would allow us to invest in our mental health organizations to promote greater job satisfaction for employees, and overall better mental health care to patients and clients.

The literature regarding how to best help clinicians who work with aggressive clients is sparse, and when narrowed specifically to working with aggressive children, almost non-existent. The few studies that do exist about working with aggressive clients tend to come from the nursing field and focus generally on settings with primarily adult patients. However, working with aggressive adults is likely very different than working with aggressive children. Generally, due to their impulsivity, children behave aggressively more frequently than their adult counterparts. It's also difficult for most people to see children as capable of inflicting as much physical damage as a full-grown adult. For these reasons, when working with aggressive children, it can be emotionally taxing and physically exhausting, and literature regarding working with aggressive adults likely does not fully encapsulate the experience of those working with aggressive children.

This grounded theory qualitative study examined the experiences of mental health professionals that work with aggressive children. This chapter is meant to provide an overview of the research study. It will include a brief description of relevant background information, identify the research problem, and explain the purpose of the study.

Background Information

According to research, between approximately 10 and 13% of children under the age of 12 can be diagnosed as having a moderate to severe emotional and/or behavioral disorder (Forness, Freeman, Paparella, Kauffman, & Walker, 2012). Approximately 10 to 25% of children are estimated to have aggressive behavioral concerns (Loeber & Farrington, 2001 as cited in Rosato et al., 2012). Attention Deficit Hyperactivity Disorder (ADHD) alone is estimated to affect 4.5 million children (Bloom & Cohen, 2006). Of these children with ADHD, 50% of those who are referred for inpatient or intensive outpatient care exhibit aggressive behaviors that meet the criteria for Conduct Disorder as well (Conner, Glatt, Lopez, Jackson, & Melloni, 2002). Various researchers have found that aggressive behaviors in childhood are likely to lead to undesirable results into adolescence and adulthood, including antisocial behaviors, drug abuse, school dropout, depression, and incarceration (Caspi, Henry, Moffitt, & Silva; 1995; Guerin, Gottfried, & Thomas, 1997; Loeber & Farrington, 2001 as cited in Rosato et al., 2012). di Martino (2003) suggests that, in the US alone, the cost of violence is \$35.4 billion.

McAdams and Foster (1999) discuss the ecological nature of aggression, stating that aggression is part of a cycle that occurs between an individual and his or her environment. For this reason, personal or individual factors cannot be solely to blame for aggressive episodes. For example, a child with co-occurring ADHD and Conduct Disorder will not simply become aggressive due to their disorder. Instead, they will become aggressive due to something or someone in their environment. Individuals typically use aggression as a coping response, often as a way to maintain feelings of autonomy and control over one's environment (McAdams & Foster, 1999).

Due to the frequent co-morbidity of ADHD and aggression, aggressive behaviors are typically psychiatrically treated with the use of stimulant medications (List & Barzman, 2011).

Stimulant medications have been found to have a relatively high success rate for many children exhibiting aggressive behaviors (Blader et al., 2013). However, when stimulant treatment does not appear successful, atypical antipsychotics have also been found to produce a moderate decrease in aggressive behaviors in children studied (Blader et al, 2013; Barzman, 2010). There have been very few studies examining psychosocial treatment for aggressive young children in inpatient and intensive outpatient settings. Those that have been conducted suggest that parent training components are a helpful adjunct to other therapeutic practices such as Cognitive Behavioral Therapy and Behavioral Therapy (Cook et al., 2014; Rosato et al., 2012)

When viewing aggression as an ecological problem, McAdams and Foster (1999) suggest that organizational approaches can be helpful in the treatment of aggressive behaviors in young children. This approach examines the factors in the environment that lead to aggression and works to change those factors. It suggests that, for those who work with aggressive young children, certain organizational changes can be made to reduce the occurrence of violent episodes in the workplace. Some of these changes include increased knowledge and training, self-awareness, reduced access to weapons, increased access to exits, establishment of clear expectations for staff and patients, and providing as much autonomy as possible to patients.

Burnout, a term coined by Freudenberger in 1974, suggests that mental health workers who experience workplace stress (such as violence) are more likely to also experience feelings of emotional exhaustion, hold negative and cynical attitudes, feel unhappy with themselves, over-bond with coworkers, feel bored at work, bounce from job to job, experience low morale, frequently miss work, use psychoactive substances, and have somatic complaints. All of these things get in the way of a mental health professional being able to function competently at their job.

Lee, Cho, Kissinger, and Ogle (2010) suggest that all mental health workers experience stress as a part of the job. However, not all mental health workers develop burnout. Some mental health workers are able to cope with job stress and experience resiliency. Resilience is the way in which individuals cope, and possibly even thrive, after stressful and traumatic events (Crants, 2013). Some characteristics that have been found to promote resiliency include engagement, meaningfulness, subjective well-being, positive emotions, and proactive coping (Crants, 2013). While some coping strategies are personal, such as balancing one's personal and professional life, and engaging in enjoyable activities (Hunter & Schofield, 2006), some are organizational, such as high-quality, professional supervision, and conducting formal and informal debriefing episodes after critical incidents (Hunter & Schofield, 2006).

This study aimed to understand which personal and organizational resiliency strategies help mental health workers to continue to provide daily care to aggressive young children. It's been stated previously that working with young children can be particularly difficult for clinicians (Crants, 2013). As stated, stress at work can lead to burnout and poorer employee and client outcomes. Thus, understanding ways that organizations can foster resilience in their employees will likely lead to higher rates of resilience following difficult situations at work, therefore leading to better outcomes for clients and patients.

Few research studies have examined the experiences of clinicians who work with aggressive young children. Some studies, particularly in the field of nursing, have considered the experiences of nurses who work with aggressive patients in general, not specifically children. For example, Estry-Behar et al. (2008) found that nurses that were male, young, and less qualified were at a higher risk of experiencing workplace violence. They also found that violent acts were more prevalent on night shifts than day shifts. . Participating nurses suggested that high

quality teamwork, clarity of treatment protocols, adequate shift transitions, and a lack of interruptions were all buffers against violence. Overall, 22% of nurses interviewed reported being exposed to “frequent” violence from patients or patients’ relatives. This number can be compared to the 72% of nurses and doctors on an inpatient psychiatric unit that reported experiencing actual or threatened aggression in one year found by Wildgoose, Briscoe, and Lloyd (2003). Marner (2008) found that 60.1% of her participants reported being injured by workplace violence at least once during their employment. Baby, Glue, and Carlyle’s (2014) qualitative study found that, following acts of violence, nurses reported feeling fear for themselves, anxiety, frustration, vulnerability, grievance, distress, and anger. In Baby, Glue, and Carlyle’s study, nurses also identified feeling a lack of support from management in regards to the violence they experienced.

This writer was only able to identify two studies specifically relating to the experience of working with aggressive children. The first, a study by Faith, Fiala, Cavell, and Hughes (2011) examined the outcomes of college-aged students who mentored aggressive school-age children for approximately 18 months. They found that mentors experienced a negative shift in self-rated attitudes and personality following the mentorship period, which was mediated by the mentor’s view of the mentoring relationship. They found that mentors that viewed the relationship as supportive were more likely to experience positive shifts in attitude and personality characteristics as compared to their counterparts who found the mentorship experience to be difficult and unsupportive. Nissimov-Nahum (2009) conducted a study to examine art therapists’ experiences of treating aggressive children in the school environment in Israel. She found that art therapists who did not feel threatened by their clients and were unconcerned with rejection were able to envision more positive outcomes for these clients. On the other hand, individuals who

struggled to identify their role in relation to their client and those who felt distant in their relationship were more likely to feel rejected and threatened by their clients. They were less likely to feel that improvement was possible for their clients.

As can be seen by the previous two studies, there seems to be agreement that the supportiveness of the relationship can moderate changes for both the aggressive client and the clinician. Client change is possible within the context of a supportive and optimistic clinician that understands their role and their ability to contain the aggressive behavior of these children. However, the paucity of research on this topic leaves much to be desired. Research suggests that there are concrete things that clinicians and organizations can do to mitigate the potentially damaging effects of aggression by young clients. However, this has yet to be tested, examined, or observed in the clinical setting. Without such research, it is impossible to know what things clinicians find helpful to the work they do on a daily basis. We currently still do not know what motivates individuals to continue working with aggressive children or what helps them to provide top-quality care to these patients.

Research Problem

As stated in the previous section, there is a surprising lack of information about individual and organizational factors that foster resiliency in clinicians who work with aggressive young children. Research suggests that resiliency leads to better outcomes for both clinicians and clients, leading one to believe that understanding how to foster resilience would be beneficial. For this reason, this study attempted to understand what specific factors mental health workers who work with aggressive young children find to be helpful to continuing their daily work. Specifically, it examined clinicians' perceptions of what helps them to work in a potentially violent environment, as well as what their organizations do to contribute to their resiliency prior to and following aggressive acts in the workplace.

Purpose of the Research Study

This grounded theory qualitative research study examined the experiences of mental health professionals who work with aggressive young children. It examined the questions “What experiences do mental health professionals have that help or hinder them from providing daily care to aggressive young children?” and “How do organizational aspects affect a mental health professional’s ability to provide care to aggressive young children?” Using an evolved Grounded Theory model (Strauss & Corbin, 1998), data was collected through the use of semi-structured interviews using a theoretical sampling method. Data was then analyzed using Strauss and Corbin’s three-step data analysis process of open coding, axial coding, and selective coding. Their conditional matrix was also used. Further information about the research methodology can be found in Chapter III.

As mentioned previously, the significant lack of research meant to understand the experiences of clinicians who work with aggressive young children leaves the field with a lack of understanding on how to help these mental health professionals. By answering the research questions and developing an understanding, grounded in the data, to explain the individual and organizational factors that support these clinicians, organizations will have a base of research off which to develop plans and policies to improve the work environment and work experiences for their employees. As stated by Crants (2013), clinicians often cite that work with young children is particularly difficult for them. A difficult and stressful work environment can lead to either burnout or resilience (Lee, Cho, Kissinger, & Ogle, 2010). Burnout leads to many negative factors that impair one’s ability to provide top-quality care. Thus, understanding ways to foster resiliency, as opposed to burnout, in these stressful environments will ultimately lead to better care for patients. Theoretically, better care for patients should lead to less aggressive acts, based

on the ecological model proposed by McAdams and Foster (1999), leading to an even less stressful work environment. Ultimately, fostering resilience will help both clinicians and clients.

The field of Counseling Psychology takes a strengths-based approach to conceptualizing and treating clients. This study fits with the strengths-based approach, as it considers ways to foster resiliency, as opposed to focusing on things that contribute to burnout. When examining contributing factors to burnout, it is with the goal of understanding ways to prevent these factors from occurring.

The use of Strauss and Corbin's (1998) conditional matrix is particularly relevant to the social justice concerns of Counseling Psychology. This matrix helps the researcher to consider the various micro- and macro-level implications of the questions being considered and researched. Aggression in children is a concern at the micro- and macro-levels and at all levels in between. The conditional matrix helps provide a visual that explains the various levels goals and considerations in regards to patient aggression. The conditional matrix will be explained further in Chapter III.

Finally, this study addresses a core theme of counselor development. However, this study goes beyond just counselor development to overall organizational and mental health development, recognizing that a system's perspective is necessary for ecological change. Counseling Psychology focuses on aspects of self-awareness and self-improvement, suggesting that counselors should want to, and work to, improve themselves, ultimately improving their care for clients. This research study assumes that clinicians are self-aware enough to recognize personal reactions to clients and when their own actions may be potentially helpful or harmful for these individuals. It also assumes that these clinicians are doing what they can to improve

their care for patients and that there is a desire for research and guidelines that will help them improve that care, for both self and others.

Definitions

Aggression- Any act of physical, verbal, or sexual behavior that threatens the safety or well-being of an individual or object. The research literature on aggression and violence has much disagreement as to the definition of each term, or specifically how they are different. In this study, the writer will primarily use the term aggression, unless citing an original study that specifically uses the term violence.

Attention Deficit-Hyperactivity Disorder- A psychiatric disorder as stated in the DSM-5 (APA, 2013) that is characterized by a pattern of inattentive or hyperactive-impulsive behaviors in children.

Burnout- A clinical syndrome that is characterized by exhaustion, depersonalization, and a lack of feelings of personal accomplishment (Maslach & Jackson, 1981).

Callous-Unemotional Traits- According to the DSM-5 (APA, 2013), this relates to a lack of empathy. Individuals with these traits are unconcerned about the feelings of others and worry more about consequences of their actions on themselves than consequences for other people.

Client- In the counseling field, a client is the receiver of mental health services. This term will be used interchangeably with the term patient, as clients are often referred to as patients in the hospital setting.

Clinicians- In this study, clinician refers to any professional individual that works with a client/patient population. It may include nurses, social workers, counselors, psychologists, and psychiatrists. This term is used interchangeably throughout the text with mental health professionals.

Conduct Disorder- A psychiatric disorder as stated in the DSM-5 (APA, 2013), that is characterized by persistent behaviors that violate the rights of others or societal norms. It includes such things as aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules.

Disruptive Mood Dysregulation Disorder- A psychiatric disorder as stated in the DSM-5 (APA, 2013), that is characterized by severe recurrent temper outbursts that are out of proportion to the precipitating situation, as well as exhibiting a persistently irritable mood between outbursts.

Ecological Model- The belief that aggression does not occur due to individual factors but due to an interaction between the individual and his or her environment.

Inpatient- Hospitalization requiring patients to stay overnight. Psychiatric inpatient hospitalizations are typically at least a few days in length.

Intensive Outpatient- A treatment program in which patients attend treatment for a specified number of hours each day, but return home in between treatment hours. This level of care is less intensive than inpatient hospitalization, but more intensive than outpatient therapy.

Mental Health Professionals- In this study, mental health professional refers to any professional individual that works with a client/patient population. It may include nurses, social workers, counselors, psychologists, and psychiatrists. This term is used interchangeably throughout the text with clinician.

Oppositional Defiant Disorder- A psychiatric disorder as stated in the DSM-5 (APA, 2013), that is characterized by persistent angry/irritable mood, argumentative/defiant behavior, and vindictiveness.

Outpatient- Treatment in which an individual comes in for specified appointments, typically once per week or less, to meet with their treatment provider. This is the lowest level of mental health care.

Patient- The receiver of services within the hospital setting. This term will be used interchangeably with the term client, as client is often the preferred term within the counseling field.

Resiliency- The way in which individuals cope, and possibly even thrive, after stressful and traumatic events (Crants, 2013)

Violence- Any act of physical, verbal, or sexual behavior that threatens the safety or well-being of an individual or object. The research literature on aggression and violence has much disagreement as to the definition of each term, or specifically how they are different. In this study, the writer will primarily use the term aggression, unless citing an original study that specifically uses the term violence.

Young Children- In this study young children specifically refers to children under the age of 9 years old.

Summary

The purpose of this research was to develop a theory of persistence in mental health work with aggressive children. The research asked individuals to identify what is helpful for them in their work, and what they would like to see different in their work environment to support the work they are doing with these children. This is an important question to answer, because it's vital that children receive the best care possible, and thus we must be certain that clinicians are getting what they need to continue to provide that top-quality care.

This chapter began by providing background information regarding the prevalence and prognosis of aggressive behaviors in children. It examined treatment for these children, focusing specifically on the ecological model of aggression. The terms burnout and resiliency were presented. This was followed by a review of two studies that have examined the experiences of working with aggressive young children. The chapter went on to explore how contributing to the literature on the experiences of clinicians who work with aggressive young children would help organizations and the field of Counseling Psychology as a whole. A description of the methodological framework and data analysis guide for this study was provided, along with the research questions. Finally, definitions to assist the reader were stated.

The following chapter will explore the previous literature in more depth. It will begin by reviewing the literature regarding the diagnosis and prognosis of children with aggressive behaviors. This will be followed by information regarding what we know about the treatment of these behaviors in young children. The next section will focus on the concepts of burnout and resiliency and include information about specific factors that can contribute to resiliency, both individual and organizational. An organizational framework for understanding aggression and resiliency will be provided. The final section will detail what little is known about working with aggressive patients, and then specifically aggressive young children. It will conclude by presenting a rationale for the current study.

Chapter II

As stated in Chapter 1, the purpose of this study was to examine the experiences of mental health professionals working with aggressive young children. This chapter will provide a review of the literature relevant to the study focusing on the diagnosis and understanding of aggressive behaviors in children, followed by literature relevant to the concepts of burnout and resiliency in general mental health populations, concluding with a more in-depth examination of these concepts as related to work with aggressive patients and clients. Finally, this section will conclude with a summary of the literature presented, as well as a description of how the literature was used to inform the research study.

Diagnosis of Aggressive Children

Research suggests that the prevalence of moderate to severe emotional and behavioral disorders in children under the age of 12 is between 10 to 13% (Forness, Freeman, Paparella, Kauffman, & Walker, 2012) and aggressive behavior problems are estimated to affect 10-25% of children (Loeber & Farrington, 2001 as cited in Rosato et al, 2012). Emotional and behavioral disorders in children may include Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder (CD), Oppositional Defiant Disorder (ODD), and the new Disruptive Mood Dysregulation Disorder (DMDD) among others, (APA, 2013). Criteria for these disorders may include aggressive behaviors such as hitting, kicking, or destroying property, as well as “callous” or “cruel” behaviors (APA, 2013). Children with more severe behavioral concerns often end up in inpatient and intensive outpatient settings for therapy and medication management for these behaviors. The psychologists, psychiatrists, social workers, counselors, and other mental health professionals are then tasked with the difficult job of treating these children, often multiple children, simultaneously.

One of the most common diagnoses for young children is ADHD, affecting an estimated 4.5 million children (Bloom & Cohen, 2006). Children with ADHD frequently exhibit aggression to the extent that approximately 50% of children referred to inpatient or intensive outpatient settings with ADHD also meet the criteria for Conduct Disorder (Conner, Glatt, Lopez, Jackson, Melloni; 2002).

Precipitants to Aggression in Children

Aggressive behaviors in children can be thought of as having two primary motivating components, meaning that aggression can be classified as either reactive aggression or proactive aggression (Poulin & Boivin, 2000). Reactive aggression occurs when a child is reacting to a perceived threat or feels overwhelming feelings of frustration or annoyance. However, these events may seem minor or commonplace to the observer, as reactive aggression is usually triggered by an event with which children without mental health concerns could easily cope (Blader et al., 2013). However, the presence of mental health concerns can increase symptoms of depression and anxiety, and the concerns often include impaired impulse control.

Proactive aggression, on the other hand, is conceptualized as a volitional behavior that is used to obtain something the aggressor wants (Blader et al., 2013). Proactive aggression, like reactive aggression is also considered to be related to impaired impulse control. However, environmental characteristics are also implicated in proactive aggression, suggesting that proactive aggression is a learned behavior based on consequences in the individual's environment. Paul and Sheffield (2004) also suggest that a factor of proactive aggression includes a lack of emotional response to the pain the aggressor has caused the victim. Since the invocation of the DSM-5, this feature has been referred to as "callous-unemotional traits" (APA, 2013). Callous and unemotional traits are often linked to psychopathy (Blader et al., 2013),

which is a value-laden term. While proactive and reactive aggression are different in terms of their motivating factors, it is important to understand that most aggressive children will exhibit both types of aggression (Poulin & Boivin, 2000).

McAdams and Foster (1999) note that aggression is often ecological in nature, as opposed to individual or personal. That is, aggression occurs in an interaction between an individual and his or her environment, and not solely due to personal or individual factors. They go on to state that aggression is typically a problem solving or coping response, as detailed in the above forms of aggression. Aggression is thus used to maintain a feeling of autonomy and control over one's environment.

McAdams and Foster (1999) also state that violence occurs in a predictable cycle that follows the model of: Triggering Event, Escalation, Crisis, Recovery, and Post-Crisis Depression. While many individuals may claim that an aggressive act occurred without any type of warning or provocation, the cycle of violence suggests that the trigger occurred outside of the awareness of the observer. More likely, the observer failed to recognize the warning sign of escalation that were present prior to the crisis occurring.

Treatment of Aggression in Children

At various levels of hospitalization, treatment for these children will often include a combination of pharmacotherapy and psychotherapy. Pharmacological treatment for aggression often involves medication used to treat ADHD, because, as mentioned previously, aggressive behavior is often found in children with ADHD (List & Barzman, 2010). These treatments will often include the use of stimulant medications. However, if aggression persists after the administration of stimulants, atypical antipsychotics may be trialed. Both classes of medications

have been found to produce moderate resolution of both reactive and proactive aggressive behaviors (Blader et al., 2013; List & Barzman, 2010).

Psychosocial treatment, on the other hand, is less clear cut. Pardini, Lochman, and Frick (2003) found that children with callous-unemotional traits show less distress when confronted with the negative effects of their behaviors on others. This suggests that the child's ability to want to learn alternative behavior is limited, especially when using proactive aggression. Furthermore, this means that the individuals who work with aggressive children may be subjected to repeated aggression by their patients, as their patients are less able to recognize the distress they've caused. These children are also more likely to show more severe patterns of aggression and conduct problems (Frick, Cornell, Barry, Bodin, & Dane; 2003). A review of the literature conducted by Rosato et al. (2012) found that the most effective psychosocial treatment for young children (under the age of 8) include a primary parent training component. Evidence has also been found supporting the effectiveness of programs such as Parent-Child Interaction Training and Triple P, despite these programs not specifically targeting aggressive behaviors (Rosato et al., 2012). Both programs focus on the therapist working with the child as well as parents, guardians, and other caregivers and retraining these caregivers' interactions with the child. They focus on the child's environment and these new interactions with caregivers teach children to get their needs met in new, non-aggressive ways (Rosato et al., 2012). As children grow older, the addition of CBT interventions have also been found to be an effective adjunct to parent training. Finally, Rosato et al.'s primary recommendation for the treatment of aggressive children is beginning with psychosocial interventions due to the reduced likelihood of side effects as compared to psychopharmacological interventions. It's important to note that Rosato et al.'s review specifically reviewed outpatient treatments for aggression, which is likely to be

different from more intensive hospitalization services due to the acuity level of their patients. To this writer's knowledge, there has been no systematic review of treatments for aggressive children in inpatient or intensive outpatient hospitalization settings. One preliminary study by Cook et al. (2014) provides evidence that an intensive outpatient program for aggressive children and their parents found promising results in reducing levels of aggression in these children. However, this program was limited in the demographics of patients it could serve, used an unreliable data collection tool, and was researched at a single site over a brief period of time. For this reason, effective outpatient treatment for aggressive children remains largely theoretical.

McAdams and Foster (1999) suggest that there are organizational approaches that can be helpful in the treatment of aggressive young children. They suggest taking an ecological approach in which aggressive incidents are viewed as a dissonance in the system, instead of blaming the child. That is, there is discordance between what is expected of the child by the environment, and what the child is capable of doing. By moving to an ecological framework, blame is taken away from the child and the impetus for change is placed on the organization. The ecological framework examines four contributing factors to aggressive acts. The first is individual risk factors, which may include a history of violence, substance abuse, lack of self-control, demographic factors, and where the individual is currently in the cycle of violence. Secondly, the responsibility of the individual clinician is to examine their views on the origins of violent behavior. Thirdly, they should also work to increase their training and knowledge relevant to the cycle of violence and clinical work with aggressive patients. Finally, it's important for clinicians to explore within themselves their own social, political, cultural, and economic assumptions about violence and how this may influence the work that they do. As an organization, a setting that reduces the risk of violent behavior should be accomplished. This

includes removing access to weapons, as well as clear access to exits for staff, as well as patients who may become escalated. It's also important for the setting to establish clear expectations regarding appropriate behaviors that are communication and upheld from the beginning of treatment. Finally, the environment should be the least restrictive as possible, within the constraints of the setting. This means that patients should be allowed to retain some sense of personal freedom regarding choices and control, as much as is reasonable. The final component of the ecological model is an overall organizational component. Organizations should have clear philosophies, policies, and procedures for dealing with client aggression. Training should be offered regularly, as the provision of training represents how important it is for an organization to keep their employees safe. An atmosphere of indifference when faced with aggressive and violent incidents sends a message to employees and patients that safety is not a priority and minimizes the impact that these events have on staff and patients. Finally, organizations should focus on inter-professional collaboration which seeks input from all levels of staff to coordinate optimal patient care and make all employees feel valued.

Prognosis of Childhood Aggression

The effective treatment of aggressive behaviors in children is vital to a child's well-being as they age. Various researchers have found that aggressive behaviors in childhood show high correlations with conduct problems and antisocial behaviors throughout childhood (Guerin, Gottfried, & Thomas, 1997), adolescence (Caspi, Henry, Moffitt, & Silva; 1995), and into adulthood. Aggressive behaviors can also lead to drug abuse, school dropout, depression, and future incarceration (Loeber & Farrington, 2001 as cited in Rosato et al, 2012).

The preceding section discussed the diagnosis and treatment of aggressive behaviors in young children. Children exhibiting aggressive behaviors may experience a variety of diagnoses,

as well as a variety of precipitants to their aggressive behaviors. As will be discussed later, attributions as to the catalyst of aggressive behavior can significantly impact how clinicians react to aggressive incidents. Thus, understanding the precipitants to aggressive behavior is vital to the treatment and management of these behaviors.

The preceding section also explained the need for high quality psychosocial interventions for the treatment of such behaviors, due to the correlation between aggressive behaviors in young children and adverse future outcomes for these children. However, this section also pointed out the lack of literature regarding effective psychosocial interventions for aggressive children beyond an outpatient level of care. Future research needs to be concerned with developing best practice approaches for inpatient and intensive outpatient programs that treat children with aggressive behaviors. It is also important for research to consider how individual clinicians may impact treatment for these children in order to ensure the providers are providing top-quality effective interventions.

While the preceding section discussed statistics, precipitants, and treatment of aggressive behavior in children, the following section will focus on cases that might prevent counselors from delivering optimal care to their clients. It will discuss the theoretical ideas of burnout and resiliency in relation to working with the general mental health population. It will begin by giving the definition of burnout, and progress into relevant literature regarding the precursors and outcomes of burnout. Finally, this will be followed by a discussion of the literature relevant to resiliency in mental health professionals.

Burnout

The term burnout was originally coined by Freudenberger in 1974 when he began working with mental health workers who were experiencing workplace stress (as cited in Crants, 2013). Freudenberger noted that these workers were experiencing feelings of emotional exhaustion, developing negative and cynical attitudes, felt unhappy with themselves, began over-bonding with coworkers, felt bored at work, moved from job to job without evidence of career advancement, experienced low morale and absenteeism, began to use psychoactive substances, and complained of physical problems. Freudenberger later went on to describe the catalyst of burnout as devotion to a cause, belief, or relationship that failed to bring about the expected reward (Freudenberger & Richelson, 1980). In other words, burnout is experienced when the expectation of a situation is dramatically different from the actual situation or outcome. These disparities eventually increase and compound, resulting in a reduction of an individual's available resources such as energy, vitality, and ability to function competently at their job.

Perhaps better known for their work on burnout, are Maslach and Jackson, due to their development of the Maslach Burnout Inventory, a scale used to measure burnout in mental health professionals (Maslach & Jackson, 1981). Maslach and Jackson describe burnout as a clinical syndrome that is characterized by exhaustion, depersonalization, and a lack of feelings of personal accomplishment. Because Maslach and Jackson's definition appears to be the most commonly used definition of burnout in the literature, this definition will be used in the understanding of burnout within the proposed study.

di Martino (2003) suggests that in the US alone, the cost of stress has been estimated at \$350 billion per year, and the cost of violence at \$35.4 billion. He suggests two models for understanding the role of stress and aggression in the workplace. The Kasarek Model suggests

that workers that have limited job control, high levels of responsibility for other people, limited opportunities for alternative employment, and experience skill under-utilization were found to be more likely to become assaultive. However, patients may then be subject to intense stress from these employees, causing them to commit actions of violence against those workers who may be perceived as more vulnerable. The Chappell di Martino model (Figure 1.1) considers occupational, personal, and environmental problems. First, it considers the relationship between the assailant and the victim and considers the characteristics of both that play into the aggressive situation. For example, di Martino suggests that aggression is more likely to occur when people with conflicting personal characteristics come into contact. This model also examines contextual and environmental factors that contribute to acts of aggression. Importantly, the model suggests that violence can be incredibly difficult to eliminate once it occurs and recommends preventative measures. Because of its focus on the interaction between clients and organizations, the di Martino model will be used for the understanding of aggression in this research paper.

Clinician Experiences of Burnout

While most, if not all, clinicians will experience high levels of stress at their jobs, they may respond in varying ways; they do not all develop burnout. Lee, Cho, Kissinger, and Ogle (2010) identified three types of counselors, well-adjusted, disconnected, and persevering. Using the Counselor Burnout Inventory, they found that well-adjusted counselors scored low on all subscales, suggesting low levels of exhaustion, incompetence, negative work environment, devaluing the client, and deterioration in personal life. Disconnected and persevering counselors both appeared to exhibit medium to high scores on the exhaustion, negative work environment, and deterioration in personal life subscales. The difference is that disconnected counselors also scored high in feeling of incompetence and devaluing clients whereas the persevering counselor

scored low on the same subscales. Thus, in response to stress it appears that counselors may variably react by depersonalizing their clients and becoming unresponsive to their needs, or continuing to be flexible and responsive in their work. It should also be noted that Lee et al. (2010) found that of the counselors they interviewed, there was a roughly even divide between each type.

Marner (2008) focused on how the three types of counselors identified by Lee, Cho, Kissinger, and Ogle (2010) experienced empathy. Marner (2008) found that staff working in a public psychiatric hospital tended to experience high levels of emotional exhaustion and depersonalization, but also high levels of personal accomplishment. She suggests that these clinicians, who are more “other-oriented” may be less likely to develop burnout due to their ability to cognitively empathize and put the client’s experience in perspective to that it does not become so emotionally overwhelming. This relates to Lee et al.’s (2010) persevering counselor. Conversely, Marner’s (2008) description of counselors with a personal-distress style of empathy were more likely to experience depersonalization as well as lower feelings of personal accomplishment. This style was also positively correlated with symptoms of intrusion and hyper arousal in regards to experienced aggression. This style was more common in professionals such as line and direct care staff. Related to Lee et al.’s (2010) disconnected counselor, the individuals with a personal-distress style of empathy who also witnessed higher amounts of aggression were more likely to report symptoms of burnout. Finally, Marner (2008) found that higher levels of patient contact, specifically in a punitive role were positively correlated with levels of burnout.

When considering these three types of counselors, Lee, Cho, Kissinger, and Ogle (2010) found significant income differences between the persevering and disconnected counselors in that persevering counselors were more likely to make more money than disconnected counselors.

Disconnected counselors were also more likely to experience lower levels of personal accomplishment and self-esteem. Conversely, persevering counselors had the highest self-esteem of all three groups. Based on these constructs, Lee et al. (2010) hypothesized that the disconnected counselor profile could be equated with burnout or compassion fatigue.

The construct of the persevering counselor as suggested by Lee, Cho, Kissinger, and Ogle (2010) can be related to the idea of resilience. Resilience is the way in which individuals cope, and possibly even thrive, after stressful and traumatic events (Crants, 2013). Resilience is composed of mental and physical components that promote effective mental health and coping. Some constructs that have been found to contribute to resilience include hardiness, feelings of self-efficacy, an ability to find the positive in situations, tolerance, spirituality, and an ability to laugh (Crants, 2013). Characteristics that promote resilience and protect against burnout include engagement, meaningfulness, subjective well-being, positive emotions, and proactive coping (Crants, 2013).

Resiliency

Authors have identified various coping mechanisms for therapists suffering from burnout (Hunter & Schofield, 2006). These strategies vary from being those that the clinician themselves can employ to strategies that an organization can employ to better support their employees. Individual strategies can include a number of self-care and professional growth characteristics, while organizational strategies include formal structure as well as informal environmental characteristics.

Self-care techniques typically vary from person to person (Crants, 2013; Hunter & Schofield, 2006; Stender, 2013). However, some common themes include balancing one's personal and

professional life (Hunter & Schofield, 2006; Stender, 2013), engaging in enjoyable activities (Crants, 2013; Hunter & Schofield, 2006; Stender, 2013), mindfulness (Stender, 2013), social and professional support (Crants, 2013; Hunter & Schofield, 2006; Stender, 2013), and physical activity (Hunter & Schofield, 2006; Stender, 2013). Helpful professional development strategies include increasing years of experience (Hunter & Schofield, 2006), attending additional training opportunities (Crants, 2013; Littlechild, 1995), becoming more knowledgeable (Hunter & Schofield, 2006), engaging in personal therapy (Crants, 2013; Hunter & Schofield, 2006; Stender, 2013), accepting one's own limitations (Crants, 2013; Stender, 2013), finishing tasks to completion (Stender, 2013), and having a more detached stance from clients/compartmentalization (Crants, 2013; Hunter & Schofield, 2006; Stender, 2013).

Organizational Strategies to Promote Resiliency

Ways organizations have been found to increase their support for employees to avoid burnout include regular, high-quality, professional supervision (Baby, Glue, & Carlyle, 2014; Crants, 2013; Dupre, 2012; Hunter & Schofield, 2006; McAdams & Foster, 1999; Stender, 2013), maintaining a manageable caseload (Hunter & Schofield, 2006), conducting formal and informal debriefing episodes after critical incidents (Hunter & Schofield, 2006), and providing support to employees that are struggling to cope (Hunter & Schofield, 2006).

One specific organizational strategy mentioned in many articles as vital to the prevention and mediation of burnout is regular, high-quality, professional supervision (Baby, Glue, & Carlyle, 2014; Crants, 2013; Dupre, 2012; Hunter & Schofield, 2006; McAdams & Foster, 1999; Stender, 2013). Dupre (2012) notes that crisis supervision is generally helpful, but can be harmful when not executed properly by a well-trained clinician experienced in crisis supervision. Clinicians report looking for a supervisor they feel that they can trust, with which they are able to building a

good and supportive relationship (Hunter & Schofield, 2006). Supervision sessions should be dedicated to the needs of the clinician and may focus on performance improvement, as well as advanced theoretical conceptualizations (Hunter & Schofield, 2006). Another vital role for supervisors is being able to limit the number of demanding cases on each clinician's caseload (Hunter & Schofield, 2006).

Finally, another pivotal responsibility of respected supervisors is accessibility (Hunter & Schofield, 2006). A qualitative study by Hunter and Schofield (2006) found that clinicians working with traumatized clients would often want to debrief with their supervisor immediately following difficult sessions. This included a willingness to call them on their personal phone or after hours for a quick debriefing. Hunter and Schofield (2006) found that debriefing after difficult sessions also occurred with co-workers, sometimes informally, and sometimes formally through group supervision.

Multiple studies have addressed the ideal organizational culture when doing difficult work with clients (Hunter & Schofield, 2006; Littlechild, 1995). One important part of the culture is a match between the values of the clinician and the values of the work environment (Hunter & Schofield, 2006). Overall feelings of support and teamwork have also been mentioned as part of a supportive organizational culture (Hunter & Schofield, 2006; Littlechild, 1995). Marner (2008) found that 12.6 % of individuals working in a psychiatric hospital did not feel supported by their co-workers. Littlechild (1995) recommends that developing a culture of support means shifting away from punitive measures and one of openness to receiving reports from employees and focusing on remediation in response to these reports. Poor organizational culture has been found to have a number of negative effects beyond burnout. These effects can include tension, poor

work performance, general unhappiness, poor social relationships, and difficulty recruiting and retaining top-quality staff (Littlechild, 1995).

In this second section, the constructs of burnout and resilience were discussed in relation to work with a clinical population. While the majority of literature about burnout has tended to focus on clinicians who work a trauma population, a broader perspective is needed. All clinicians, regardless of the population they work with, can be at risk of burnout using the definition provided by Maslach and Jackson (1981). Specifically, none of the research presented examined burnout relevant to clinicians who work with young children. Participants in the Crants (2013) study did state that working with children was particularly difficult for them, but this concept has yet to be explored. Anecdotally, it would seem that clinicians working with young children experience high levels of burnout resulting in frequent staff turnover. Frequent turnover would thus likely lead to less qualified and experienced staff, suggesting less than optimal benefits for these child patients. To combat this high rate of burnout and turnover, researchers would first be tasked with proving that it, in fact, truly exists. Secondly, researchers would need to begin to understand what leads to this burnout in hopes that this knowledge could, in turn, foster resiliency practices for these clinicians.

This section also explored organizational tools and supports that can best assist clinicians to prevent burnout in the workplace. The most commonly cited source of organizational support was the use of high-quality supervision. However, supervision literature, in general, is quite lacking. While some of the cited studies discussed characteristics of a “good” supervisor, further research needs to continue to examine effective components of quality supervision specifically in regards to supervision following crisis events, and supervision of clinicians working with aggressive children. This literature should also continue to examine organizational responses to

aggressive incidents to develop best practices. Much of the literature in this area is relatively dated in nature (from the 1970s and 1980s), so it is difficult to determine its relevancy to the current counseling field.

The preceding section examined the theoretical constructs of burnout and resilience. It also discussed research relevant to the effects of burnout, as well as self-care and resilience strategies that can help prevent or manage burnout. In the following and final section, research directly related to working with aggressive patients will be examined. It will start by discussing research about working with aggressive patients in general, typically coming from the literature on psychiatric nursing. It will then progress onto research that specifically discusses the challenges of working with aggressive children.

Training to Work with Aggressive Children

One assumption regarding clinical work with aggressive children that needs to be explored is that the individuals working with these children actually know how to work specifically with aggressive children. This assumes that, not only have they received training in the therapeutic management of aggressive behaviors in children, but also that they feel confident in their ability to do so. Gately and Stabb (2005) directly examined this assumption by surveying a group of doctoral level graduate students in clinical and counseling psychology. Using the Violence Management Training Survey, Gately and Stabb found that approximately one third of those interviewed had experienced a client act aggressively towards them in a clinical setting. The most commonly reported act of aggression was verbal assaults. Most of the students interviewed felt that their general preparation increased their confidence in dealing with aggressive patients, however they simultaneously reported feeling particularly unprepared in dealing with client violence including: overall perception of violence, assessing for potential violence, prevention

strategies, workplace safety, phases of a violent episode, intervention strategies for when a client becomes violent, and verbal and physical de-escalation strategies.

Training courses have been developed to teach employees about verbal and physical de-escalation techniques. The most common forms of training include Therapeutic Crisis Intervention, Nonviolent crisis intervention, Positive Behavioral Support, Positive Behavioral Management, Control and Restraint, and Zero Tolerance Programs (Braun, 2013). These training programs often focus on the cycle of aggressive escalation, as well as verbal and physical de-escalation techniques. Braun reports that many individuals who received specific agency training in crisis intervention techniques reported higher confidence in coping with client aggression along with higher levels of job satisfaction. However, others have found that some employees felt as though prescribed techniques were not necessarily realistic (Nunno, Holden, & Leidy, 2003). Others have found that training was only helpful with repeated practice and further training (Grenyer et al., 2004). These trainings also take away from time that employees can spend with patients.

Needham, Abderhalden, Halfens, Dassen, Haug, and Fischer (2005) piloted a new training program for psychiatric nurses. This program was computer-based and consisted of 20 50-minute modules designed to be completed over five days. This allowed nurses to complete the modules during times convenient for them. These modules included topics such as types and causes of aggression, genesis of aggression, reflection on one's own aggressive components, theory on the various stages of aggressive incidents, behavior during aggressive situations, types of conflict management, communication and interaction, post aggression procedures, workplace safety, prevention of aggression, breakaway techniques, and role play. The training intervention was completed by full nursing teams on three different units. Specifically, they were interested in

nurses' perception of the genesis of aggression, as Duxbury (2002) found that how staff perceived the origin of aggressive episodes would influence how they interacted with these patients. Needham et al. (2005) found that the training intervention had no significant effects on nurses' perceptions of the genesis of aggression, their understanding of aggressive incidents, nor the personal impacts of aggression on nurses.

Braun (2013) considered individual characteristics and their links to confidence in coping with client aggression. He found no significant effects for any individual characteristics or previous exposure to aggression and job satisfaction or confidence in coping with client aggression. He found a significant main effect for the presence of academic training on job satisfaction, but this was found to have a small effect size. Additionally, a significant main effect was found between the presence of agency training, job satisfaction, and counselor confidence in coping with client aggression, but this was found to have a very small affect size as well. It should be noted that within this study, like most studies on workplace environment and working with aggressive children, the sample only includes those currently employed. This leaves out employees that have left the organization, which would be an important comparison sample. Such a comparison sample would allow researchers to examine differences in reactions to physical aggression that may lead differentially to resilience, or burnout that causes one to leave one's job.

Organizational Environment Related to Coping with Aggressive Clients

As noted previously, McAdams and Foster (1999) implicate the organizational environment as related to confidence in coping with client aggression. Organizations can work to create a setting that reduces the risk of violent behavior. This includes removing access to weapons, as well as clear access to exits for staff, as well as patients who may become escalated. It's also

important for the organization to establish clear expectations regarding appropriate behaviors that are communication and upheld from the start. Finally, the environment should be the least restrictive as possible, within the constraints of the setting. This means that patients should be allowed to retain some sense of personal freedom regarding choices and control, as much as is reasonable. Another component of the ecological model is an overall organizational component. Organizations should have clear philosophies, policies, and procedures for dealing with client aggression. Training should be offered regularly, as the provision of training represents how important it is for an organization to keep their employees safe. An atmosphere of indifference when faced with aggressive and violent incidents send a message to employees and patients that safety is not a priority and minimizes the impact that these events have on staff and patients. Finally, organizations should focus on inter-professional collaboration which seeks input from all levels of staff to coordinate optimal patient care and make all employees feel valued.

Related research conducted by Chang, Eatough, Spector, and Kessler (2012) suggests that an organization's policies and procedures have the ability to affect employee motivation to engage in violence prevention procedures. However, when employees felt that management was pressuring them to use unsafe practices, there was a strain on prevention compliance procedures. One such example of this would be Wildgoose, Briscoe, and Lloyd's (2003) finding that only 60% of incidents involving violence or threatened violence in the workplace are reported. Overall, Chang et al. found that a violence prevention climate is shared by all members of an organization, so a lack of dedication by management had a trickle-down effect to employees.

di Martino (2003) suggests that violence in the workplace has a number of direct and indirect influences on the workplace and organizations (see Figure 1.1). Primarily he suggests that once violence becomes a part of the workplace, it can be difficult to eliminate. Instead, he promotes

prevention strategies as the primary way of managing violence. di Martino suggests that when violence does occur, victims can often experience suffering and humiliation that can lead to a lack of motivation, lack of confidence in oneself, and overall reduced self-esteem. Thus, employers bear the direct cost of loss of productivity in regards to the loss of quality output from staff suffering from a lack of motivation and confidence, which is a finding replicated by Chang, Eatough, Spector, and Kessler (2012). Another indirect cost of violence in the workplace, noted by di Martino, is competitiveness between employees. More direct costs include absenteeism, high staff turnover rates, accidents in the workplace, and the possibility of illness, disability, and death. Overall, di Martino estimates that workplace stress and violence may account for about 30% of the total costs of ill-health and accidents in the workplace. Wildgoose, Briscoe, and Lloyd (2003) found that 10% of individuals they surveyed took time off, up to or greater than 1 month, following being aggressed upon by a patient. Besides the economic impact, violence may also negatively impact the company image, employee motivation and commitment to the company, creativity, working climate, openness to innovation for both employees and organizations, and the ability to build and gain knowledge.

Littlechild (1995) produced a seminal work in which he details ways in which organizations can establish a culture of violence prevention and support. He suggests that it is vital for organizations to shift away from punitive measures and towards one of support for both their employees and their patients. This includes a change of attitudes and a change in policies. He starts with a recommendation for training, which should take places within treatment teams, and should clarify expectations of all team members. He also emphasizes a need for organizations to provide feedback to employees following incidents of aggression. He notes that debriefings should help staff to identify the environmental elements that led to the incident in an attempt to

prevent future recurrences. Finally, he notes the importance of open communication between management and employees regarding changes to policies and procedures in response to incidents of violence and aggression.

The Experience of Working with Aggressive Patients

Much of the knowledge we have regarding the experience of working with aggressive clients or patients comes from nursing literature. A comprehensive study of nurses in eight countries found that male gender, young age, and lesser qualified individuals were more at risk of violence in the workplace (Estryn-Behar et al., 2008). It was also found that violent acts were more likely to occur on night shifts than day shifts, and individuals who reported higher levels of harassment from supervisors were also more likely to be victims of violence perpetrated by patients or relatives. Participating nurses suggested that high quality teamwork, clarity of treatment protocols, adequate shift transitions, and a lack of interruptions were all buffers against violence. Overall, 22% of nurses interviewed reported being exposed to “frequent” violence from patients or patients’ relatives, and violence was strongly correlated with an intention to leave the nursing profession, change places of employment, and overall burnout. That number is significantly lower than that 72% of nurses and doctors working at an inpatient psychiatric facility that reported experiencing at least one act of threatened or actual aggression in the past year (Wildgoose, Briscoe, Lloyd, 2003). This number is similar to that of Marner (2008) who found that 60.1% of her participants reported being injured at least once during their employment. She also found that 50% of her participants reported witnessing seven or more incidences of aggression in a single month. It should be noted that the differences in these statistics may also be related to their varying measures of workplace violence.

Baby, Glue, and Carlyle (2014) conducted a qualitative study to examine mental health nurses' experience of violence on the job. They found that verbal abuse was the most prevalent abuse experienced by their participants. After acts of violence, nurses reported feeling fear for themselves, anxiety, frustration, vulnerability, grievance, distress, and anger. However, these emotional responses are just the first affects to appear. They are then linked to professional and personal changes, as the use of self is vital to the therapeutic role played by these nurses. Some nurses were able to use the experience to learn new skills while others experienced consequences including a loss of self-esteem, loss of confidence, burnout, and strained family and social relationships. Baby, Glue, and Carlyle found that after incidents of violence, nurses were most likely to turn to peers for support first, and management second. Nurses identified feeling a lack of support from management in regards to the violence they experienced. Those that reported a lack of managerial support and also reported high job demands were likely to experience poorer outcomes in their management of aggression and violence. Positive responses from management often included the provision of clinical supervision, as well as an opportunity to debrief.

The Experience of Working with Aggressive Children

Finally, we turn our attention to the sparse literature containing what is known about the experience of working with aggressive children. Crants (2013), when interviewing experienced clinicians about burnout, found that 75% of his participants rated working with children as a particularly difficult part of their job. Faith, Fiala, Cavell, and Hughes (2011) examined how college students' attitudes changed over the course of a mentoring relationship with highly aggressive children. This study included 102 college-age mentors and their school-age mentees. All mentors were enrolled in college classes in education or psychology and received course credit for their participation in the mentorship program, which took place over four semesters.

The majority of mentors were single white females with an average age of 20 years. With the exception of age, this is a similar demographic to most clinicians working with aggressive young children in intensive outpatient settings. Mentees were second-and third-grade children that were participating in a larger prevention study that specifically targeted children at risk of future delinquency and substance abuse. The mentee group was comprised of primarily males, approximately half of whom were African American, with an average age of 7.8 years. It is difficult to estimate a match in demographic makeup with intensive outpatient patients, due to drastic differences based on treatment locations.

Prior to the start of mentoring, mentors participated in a semester-long didactic training that consisted of lessons addressing childhood aggression, the prevention of juvenile delinquency, and skills chaining in child-directed play (Faith, Fiala, Cavell, Hughes, 2011). Mentors were also advised on how to manage the behavior of highly aggressive children. Pre- and post-test measures included the Mentor Self-Efficacy Scale, the Future Parenting Scale, Goldberg's 100 Unipolar Markers, the Adult Attachment Questionnaire (AAQ), Mentoring Relationship Support, the Impact of Mentoring Scale, and Child Aggression. These scales were chosen to measure attitudes towards aggressive children, mentor personality traits, and overall impacts of mentoring on the mentor.

The mentoring relationship consisted of a minimum of one hour per week of face-to-face mentor-mentee meetings (Faith, Fiala, Cavell, Hughes, 2011). Mentors were also required to attend weekly group supervision meetings, led by doctoral students, who were in turn supervised by doctoral-level psychologists with 10 or more years of practical experience. The supervision sessions often focused on the management of conflict within the mentor-mentee relationship.

The final few months of supervision were dedicated to preparation for the termination of the relationship.

Faith, Fiala, Cavell, and Hughes (2011) found that mentors experienced a negative shift in self-rated attitudes and personality following the mentorship period. However, this relationship was partly mediated by the mentor's view of the mentoring relationship. When mentors viewed the relationship as supportive, they were more likely to experience positive shifts in the areas of mentor self-efficacy, openness, conscientiousness, extraversion, and agreeableness. This suggests that the mentor's view of the supportiveness of the relationship could have a strong impact on personality outcome characteristics. Overall, the researchers found a drop in self-efficacy over the course of the mentoring relationship. While negative changes were found in self-efficacy and many personality domains, it should be noted that these changes, while statistically significant, were numerically minor. Post-test data also revealed that despite the negative changes, mentors continued to report personality scores above the mean for the test. Faith, Fiala, Cavell, and Hughes (2001) also found that, in relationships that mentees rated to be less supportive, mentor-rated support was a stronger predictor of self-efficacy. That is, the positive relationship between self-efficacy and mentor-rated support was stronger for those relationships that were rated as less supportive by the mentees. Researchers also found that when mentees rated the relationship as more supportive, mentors were more likely to report a decrease in positive attitudes about future parenting. In terms of attachment ratings, mentors who rated their relationships as more supportive also rated themselves to be less avoidant over the course of the three-semester period. Overall, this research suggests that mentors who view their relationship with aggressive mentees as supportive were more likely to report positive gains than

mentors who viewed the relationship as unsupportive, implicating attitudes towards these children as having a significant impact in mentor functioning.

Finally, Nissimov-Nahum (2009) conducted a study to examine art therapists' experiences of treating aggressive children in Israel. Citing her doctoral dissertation from 2007, Nissimov-Nahum found that when clients acted aggressively, their therapists reported feelings of rejection, and reported coping by rejecting the client themselves (as cited in Nissimov-Nahum, 2009). This study followed a qualitative constructivist framework with a phenomenological approach. Participants were art therapists who self-reported experiences of working with aggressive children. The therapists were separated into 2 groups, Group A and Group B. Group A consisted of therapists who reported the highest levels of improvement in the aggressive behavior of a focus client previously described in a questionnaire who simultaneously reported little to no difficulty in working with aggressive children. Group B consisted of therapists who reported either no improvement or increased aggressive behavior in their focus client, along with experiencing the greatest amount of difficulty in conducting therapy with aggressive children. An analysis of differences between the two groups found that the only significant difference was that therapists in Group A were reported to have more experience than those in Group B.

As part of the task, the therapists completed a questionnaire focused on a single case of a child ages 5-14 that the therapist reports working with, primarily due to their aggressive behaviors (Nissimov-Nahum, 2009). Prior to stage 2 of the research, participants were asked to complete a structured drawing task to represent the therapeutic relationship with the client described in the questionnaire as well as a short written description of the picture, answering structured questions. Participants then brought this drawing and written response to a semi-structured interview with the researcher. Nissimov-Nahum (2009) found that the therapists in

Group A typically did not feel threatened by their clients and were not concerned with possible rejection from these clients. They were thus able to visualize better outcomes for these clients. Conversely, Group B therapists struggled to identify their role in relation to the client, causing them to feel distant in the relationships. They often felt rejected and threatened by their clients and expressed despair at the possibility of improvement for the client. She also found that therapists that had not previously explored and integrated their own capability for aggression found it difficult to develop a close relationship with their aggressive clients. Overall, this research suggests that by having a clear understanding of one's role in the therapeutic relationship as well as optimism for change for the client, the therapist and the client are more likely to develop a positive relationship and the client is more likely to experience positive change and a reduction of aggressive behaviors.

As can be seen by the previous two studies, there seems to be agreement that the supportiveness of the relationship can moderate changes for both the aggressive client and the clinician. Client change is possible within the context of a supportive and optimistic clinician that understands their role and their ability to contain the aggressive behavior of these children. However, the paucity of research on this topic leaves much to be desired. It is vital to contribute to the literature on the actual experiences of those who work with aggressive children in order to ensure the best outcomes for both those children and their clinician counterparts. Further research should continue to consider the various roles that clinicians may play in working with these children, as well as how different settings may produce different impacts on these clinicians.

Summary

Overall, this final section began by exploring literature related to the training of clinicians to work with aggressive individuals. It went on to consider, again, how organizational culture can affect the experiences of both clinicians and patients when aggression occurs. The experiences of psychiatric nurses working with aggressive patients were explored next, ending with a thorough discussion of two studies that specifically explored the experiences of individuals working with aggressive children.

From the literature it appears that organizational support is strongly linked to positive experiences for clinicians and patients when aggressive incidents occur. However, the majority of studies examine single organizations and their employees. This suggests that the research is not comprehensive enough to make conclusions beyond that single organization. Future research needs to be conducted across a number of organizations to determine common factors and identify specific practices that lead to best outcomes for both employees and patients.

When considering the literature regarding the experiences of working with aggressive patients, one cannot help but notice that a majority of these studies focus on adult patients. However, it would be imprudent to assume that the related experiences and results of these studies directly or indirectly relate to those individuals working with aggressive young children. For this reason it is vital to have research that specifically focuses on the experiences of those individuals who work with aggressive children.

Finally, this writer was only able to find two articles that specifically examined the experiences of individuals who work with aggressive young children, and only one of those articles included mental health professionals. This is a severe gap in the literature, which

suggests a blind spot for researchers and clinicians alike. It is vital that future research examines the experiences of those who work with aggressive patients, in general, again focusing on adult and child patients separately, as a link should not be assumed.

This chapter provided a look at research relevant to working with aggressive children. It began by discussing the diagnosis, precipitants, treatment, and prognosis of young children who exhibit aggressive behavior. This was followed by an overview of the concepts of burnout and resiliency, and how these are experienced by clinicians working with a variety of clients. Finally, research examining a supportive organizational culture regarding working with aggressive children, and experiences specific to working with aggressive children and adults were presented. As was mentioned, significant gaps exist in each of these bodies of literature. Specifically, research needs to begin to examine how clinician attitudes and behaviors can lead to differential treatment and outcomes for aggressive children. Secondly, research has generally focused on clinicians working with adult populations, ignoring those who work with children. The concepts of resiliency and burnout need to be studied in regards to these individuals working with children, in hopes of developing resiliency practices. Much research is also conducted in single organizational settings, which precludes the reader from being able to generalize to other organizations, suggesting the need for cross-organizational research. Finally, research is severely lacking in regards to the experiences of clinical professionals working specifically with aggressive children. This study aimed to address a number of these gaps in the literature. Specifically, this study was cross-organizational, and examined the experiences of clinicians who work with aggressive children. It aimed to understand resiliency practices that support continued and optimal treatment for aggressive children. Finally, it attempted to understand individual

clinical practices, as well as organizational practices that help lead to resiliency in working with aggressive children. The following chapter will describe the research in more detail.

Chapter III

This chapter will present the methods that were employed in the research study. First, the research questions will be identified, followed by a description of the research paradigm. The next section will describe the research team and their training. The participants in the study will then be described. The following section will describe the data collection procedures, including participant recruitment and the interview protocol. Researcher biases and expectation will then be addressed. Finally, the procedures for preparing, analyzing, and presenting the data and results will be described, followed by a chapter summary.

Research Question

As stated previously, there is an incredible lack of research regarding the experiences of clinicians who work with aggressive children. The purpose of this study was to gain a broader understanding of the experiences of mental health professionals who work with young children with behavioral disorders. Specifically, this study explored factors of counselor stamina and resilience that allow professionals to continue providing top quality care to clients. It focused on the questions, “What experiences do mental health professionals have that help or hinder them from providing daily care to aggressive young children?” as well as, “How do organizational aspects affect a mental health professional’s ability to provide care to aggressive young children?” By understanding experiences that help clinicians, as well as those that may prove hindering, organizations that provide mental health care to aggressive young children will have a knowledge base from which to better provide supportive environments and experiences that retain top-quality mental health professionals.

Theoretical Foundation for Research

This study assumes that mental health professionals are at risk of *burnout* (Lee, Cho, Kissinger, & Ogle, 2010) and that working with aggressive young children may increase this risk. However, it also assumes that mental health professionals are capable of *stamina* or *resiliency* to continue doing their jobs as well as they are able (Cohen & Collens, 2013; Costello, 2015; Osborn, 2004). Theories of resiliency and stamina suggest that individuals are able to grow after experiencing a traumatic event (Costello, 2015). For mental health professionals, posttraumatic growth and resiliency promote emotional development on the part of the counselor that can further enhance their work with clients (Costello, 2015).

As mentioned in the previous chapter, resiliency is the process of coping, and possibly thriving, after experiencing stressful and traumatic events (Crants, 2013). If burnout and resiliency are thought of as a continuum, if an individual experiences a stressful and traumatic event, but does not experience resiliency, they are more likely to exhibit signs of burnout and posttraumatic stress (Lee, Cho, Kissinger, & Ogle, 2010). Clinicians experiencing burnout are likely to feel emotionally exhausted, develop cynical attitudes, feel bored at work, avoid work entirely, and jump from job to job, all of which decrease their ability to provide adequate care to clients and patients (Crants, 2013). Lee et al. (2010) remind us that most, if not all clinicians, experience high levels of stress at their jobs, making it nearly unavoidable. Thus, it would make sense that organizations would want to promote reactions to these stressors that foster resiliency as opposed to burnout.

Using the research presented in the previous chapter, the researcher considered strategies used to prevent burnout and promote resiliency as possible categories when analyzing and coding data. In the same manner, the researcher considered the various types of counselors

suggested by Lee et al. (2010) as possible categorical descriptors. This previous research was used as a starting point from which she formulated questions for the initial interview, as well as subsequent interviews. Because the focus of this strengths-based research was on ways to promote resiliency, the primary focus in interviews and data collection was on factors that encourage optimal well-being and mental health practices despite experiencing job stress.

Research Paradigm and Design

This research was based on a constructivist paradigm. It's important to note that qualitative research based on a constructivist paradigm believes that meaning is constructed within and between individuals (Cobern, 1993) and based on each individuals' prior experiences. Because no two individuals have the same experiences, it is likely that each individual's construction of and meaning ascribed to an event will be different. Therefore, within constructivist-based research, Truth cannot be reported. It will always be colored by the experiences of the researcher, as well as the participants.

As mentioned in the previous section, this research is based on the theories of burnout and resiliency, as well as the ecological framework for understanding aggression and organizational frameworks that can help to prevent aggression. The first research question asks, "What experiences do mental health professionals have that help or hinder them from providing daily care to aggressive young children?" This question directly relates to the concepts of burnout and resiliency. The research aimed to understand what background and experiences promote resiliency in mental health professionals, and what experiences are more likely to lead to feelings of burnout. The di Martino (2003) model shown in Figure 1.1 also helps to represent how mental health professionals who experience aggression may go on to experience burnout, leading to an increased likelihood and experiencing further aggression from clients.

When reviewing the concept of burnout, it's important to remember that research has found that individuals who witness aggression in the workplace more frequently are also more likely to suffer from symptoms of burnout (Marner, 2008). This suggests that if organizations can employ strategies that reduce the risk of aggression in the workplace, they will simultaneously be reducing the risk of burnout for their employees. The ecological approach suggests that aggressive incidents occur due to discordance between what is expected of a child by the environment and what the child is capable of accomplishing (McAdams & Foster, 1999). By moving to an ecological framework, blame is taken away from the child and the impetus for change is placed on the organization. The ecological framework examines four contributing factors to aggressive acts. The first is individual risk factors of the client, which may include a history of violence, substance abuse, lack of self-control, demographic factors, and where the individual is currently in the cycle of violence. Secondly, the responsibility of the individual clinician is to examine their views on the origins of violent behavior. Thirdly, the clinician should also work to increase their training and knowledge relevant to the cycle of violence and clinical work with aggressive patients. Finally, it's important for clinicians to explore within themselves their own social, political, cultural, and economic assumptions about violence and how this may influence the work that they do. The organization itself can also set up an environment that reduces the risk of aggression, including reduced access to weapons in the environment, increased access to exits, the establishment of clear expectations for staff and patients, and providing as much autonomy as possible to patients (McAdams & Foster, 1999).

Organizations can also provide support to their employees to reduce the risk of burnout when working with aggressive clients. Some ways research suggests that organizations can prevent burnout in their employees include regular, high-quality, professional supervision (Baby, Glue,

& Carlyle, 2014; Crants, 2013; Dupre, 2012; Hunter & Schofield, 2006; McAdams & Foster, 1999; Stender, 2013), maintaining a manageable caseload (Hunter & Schofield, 2006), conducting formal and informal debriefing episodes after critical incidents (Hunter & Schofield, 2006), and providing support to employees that are struggling to cope (Hunter & Schofield, 2006). The overall organizational culture is another aspect necessary to build resilience in clinicians. Cultural aspects of organizations that can promote resilience include the match between the values of the clinician and the values of the work environment (Hunger & Schofield, 2006), feelings of support and teamwork (Hunter & Schofield, 2006; Littlechild, 1995), and shifting away from punitive measures towards a culture of openness and remediation (Littlechild, 1995).

The second research question asked, “How do organizational aspects affect a mental health professional’s ability to provide care to aggressive young children.” Using the environmental and ecological frameworks, the researcher better understood how organizational factors may contribute to resiliency for mental health professionals. It’s also important to note that individual clinician factors and environmental factors likely interact in their ability to prevent burnout and promote resiliency.

Qualitative Approach

This study was conducted using a grounded theory qualitative research approach (Glaser & Strauss, 1967; Strauss & Corbin, 1998), and used interviews as the primary mode of data collection. This topic called for a grounded theory approach due to the lack of evidence currently available on the topic resulting in a lack of a comprehensive theory to explain how to best promote resilience in mental health professionals that work with aggressive young children.

Grounded theory allowed the researcher to understand counselor resilience and stamina specific to the experiences of mental health professionals that work with aggressive young children.

Grounded theory is a method of data analysis and theory formation originally developed by Barney Glaser and Anselm Strauss and communicated in their book The Discovery of Grounded Theory: Strategies for qualitative research (1967). However, as explicated in Walker and Myrick (2006), Glaser and Strauss eventually began writing about Grounded Theory independently of one another. Glaser adhered to the original tenants of Grounded Theory proposed in The Discovery of Grounded Theory while Strauss's writing appeared to evolve the theory, joining forces with Juliet Corbin (1998). This led to two separate traditions of Grounded Theory: the original Glaserian Theory, and Strauss and Corbin's evolved Grounded Theory (Mills, Bonner, & Francis, 2006). Where original Glaserian Grounded Theory relies more heavily on objectivity on the part of the researcher, evolved Grounded Theory acknowledges the impossibility of this and sticks to a Constructivist approach. Therefore, this research relied on the Grounded Theory methods explained by Strauss and Corbin (1998). A table showing the similarities and differences between Glaserian Grounded Theory and Evolved Grounded Theory can be found in Table 1.3.

The name "Grounded Theory" is derived from the process by which Glaser and Strauss believed theories originated-as grounded in the data (Glaser & Strauss, 1967). This remains the same in Strauss and Corbin's evolved theory (1998). For a theory to be grounded in the data, it must be gathered systematically and analyzed throughout the research process (Strauss & Corbin, 1998). It is important to Grounded Theory that the researcher does not start with a preconceived hypothesis, as this would taint their ability to view the data as objectively as possible. Glaser, Strauss, and Corbin all argue that "theory grounded in the data is more likely to

resemble reality” (Strauss & Corbin, 1998, pg 12) than theory derived from ideas parsed together through speculation. Grounded theories, they argue, are also more likely to be practically applicable, bridging the gap between research and practice. Because the purpose of this research is practical applicability, Grounded Theory is the ideal methodological tool.

Data was gathered through the use of interviews with a variety of mental health professionals. Interviews are a common instrument of data collection used in qualitative research (DiCicco-Bloom, Crabtree, 2006). It should be noted that the use of interviews was primarily an issue of feasibility for this study. The ideal mode of data collection would be through ethnographic observation. However, due to the increased confidentiality requirements of mental health settings, coupled with increased confidentiality for minors, this form of data collection should be considered more conceptual than realistic.

An advantage to interviews as a data-collection tool is that they allow the researcher to get a glimpse of individuals’ interpretations of daily events (DiCicco-Bloom, Crabtree, 2006). However, interviews, like most qualitative data collection tools, are highly subjective. They do not represent events as they happened, but instead provide the interviewee’s construction of the events and their meaning. These interviews are then interpreted and constructed by the researcher as well. However, this subjectivity relates directly to the research questions, which ask about participants’ perceptions of what they find helpful to the difficult work that they do.

The Interview Process

For this study, interviewed were semi-structured in nature, as this provided structure regarding a standard set of questions for participants, as well as provided the researcher with freedom to follow up on participant responses as appropriate (Price, 2002). Participant interviews lasted approximately one hour.

The research began with an original set of interview questions that were informed by the literature presented in the previous chapter. As noted in the preceding sections, Grounded Theory requires that the researcher does not begin collecting data with a theory or hypothesis in mind. Using traditional Grounded Theory, Glaser did not believe in conducting a literature review prior to conducting Grounded Theory research, as he believed this would contaminate the researcher's thoughts about the data collected (Glaser & Strauss, 1967). Strauss and Corbin (1998) take a more flexible stance on literature reviews. They believe that background literature can be helpful in stimulating initial and follow-up questions and thoughts in regards to the data collection process. Therefore, as mentioned previously, the background data presented was used in forming initial interview questions and categories for the open coding process; it was a springboard for intellectual thought and questioning related to the research questions.

A list of potential interview questions were created through an iterative process with the primary researcher and the research team. All team members reviewed the background literature and agreed on a set of starting questions that were believed to address the heart of the proposed research questions. These potential interview questions, broken down by participant role, research question addressed, and corresponding theoretical framework, can be found in Figure 1.2.

Questions for follow-up participants were developed throughout the research process. Evolved Grounded Theory begins data analysis with an open coding process. This occurs after each interview has been conducted. The exact process will be more fully explained in an upcoming section. The purpose of open coding following each interview is for the researcher to begin developing hypotheses about the data and how each piece of data is connected. These hypotheses are later "tested" against further data collected. This means that after each interview

is coded, tentative hypotheses are developed, and follow-up interview questions are developed that allow the researcher to test the applicability of these newly generated hypotheses. During this study, follow-up research questions were developed following each interview by a collaboration of research team members and the primary researcher on an ongoing basis.

Elwood and Martin (2010) discuss numerous issues regarding the location of interviews for qualitative research. If the researcher conducts interviews in a place of their own choosing, participants may feel anxious or unwelcome. On the other hand, participants may not feel comfortable sharing their personal space or office space with a researcher, or they may not have access to a private meeting space. Participants were given the opportunity to choose a comfortable meeting space. All interviews took place in participants' offices or open rooms at participants places of work.

Confidentiality was paramount in this study, not only as it relates to participants, but also as it relates to clients. When discussing situations and interactions, the possibility existed that a professional may inadvertently have shared confidential information about a client. For this reason, the confidentiality of all participants and participant interviews and transcripts were of utmost concern. Participants were given the option to be audio-recorded, which most participants subsequently refused. Audio-recordings were immediately transferred to a password-protected personal storage device. After transcription, the recordings were deleted, and the transcripts were stored on a password protected file storing database. Transcriptions were de-identified, using a participant code that identified the participant only to the primary researcher. When individuals refused audio-recording, the research took hand-written precise notes, which were later typed verbatim. These transcriptions were de-identified and stored using the same process as audio-based transcriptions.

Participants

This study focused on professionals who work in mental health hospitalization settings, because the children in these settings are likely to exhibit aggressive behavior above and beyond what an outpatient therapist would experience, and these behaviors are likely to occur on a daily basis. In short, these professionals likely work with the most severely aggressive children and thus are likely in the most physically and emotionally difficult work environments.

The researcher contacted the directors of all child and adolescent day treatment facilities in a specific region of the state. These directors were sent an e-mail explaining the purpose and process of the research study and asked directors to forward the research information onto employees who met criteria for the study. Individuals from six different organizations responded to this participation request. Two participants from one organization were found to not meet criteria for this study, as they do not work in an intensive outpatient setting. The remaining 14 participants who expressed interest in the study were subsequently interviewed, representing five different organizations. These participants all served children under the age of 9 years old. The age of 9 years old was chosen as a general cut-off age, as this is the age that males may begin to experience puberty (DeNoon, 2012). Changes that accompany puberty were considered to affect the experiences mental health professionals have working with these older children.

Professionals were chosen from multiple area locations, because Grounded Theory involves collecting data from different settings and different types of people (Strauss & Corbin, 1998). Per Strauss and Corbin (1998), a true grounded theory study requires that the research question be examined from multiple different angles and perspectives. They note that it's important to realize that researchers cannot determine in advance who each of their participants will be. Grounded theory requires theoretical sampling, which means that participants are

purposely chosen throughout the research process, because the researcher believes that that individual can provide insight on the research topic or questions the researcher may have. Theoretical sampling requires the researcher to gather information from a variety of sources related to the topic as a way to maximize the information gathered and to discover variations on the dimensions of the research question in an effort to develop a more robust and applicable theory. This variety may be achieved in terms of educational or vocational background, as well as situational and environmental background. For this reason, the research considered the perspectives of a variety of professionals that work with aggressive young children. Individuals of various backgrounds, including counselors, group leaders, psychologists, social workers, mental health technicians, manager, psychiatrists, and nurses were all contacted for participation in the study. The only professions that responded after three rounds of research requests were groups leaders, psychologists, social workers, and counselors. The researcher sent out individual research requests to nurses, psychiatrists, and managers from a variety of locations, along with a reminder e-mail. None of these contacts were met with a positive or negative response. Based on the responses of individuals willing to participate, a participant bank was created and utilized. All volunteers were interviewed.

The first research interview was conducted with a group leader with 8 years of experience in the mental health field. This individual was chosen, because she has worked daily and directly with aggressive children, for several years. The initial participant was chosen based on her ability to provide a wealth of information directly related to the research questions, which allowed the research team to begin developing hypotheses about the topic. After the initial interview, follow-up interview participants were chosen from the participant bank and interviewed. Figure 1.4

represents this typical organizational structure of intensive outpatient treatment programs and shows which participants were interviewed for this study.

In qualitative research, the number of participants and amount of data gathered is usually towards a goal of saturation (Glaser & Strauss, 1967). Saturation is the point at which no new substantial information is being gained about the research topic. Sources cite varying numbers for an expected saturation point, because there is no way to know in advance when saturation will be obtained. For this study, some questions reached saturation early on, with less than 5 interviews (How often do you experience aggression? What types of aggression have you experienced?).

It's important to note that this sample was a convenience sample. There are limited facilities that serve aggressive young children in the local metropolitan area. Research in such facilities, especially those that serve children, is notoriously difficult, due to issues of consent in minors. Thus, I was limited to the organizations that allowed me access to the mental health professionals that work there. The limited facilities also employ limited numbers of professionals to work with these individuals. Thus, my study was limited by the individuals willing to volunteer their time to meet with me.

Initially, I contacted the clinical director for the various children's programs at the various locations. I explained the purpose and methods for my study and obtained their consent for me to collect data at their location. I then requested they forward my information to participants who meet my inclusion criteria (work primarily with children ages 9 and under, who have exhibited aggressive behavior, in a professional role). Individuals who volunteered to participate in the study were used to create a participant bank, all of which were subsequently interviewed.

Research Team

The research team for this Grounded Theory project consisted of the primary researcher, and two other team members. The purpose of the research team is to increase the objectivity of the researcher and the theoretical findings ultimately presented. The research team was trained by the primary researcher in the process and purpose of Grounded Theory research, the purpose of the research study, as well as their purpose and expectations as a research team member. This was a full-day training in which the Evolved Grounded Theory paradigm was explained, as well as how this fit into the overall framework of qualitative research. The team was then trained in the data analysis procedures for the Evolved Grounded Theory framework, along with hands-on practice components.

The primary researcher conducted all interviews. The research team took turns transcribing audio-recorded interviews. However, because most participants refused audio-records, the primary researcher typed up most interviews. Following the transcription of each interview, each member of the research team was provided with a copy of the transcription via a private password protected file storing database (One Drive for Outlook). Each team member then read over the transcript and took notes via the open coding process. This involved recognizing all potentially relevant bits of information and making notes of these. Each member also kept notes about further questions they had and ideas they had about the links between bits of data they discovered. Each week one new interview was transcribed, coded, and analyzed by the team.

The research team met weekly to discuss the most recent transcript that was open coded. The team discussed open codes and categories they identified to detect all possible codes and categories from the data. Links between the pieces of data were then discussed. Finally, thoughts

about the transcript and data were discussed, and follow-up participants and questions were determined.

Biases and Expectations

As mentioned previously, it is important that the researcher not approach the research with a preconceived theory or hypothesis in mind. However, Strauss and Corbin (1998) also point out that objectivity on the part of the researcher is impossible. For this reason, it's important that the researcher present any possible biases prior to the conducting and presentation of the final research product. It is also important for the researcher to do their best to avoid allowing these biases to affect their interpretation and analysis of the data. These biases may be a result of personal and background experiences of the researcher. Because the research team is an integral part of the data analysis of this final research product, it will also be important that all members of the research team consider their own possible biases and expectations regarding the research questions.

As a counselor, throughout training, the primary researcher has been challenged to identify her worldview, or theoretical orientation. This is the way that she sees the world and how it works and how she make sense of the information that she finds. In counseling the primary researcher uses a Dialectical Behavior Therapy (DBT) framework for conceptualizing clients that assumes that there is an interaction between an individual's genes and environment that cause dysfunction (Linehan, 1993). Similarly, the primary researcher has found herself drawn to a system's perspective that assumes that problems in working with aggressive children arise from an interplay between an individual's personal struggles and struggles within the environment.

It is also important to note that much of the primary researcher's professional background is in working with aggressive young children in both intensive outpatient/day treatment and inpatient settings. Thus, she has personal experience with the topic she is exploring. She reports having been hit, kicked, and bitten by numerous children on a regular basis. It's also important to mention that, due to the lack of sites providing intensive outpatient and hospitalization services to young children in the local metropolitan area, some participants in this study will be individuals that the primary researcher has previously worked with.

Data Analysis

Participants were given the option to be audio-recorded, which they were able to refuse while still participating in the study. Audio-recordings were immediately transferred to a password-protected personal storage device. After transcription, the recording was deleted, and the transcripts were stored on a password protected file storing database. Transcriptions were de-identified, using a participant code that identified the participant only to the primary researcher.

The primary difference between traditional Glaserian Grounded Theory and Evolved Grounded Theory is the method of data analysis (Walker & Myrick, 2006). Evolved Grounded Theory follows a three-step model for data analysis (Strauss & Corbin, 1998). It should be noted that both Glaser and Strauss use similar terms to refer to various steps in the coding process, but despite the similar terminology, the process is quite different. Only Strauss's coding process will be described here. Again, all members of the research team took part in all steps of the coding process for this research project.

The first step in the data analysis process was open coding. Open coding is the initial iterative process of identifying all possible codes and concepts from the original data. Strauss describes it as a process by which concepts are identified and their related dimensions and

properties are discovered (Strauss & Corbin, 1998). The primary goal is dimensionalization, or understanding the core properties of each category related to the research question. Important to open coding is the ability of the researcher to maintain theoretical sensitivity, which is the ability of the research to simultaneously sustain theoretical and conceptual thinking about the data while also preserving a level of sensitivity and understanding about the researcher's own presence and process with the data. In this research project, that was achieved by keeping detailed and frequent memos and reflections about the data in a personal research journal, and openly sharing these thoughts and reflections during research team meetings. Open coding was the process by which all members of the research team read through interview transcripts and took notes about possibly relevant pieces of information obtained. Open coding concluded when the research team identified a couple core categories to which all other categories were systematically linked. This core category was agreed upon by the entire research team.

The second step of data analysis was axial coding. Axial coding is the process of relating categories to their subcategories (Strauss & Corbin, 1998). Strauss and Corbin liken this phase to putting a puzzle back together by taking fractured pieces of data and reassembling them in new ways. This phase focuses on the conditions in which an event or phenomenon occurs, the actions or interactions of people and how they respond to these events or phenomenon, and the consequences of these actions or lack of action. The goal is to understand the relationship between categories and subcategories. During the axial coding phase, the researcher vacillates between inductive and deductive thinking based on the data.

The researcher and team discussed possible theories and links between codes, and then checked them with already gathered data. Further interviews were conducted as necessary, when clarification was needed. During the axial coding process, the research team independently

developed possible theories about relationships between codes, which were then presented to the team. The team then discussed these proposed relationships and discussed further data needed to understand or clarify the relationships. This continued until a solid conceptual link between categories and subcategories was developed that considered all data that was collected.

The final step to data analysis was selective coding, in which the themes were integrated and combined (Strauss & Corbin, 1998). During this stage, the researcher confirms that all categories directly relate to a few single core categories. During this stage, it should be determined that all data is represented by the themes, and no new data should be gathered that does not fit into those themes. Theoretical saturation has been accomplished. This stage was considered completed when the research team agreed on the smallest subset of themes that encompassed all discovered codes, and no new codes were being discovered.

Strass and Corbin (1998) also suggest the use of a conditional matrix when creating and understanding theory. The conditional matrix considers the various micro- and macro-level connections of the theory. It follows an ecological framework in which intrapersonal, interpersonal, organizational, and societal implications of the research problem are considered. Each of these levels were considered and discussed throughout the coding process.

Credibility

When reading a research study, it is important for the reader to be able to make a decision about the credibility and trustworthiness of the data gathered and conclusions presented. Because evolved Grounded Theory assumes that the researcher cannot be truly objective, it is important for the researcher to find ways to minimize any potential biases they may have about the data gathered. This begins by presenting any potential biases they might have in an honest and

forthright manner. This allows the reader to determine how potential biases may have impacted research conclusions.

The use of a research team is another way that Strauss and Corbin (1998) suggest to minimize potential biases in the research. Having a research team of individuals with various viewpoints allows for discourse regarding conflicting views and interpretations of the data. This allows all members to expand their thinking and for the team to develop and determine a theory in consensus.

To have a credible study, the use of notes, memos, and a coding manual is required. All members of the research team kept a notebook of notes, codes, and memos. The primary researcher was responsible for the maintenance of the final coding manual. In accordance with solid qualitative research, these notes are required, should readers and interested parties ask for them, as they should help readers to understand each of the data analysis steps and ultimate creation of the theory. Those that inquire should also be able to trace the entirety of the theory back to the initial notes, codes, and quotes from the original data.

Data Presentation

The results of this research project are written as a novella, detailing information regarding the daily experiences of professionals who work with aggressive children. The novella was an ideal way to include Wolcott's (1994) concept of description, particularly detailing the different experiences that professionals have with aggressive children on a daily basis. This description is vital to the reader's understanding of the problem, as professionals agree that one "can't understand what it's like to work with these children until you've seen it for yourself" (Goranson, personal communication, 2015). Providing a vivid description of "a day in the life of" was the best way to accomplish this task. The novella was arranged so each participant has

roughly one chapter devoted to themselves and their experiences, although the experiences of some participants were combined into a single character to maintain confidentiality. This format also gives “voice” to the participants, honoring each individual’s experiences and thoughts (Strauss & Corbin, 1998). The analysis is presented as the final chapters in the novel, where the fictional Dr. Felecia attends a meeting with the program manager and board of directors. Recommendations are given to the manager and board, and the board’s response ensues. Repercussions of this meeting are presented in the final chapter. A final epilogue was included to describe the researcher’s reflections and final thoughts about the research topic and findings.

The majority of the novella is devoted to description of the data collected. This is because, in the primary researcher’s experience, and based on the interviews conducted, individuals who do not work with very aggressive kids struggle to understand exactly what “very aggressive” means. Many times she has been told that she is overreacting or over reporting the aggressive behaviors of her patients. Many times she has seen new therapists come in and struggle, because they did not know, or did not believe that the children behaved in the way they had been “warned.” For these reasons, she felt it important to paint the picture, so to say, of what the work truly looks like, so that the reader can fully grasp, not only the suggestions being made, but also the necessity for such suggestions.

The researcher’s reflexivity is interwoven in the text of the novel. It is believed that this presentation allows readers to understand the full depth to which the primary researcher was immersed in this research question and project. However, giving the participants each their individual chapters (voices), allowed the researcher to disengage from the research to be sure the research presentation and results centered around the participants instead of the writer.

To be certain that the novella captured the voices of the participants instead of the biases of this writer, the novella writing process was long and iterative. The researcher printed copies of each interview, as well as a copy of the coding manual, in which all participant quotes related to each code were available. For each chapter, the researcher identified the codes most often spoken about by each participant, and also looked at stories told by each participant regarding memorable experiences that stood out to them about the work that they do. These stories and memories formed the basis for each chapter, around which the story-line revolved. The researcher then interwove the codes mentioned by these participants using their own words and examples to the best of her ability. This novel writing process ensured it was the participants' stories being told instead of the researcher's.

Ethical Considerations

As mentioned previously, consent was obtained from both site supervisors and individuals participating in the interview process. Consent was gathered via formal informed consent paperwork that detailed the purpose, procedures, and possible risks of the study. All individuals were allowed to ask questions and consent or refuse participation prior to the beginning of the interview. No participants refused following the explanation of informed consent. All methods and procedures were approved by the Institutional Review Board at the University of Wisconsin Milwaukee prior to the initiation of the study.

Summary

This chapter offered an overview of the methods employed in the presented study. This included the research questions examined, the research design used to examine these questions, a description of the use and training of the research team, an overview of the selection and recruitment of participants, the data collection procedures, the biases of the researcher, the

method of data analysis, measures of credibility of the study, and ethical considerations. As mentioned, this grounded theory research study examined the questions, “What experiences do mental health professionals have that help or hinder them from providing daily care to aggressive young children?” and “How do organizational aspects affect a mental health professional’s ability to provide care to aggressive young children?” The data was collected using theoretical sampling and analyzed using the three-part process presented by Strauss & Corbin (1998). The researcher trained and employed a research team of three individuals for the coding and analysis process. Credibility of the study was increased through the use of transparency and the use of a research team. This grounded theory study concludes with a presentation of themes, grounded in the data, that explain the multiple facets of the research questions. The final product is a novella detailing the research data collected and codes uncovered. The following section is a novella that is a creative way to present the data analysis and uncovered themes that explain organizational and personal factors that help mental health professionals provide daily care to aggressive young children.

Chapter IV

Thursday September 16, 2018

To: Felecia A. Hanline (hanlinef@marshallcommunity.org)

From: Charles J. Block (blockc@marshallcommunity.org)

Subject: Staff Retention Concerns

Felecia,

The administrative board has noticed a rise in staff turnover on your unit over the past few quarters. Frankly, we have some concerns about this. We would like to meet with you Monday, September 27th at 11am as a team to discuss ways administration could better support your staff retention efforts.

Charlie

Felecia

Dr. Felecia rubbed her eyes as she looked away from her computer screen. The weight from late nights and early mornings filled her head with a fog she just couldn't shake. The kids wouldn't be in for two more hours and she already felt behind for the day. This recent e-mail from the hospital administrative manager just another in a long line of requests making her feel that administrators didn't understand the structure of her schedule or time. She looked at her calendar for the mentioned Monday to attempt to determine how she could rearrange her appointments to make room for a new meeting.

Like she tells her patients, one step at a time. She permits herself to focus on her schedule for the morning. Morning huddle as always, 3 new patients starting, supervision with Callie, and Consultation team over the lunch hour. Two hours suddenly wasn't feeling like enough time to catch up on progress notes from the day before. She sighs and starts in.

The hours passed faster than she imagined possible. She heard her staff coming in the door, laughing and sharing plans for the weekend. She was happy to hear their enthusiasm as they returned for another day. She could never shake that small voice in the back of her head suggesting that one day one of them may have had too much and not return to work the next day. She says a silent prayer of thanks that they not only returned, but nobody is on vacation or out sick today. The customary summer vacations had been taking a heavy toll on her staff. She almost felt guilty about her own upcoming trip to Punta Cana, but recognized her own need for self-care and time away. Of course, it wouldn't truly be time away as she'd be bringing her laptop to keep up on work so she wouldn't return to a pile of files, notes, and e-mails that were even more never-ending than usual.

She hears yelling and the thunder of little feet running down the hallway. She considers closing her office door to get a few more tasks done before the day sweeps her away. The cacophony of little laughs paired with frequent cursing suggests this day wouldn't be any different than the chaotic past few days. She rubbed her temples; she could already feel the headache building.

Somehow lunch time arrives. Felecia glances between her wilted salad from yesterday she pulled out of the refrigerator, and the building pile of referrals on her desk. She tosses the salad in her bag and pulls the top referral off the pile.

Name: Zion Robinson

DOB: 4/13/2011

Sex: Female

MRN: 001087516

Primary Guardian: Foster Mother- Marie Adams

Referral Source: Foster Mother, School

Primary Concern: Mother reports daughter has been getting into frequent trouble at school, engaging in physical altercations with peers and school staff, running away from school when she's told she cannot do something she wants to do. Last week, when she was asked to return from recess for throwing a ball at another child on the playground, she bit the principal and ran out the front doors of the school and into the busy street out front. Police were able to catch up with her about 5 blocks away from the school. When police attempted to restrain her to return her home, she tried to punch them and kicked one officer in the leg. At home, mom says Zion will become easily upset and throw things, scream that she wishes she was dead, and on two occasions has hit her infant brother. Mom said this behavior has been occurring since her daughter was moved into her care this summer. Daughter was removed from her biological mother's care at the age of 3 due to substantial physical abuse and neglect. Mom says the school calls her to pick her daughter up early from school due to uncontrollable behavior approximately 3 days a week. School has told mom that unless Zion receives treatment, she will no longer be allowed at that school. She does not have an IEP currently.

Mental Health History: Zion completed intensive outpatient treatment at Marshall Community Hospital in Summer of 2017.

History of Self-Harm: Zion frequently will hit herself in the head or hit her head on the wall when she becomes upset or when she receives consequences at home or at school.

History of Suicide Attempts: Zion has a history of running into traffic when running away from home or school. She also frequently makes statements like, “I wish I was dead” when she becomes angry or is facing consequences.

Dr. Felecia remembers Zion from the summer before. She was a difficult patient for her staff to work with, with the frequent outbursts and unpredictable aggressive behaviors. Once Natalie needed to go to the hospital when Zion bit her so hard it broke the skin. Dr. Felecia also remembered reading Zion’s history, particularly the gruesome details of why she was removed from her biological mother’s care. She couldn’t help but be surprised and appalled that Zion still got supervised visits with her mother. She couldn’t help but hold a soft spot in her heart for this little girl that seemed to have the world against her. The fact that she was in a new foster home suggested that her previous foster parents gave up on her, just like the multiple families before.

As Felecia was about to add Zion to the wait list, her phone rang. She looks at the caller ID. Dr. Nahmohra from Lakeside Youth and Family.

“Marshall Community Hospital. Dr. Hanline speaking.”

“Dr. Hanline, it’s Dr. Nahmohra here. We aren’t going to be able to host the monthly child care network meeting here next week, because we are running short on space. Would Marshall Community have a meeting space for us?”

“We should have enough space in our conference room.”

“Great. We’ll see you then. Have a great weekend.”

“You too.”

Dr. Felecia looks at her clock. It was almost time for the afternoon group to arrive.

Callie

Callie races through the staff doors at Marshall Community. The line at Habaneros was longer than she expected, and she was running out of time to prepare for her afternoon group. Her current kids were struggling with cooperative games, so Callie was focusing her groups on individual therapy-related projects. She stayed up late the previous night looking for new group ideas, because she felt at a loss, and she'd been relying on her fallbacks all too often lately. It took a few hours of various Google and Pinterest searches, but she'd finally found an activity she was excited about. She had 10 minutes before the children started showing up to print off the activity and cut out enough pieces for her 12 person group.

Callie gets to her room and can't help but notice the garbage and general disarray left from the morning group: orange peels on the floor, marker stains on the desks, random game pieces scattered about. "What game are those even from?" she thought to herself.

She exhaled loudly as she flopped into her seat. "To clean or to prepare for group? That is the question." She reluctantly stood up and began picking peels and wrappers up off the floor. Her new therapy group put on hold for an uncertain day in the future she'd actually have time to prepare for. Stations it is. This will be the second time this week doing stations for group. She hoped nobody would notice and the kids didn't seem to care. It also would give her time to get her backlog of charting finished. She anxiously watched the clock as it crept closer and closer to 1 pm. Just as she straightened the last chair, the first patient arrived.

The first half hour of treatment always seemed to pass simultaneously fast and slow for Callie. It's a constant balancing act of daily check-in, managing appropriate behaviors and rewards, and generally aiding the difficult transition from school, to the bus, to treatment.

“9. 10. 11. ...Who am I missing?” She glances from her group list to the patients for what feels like the millionth time. “Where is Deonte?” she thinks to herself. “Have I even seen him yet today?”

Like they could read her mind, one of the kids yells. “Miss Callie, Deonte keeps running in the hallway.”

“Deonte! Come back. You supposed to be in your seat. Come back or Miss Callie gonna yell at you and you aint’ getting your play time.”

“James, please focus on yourself and eat your apple. Snack time is almost over.”

“Deonte, running in the hallway doesn’t show me you’re ready for group. Remember we have to be in group to earn play time at the end of the day.”

“Sorry Miss Callie. I just got so much energy.” Deonte barreled through the door just as it was time for Callie to begin group.

“I need to see everyone in their seats so we can get started with group.” Callie goes to the closet to grab supplies for stations. As she begins to set them up, she hears Deonte.

“Stations again?! This is bullshit! I’m outta here,” as he takes off out the door. Over the walkie Callie lets Mr. Aaron know Deonte has left group.

The rest of her group goes relatively uneventfully. Collin didn’t want to leave the lego station and her two girls started arguing over markers. She considered it successful overall. Nobody threw anything or hit anyone. She turned the group over to Miss Cathryn and left to work on her treatment notes.

Callie checks The Closet for an open computer. It's not really a closet, but she and the other group leaders call it that due to its small size and lack of windows. Samantha is already there using one of the two available computers. Callie logs onto the other.

"Be careful," Samantha warns her. "That one shut down on me yesterday and I lost all my notes. I was here until 5 o'clock finishing them up."

Callie rolls her eyes. They already didn't have enough computers for the three group leads, and it always seemed as though at least one of the two they had was not working properly. As she began her group notes, she pondered over the "Intervention Targets" for her notes as she always seemed to do. She never knew how to answer that question. "Social skills and adaptability," she entered. Weren't all her treatment groups about appropriate social skills?

Adrian entered the office.

"Here, you can use this computer. I'm just about done." Samantha moved to a seated position on the floor. "Did you hear Guiding Light is looking for patient care techs? Starts at \$12 an hour."

"Man, that would be sweet," Adrian chimed in. "I had to pick up 6 extra float shifts in inpatient last month to pay for my car repairs. And those kids are brutal over there."

"I didn't know they took children at Guiding Light."

"They don't. But I figure adults can't be that bad. I can do anything for \$12 an hour."

"I don't know. Wouldn't you miss working with the kids?"

"Yeah. Maybe, I suppose; Bust ask me again next week. I hear we've got a real difficult one coming in."

Callie can't help but notice it's time to return to group. As much as she enjoys working with kids, she's surprised at how often she doesn't look forward to returning to them. She's happy to see them all sitting quietly and smiling in their seats. She wonders what kind of magic Miss Cathryn works that she never seems to struggle in group.

It seems as though all hell has broken loose as Miss Cathryn leaves the room. There's crying, yelling, and running out of the group. Callie wishes she could do the same. "Anthony, I need you to put your toy in your backpack. You can't have that here."

...

"Anthony, if you can't put your toy in your backpack, I'll hang onto it up here until the end of the day."

...

Callie walks over to Anthony's desk. "Okay, this toy is mine now, because you didn't make the choice to put it away." As she's grabbing the car from his hands, Anthony lets out the loudest and highest pitched scream Callie could not believe was coming from such a small body.

"I fucking hate you, you stupid bitch." Anthony sobs. Callie is taken aback. She rarely has trouble with Anthony, and, on more than one occasion, has wondered why he's in treatment at all.

"Anthony, that's not very nice language. When I hear you talk like that it makes me not want to talk to you."

"Fine, then don't. Don't ever talk to me again. I hate you anyway." Anthony grabs a nearby puzzle and throws it at the wall."

“Staff assistance needed in Miss Callie’s room,” Callie radios for help. She turns around and walks away as Anthony continues screaming louder and crying harder, ignoring the behavior. “What’s wrong with him?” Callie wonders to herself. Staff come and coax Anthony out of the room. Callie counts the seconds until the end of the day, surprised that Anthony does not return. Slowly the kids are picked up. It seems slower than usual as she waits for the mother of her last child. Of course she’d choose today to be late. The one day she’d agreed to be at her waitressing job early. She jots a few notes to helpfully jog her memory tomorrow when she gets around to writing her notes as she races out the door. It’s already feeling like a long night.

Amanda

It's Friday morning as Amanda gets ready to head into work. She thinks back to the prior day when Collin had a complete meltdown and started tearing pictures off the walls in the hallways. She remembers joking to her office mate that she might call in sick today. She smiles as she briefly considers it, but then finishes packing her lunch and heads out the door.

As she drives into work Amanda finds herself thinking about her new client Anthony. She needs to schedule a family therapy session with his adoptive mother and needs to call his caseworker to see if his biological mother should be there as well. Amanda was surprised Anthony's mother was still in the picture, considered the amount of abuse and neglect occurring when Anthony was removed from the home. Anthony had been through 6 foster care placements before settling with his adoptive family. Anthony was so quiet and timid looking when he started last week. It's hard to believe that he's in danger of being expelled from his 2nd grade class for chasing his teacher with a scissors while threatening to kill her. She thinks to herself that maybe she doesn't want to take a chance with her group activity today, as it involves scissors, so she makes a mental note to change the plan a new group when she gets in.

That's when she realizes that she's thinking about work on personal time again. She verbally redirects herself to stop thinking about work outside of work. She turns the radio up in the car and hears The Doors on the radio. She starts singing along as she waits for traffic to sweep her towards work.

As Amanda enters the building, Dr. Felecia greets her. She quietly wonders if Dr. Felecia ever leaves. She always seems to be there before Amanda gets there in the morning and is quietly working in her office when Amanda leaves. She walks to her office where she sees a note from Chrissy, the office assistant. Collin's mom called to say he had a rough weekend. She lets out a big exhale as she sits down and logs into her computer, bracing herself for a difficult phone call with Collin's mom. With eight other children at home, it's reasonable that she has had difficulty providing Collin with the support and structure he needs to feel safe and supported. However, Amanda was starting to feel like Collin's mom was using the hospital as more of a daycare than a place for Collin and the family to receive treatment and help.

When Amanda pulls up her client database, she realizes her client list is shorter than when she left on Friday. A quick scan and she sees that Georgia is missing. She was admitted to inpatient again Saturday night. Amanda adds discharge paperwork to her already increasing to-do list for the day. She decides it's time for a break and walks to the cafeteria to fill up her water bottle.

When she gets back to the office she sees her office mate is in. Cathryn tells her about a dinner party she attended with her husband. They have a laugh about a funny story that happened with Cathryn's youngest child, and then they turn back to their steadily growing task lists for the day. Soon the kids will be coming, making it more difficult to complete the more administrative parts of their jobs.

“Fuck you bitch.”

It must be eight o'clock. Amanda doesn't recognize the voice, so she figures it must belong to a child in a one of the other group rooms. “Happy Friday,” she thinks to herself. She waits a few minutes before checking in on her group of kids to get an idea of how they are doing

and to mentally prepare herself for the day. She notices that most of them are sitting at their tables completing their check-in sheets. Andrew, on the other hand, is in the corner tearing up papers, throwing them, and crying. Amanda realizes she has to make a quick decision to try and help Andrew or to remove the other kids from the room. She decides to attempt to remove attention from Andrew by removing the other children from the room. She announces for the other kids to line up. She's going to take them to the cafeteria for ice water. She hates using this reward so early in the day, but she knows she needs to remove the other kids from the room, and she has nowhere else to take them. As she's leaving, she tells Andrew that she's available to talk to him and help him with what he needs when he calms down. She then calls Mr. Aaron to keep an eye on Andrew to be sure he's able to remain safe. As she's walking out, she feels a block bounce off her back, thrown by Andrew. She hopes that Mr. Aaron is able to encourage Andrew to de-escalate or take a break outside the room by the time the group returns.

When Amanda returns, she sees Andrew with Mr. Aaron in the quiet room. She wonders if he went there by himself, or if he needed to be escorted there. She heads back to her office to prepare for an individual therapy session with Anthony. Amanda spends the next half hour or so reading Anthony's chart. He appears to struggle creating and maintaining relationships with caregivers. He has a history of frequent changes in foster home placements but was recently adopted. His younger biological brother was not adopted with him. Amanda has seen this before and knows that it will be difficult for her to form a therapeutic relationship with Anthony, as he is likely to be preparing himself for her eventual abandonment of him. Her plan is to go in slow and allow Anthony the opportunity to warm up in his own time. She then sees his insurance and realizes that he, unfortunately, will not be allowed that time. That particular insurance company

will only authorize three days at a time. She plans for a short time with him. Amanda can't help but feel disappointed, knowing that Anthony deserves longer term, more consistent care than she will be able to provide him within the constraints of managed care.

As the morning session winds to a close, Andrew is still in the quiet room and Amanda can hear him cussing at Mr. Aaron down the hallway in her office. Her attempts, Dr. Felecia's attempts, and Mr. Aaron's attempts to de-escalate him have failed. She sighs as she returns his mother's phone call. The two decide that it is in Andrew's best interests that he transfer to inpatient care for medication management and safety concerns. Amanda explains this to Andrew and he appears calmer than she had prepared for, almost excited. On the walk over to inpatient he tells her that he hasn't taken his medication since last week, because he doesn't think his mom remembered to pick it up at the pharmacy.

On the walk back to her office, Amanda begins to debate whether Andrew will come back to the intensive outpatient program. She has enjoyed seeing his progress, and they have a good relationship, but with his mother's lack of engagement in his treatment, Amanda worries that they've made all the progress possible, and it's now up to his family. She thinks back to her first patient like Andrew. That was back when she was a group leader. She remembers that they also had a close relationship. He was also the first patient that had ever physically hurt her. She remembers it like it was yesterday. The kids were struggling a lot that day. They were yelling, throwing things, and defiant. Her one solace was Davonte. He had no history of aggression, and always listened to the limits Amanda set. Until that day. That day, while she was writing on the board, he walked up to her and punched her square between the shoulder blades. She immediately felt the tears swimming in her eyes. She was able to call for support as she rushed out of the room so nobody would see her crying.

Since then Amanda prided herself in being able to “harden herself.” It had been almost 10 years and she hadn’t cried at work in the recent years. In fact, most of the time she didn’t even notice patients being aggressive in the hallways; she just continued to walk and focused on her work. She had gotten hit plenty of times since then, but it didn’t seem to bother her anymore. She briefly wondered if this was a good thing and then hurried off to the inter-disciplinary weekly staff meeting. By the time the meeting had ended, it was noon. Her day was halfway done, but she couldn’t help herself thinking about how exhausted she was and yet how much was left to do before she could go home.

Paige

Paige sits at her computer and looks at her calendar and to-do list. “What am I doing?” It feels like she asks herself that question multiple times a day. She feels so scatterbrained since

starting her new job. Transitioning from group leader to individual and family therapist was supposed to be easy, but the new location and role was really throwing her off. To be honest, she wasn't entirely sure what her new role consisted of.

She logged onto her computer and checked her e-mail.

Sept 17, 2018	admin@marshallcommu	[No Reply] You have 6 trainings due on 9/30/18.
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“What trainings?” she wondered to herself.

The last few weeks had felt like a never-ending parade of trainings expected to somehow be crammed into a full-time therapy schedule. Paige was thankful to be out of the group room and feeling constantly responsible for maintaining order among 12 energetic and aggressive young children, but the constant case management demands felt like a nearly impossible burden and too often felt like it was taking time away she'd prefer to be spending with her patients.

She'd gotten this job 3 months after finishing her Social Work Master's program. She was excited to start accruing her hours to finally be a licensed social worker. She got into this field to make a difference and she could finally do that now. She always pictured herself getting aggressive little Johnny to stop fighting and helping Jane to identify the was feeling anxious at school because she'd heard her mom making comments about how much smarter her brothers were at her age. Instead, Paige felt as though all her time was spend rescheduling family sessions and calling providers to set up aftercare plans for her patients.

After a fun-filled morning of CPI training, Paige was ready to jump back into work that actually mattered. Looking at her weekly task list she hoped she would have just enough time to

squeeze in an individual session before a family session (that had already been rescheduled twice!) and supervision with Dr. Felecia.

She was able to fit the individual session in, but didn't feel very attentive, as she couldn't help but worry about her upcoming family session. It would be her first family session on her own, and frankly she felt like she had no idea what she was doing. She wished her supervision was before her family session. As the appointment grew nearer, the butterflies in her stomach seemed to double in size.

Paige's phone rang. "Your 2 o'clock family session is here." There was no more avoiding it. The only way around it was through it.

Step 1: Orient the parent to Treatment

Paige: Miss Johnson, it's nice to meet you. I'm Jarmell's Social Worker, Paige.

Miss Johnson: Yeah you too. Is this gonna take awhile? My daughter's with my cousin and she's gotta be to work at 3.

P: Well usually we plan family session to last an hour, but I guess today we'll make sure to get you out of here on time to be back by 3.

MJ: Okay

P: So I thought we could start by talking a little bit about what treatment looks like...

MJ: Well I already know what treatment is. Jarmell's been here 2 times and my older daughter's been here once. Maybe this time will fix him.

P: We're certainly trying our best to help him out. Miss Johnson, can you tell me a little be about Jarmell's behavior at home and what he expectations and consequences look like?

MJ: Look lady. You seem real nice and all, but like I said, this isn't Jarmell's first time here. I know all about setting rules and following through on consequences and sticker charts and things like that. I really don't need your help. I'm only here because you told me if I didn't show up you'd kick my baby outta treatment.

Miss Johnson stands up and heads towards the door, a clear sign that she thinks this meeting is over.

P: Wouldn't you like to see Jarmell before you leave?

MJ: No. I gotta get home to my baby girl."

And with that Miss Johnson leaves.

As Paige walks by Miss Samantha's room, the door is open and she hears Jarmell's voice.

"Miss Paige, you comin to get me for my meeting with my momma?"

"Sorry buddy, your mom was in a big hurry today, but she says she misses you and will see you at home tonight." Paige hurries away before she can see the disappointment in his eyes. How can a parent be so damn selfish? Doesn't she see how much she's hurting him? And clearly she doesn't know it all if her kids have been in treatment so many times. Paige doubts she'll ever see Miss Johnson again.

She detours and makes a stop in Amanda's office. "Why do parents not care?" she sighs, slumping in to the spare seat. She sees Cathryn chuckle out of the corner of her eye.

"Whose family session did you have today?" Amanda asked.

"Jarmell's mom finally," Paige replied.

“Oh I remember her from his last two times here. So difficult to get her in. I feel like we ended up discharging him because she refused to participate in treatment.”

“Well she’s not participating now either. I think I saw her for maybe 5 minutes. I’m surprised she even sat down.”

“Yeah. She’s difficult to work with.”

“I just feel like maybe if she’d start paying more attention to him and giving positive reinforcement he wouldn’t be fighting for her attention all the time. And she says she knows all the treatment stuff, but if that were true I bet he wouldn’t have all these problems and keep ending up back here.”

Amanda nods, “Parents are the hardest part of this job. I can only help a kid so much. If I send them back to an environment that hasn’t changed, how much will it really matter?”

Paige returns to her desk to document her failure of a family therapy session. Before she could get more than 3 sentences into her progress note she hears a commotion in the hallway just seconds before Samantha radios for help via the walkie talkie. Paige is supposed to be shadowing Aaron all week, because Dr. Felecia told her it would help her learn de-escalation techniques, but Paige couldn’t help but wonder if Dr. Felecia would notice her skipping just this one time so she could finish up her note. After all, she’d done the CPI training; she didn’t see the need for all the additional shadowing and the crises moments made her feel quite uncomfortable. Just then her phone rings: Dr. Felecia. Paige picks up the phone and lets her know she’s on her way to help.

A half hour later Paige finds her way to Dr. Felecia's office for supervision. She has to many questions she hopes they will have time. Lately she's felt as if she's been living in Dr. Felecia's office she needs to much help. She's really been struggling to work with her patients and wishes Dr. Felecia would just be more direct in telling her what to do. "Doesn't she understand how difficult it is with some of these kids? And how am I supposed to do all this other work she asks me to do and also do good therapy with my patients? So many of them need extra time with me."

Felecia is on the phone when she enters so Paige takes a seat and sits quietly.

"Sorry about that," Felecia hangs up the phone a short time later. "Why don't we start by reviewing your kiddos."

Felecia

As Paige leaves her office Dr. Felecia slowly and intentionally focuses her attention back onto her computer screen. She notices the tension that's built up between her shoulder blades over the past hour as her left hand begins absentmindedly rubbing her neck and shoulder. She's again reminded of Paige's newness.

Dr. Felecia considers herself a relatively easygoing and flexible supervisor that is able to direct supervision wherever her employees may lead. But lately she's been finding that some new employees struggle with the open-endedness that supervision can provide and need a more structured approach. They need to focus more on content than process and personal and professional development. This high need for structure leaves Dr. Felecia feeling drained at the end of each session. She thinks about the motto she learned in graduate school, "You should never be doing more work than your clients," and wonders if that applies to supervision as well, because she certainly feels like she's doing more work than Paige right now. She'd really like to see Paige start taking some risks and working more independently. It's as if Paige was using her as a crutch. Felecia tries to remember back to when other staff started. Were they this needy and co-dependent? They were. She knows they were. They all seemed to go through a natural progression. The first year or so seemed to be consumed with training and learning how to do this work. Most people left within this first year, because it was likely just too overwhelming to them. Felecia chuckles to herself. Paige was still a superhero as Felecia liked to call them. New professionals coming into the role thinking they could save everyone. The naivete was endearing, but difficult to cope with when the illusion fades.

She turns back to the task at hand. She had recently completed interviews for the seemingly perpetually vacant group leader position. They interviewed three people this last round. She knew for sure that interviewee number one was not going to get hired. It was clear throughout the interview that he was not interested in the job whatsoever outside of the biweekly paycheck. The other two interviewees she was less sure about, and she felt like she was constantly changing her mind. She had agreed to extend an offer to someone by the end of the day.

Interviewee number two seemed like a good fit in terms of education. She had worked for Easter Seals throughout her undergraduate education. Now she is getting her Master's Degree in Counseling Psychology, and her night classes make the work during the day perfect timing. But Felecia wondered about the longevity of number two in the position. As it was, they were struggling to keep consistent staff. She wanted educated and trained staff, which was difficult to do considering the pay and stressful environment. However, staff with more education were often looking for higher paying careers with more autonomy and possibility for advancement. The glass ceiling at Marshall Community is pretty low, and it seemed like counselors and social workers frequently used it as a platform to fulfill hours for licensure before leaving for the greener grass elsewhere.

Interviewee number three, on the other hand, was fresh out of college with really no professional experience, unless you count his sales associate gig at Old Navy. However, he expressed a strong passion for working with children, including volunteering as a day camp counselor and a desire to start a non-profit after school program for foster children. He was genuinely engaging, and frankly, Mr. Aaron might like another male on the unit.

Deep in her heart, she knew number three was the right one to choose. When she thinks about her employees that persist and succeed, they seem to have a few similar attributes. They enjoy working with kids, they have some sense of the difficulty of the job (though nobody could really understand it until they're thrown in), and they have a passion for learning more and doing better in their career. She was ready to make the call.

Cathryn

It's a quiet Tuesday morning in Cathryn's office. Amanda was leading group, so Cathryn was enjoying some quiet time in her office. She loves sharing an office with Amanda and having a peer to decompress with, but she also found it energizing to spend time to herself. She takes advantage of the silence to do some mindfulness practice. Her eyes are closed and she focuses on her breathing in and out. She notices the thought that when she started doing mindfulness a few months ago on a regular basis, her breaths only last until the count of 4 and were high up in her chest. Today she starts counting 8 seconds in and 10 seconds out all the way down in her belly. She tries to keep her mind focused on her breathing. Occasionally it wanders to her concerns about today's group and whether her family sessions would show up on time. She was getting used to these thoughts now and working hard at just allowing them to be.

After a few minutes she drew her attention back to what she was doing. What was she doing? The week always seemed to go by in such a blur, and the weekends went even faster. Mindfulness had been helping to keep her focused on her moment to moment and day to day activities, but it didn't help with the ache in her heart missing her daughters. She wonders what they were doing at daycare today. "Maybe I can just give them a call?" She picks up the phone and then places it back on the receiver, knowing she will just miss them more if she calls. Cathryn loves her job but being away from her girls just seemed to be getting more difficult each day.

Cathryn hears a call over the walkie for Mr. Aaron to come to Callie's room to assist with Michael. Michael is on Cathryn's caseload and she wants to leave to try and help Aaron. She knows she has time, and this could be some of Michael's individual therapy hours required for the week. Yet she hesitates. She knows Aaron means well, but Cathryn often finds herself

frustrated when trying to work with him. It feels like he does whatever he needs to so the kids calm down, but it often feels like he's working against any therapeutic progress she's made. Cathryn decides this time she'll let Aaron work it out with Michael himself in the name of her own self-care.

Instead, Cathryn decides to meet with Maria. She'll wait a bit to be sure Michael isn't causing a ruckus in the hallway. But she needs to get some individual hours done now, because it's one of her few allotted times to use the therapy room. She's got about 45 minutes left in there today, otherwise she'll need to hope another space is open, and she hasn't had much luck with that lately. Cathryn listens quietly with her ear at the door. She recognizes how silly she must look, but it seems much too quiet when Michael was just screaming and throwing what sounded like very heavy items just a few minutes ago. She determines her path is clear, and is about to open the door, when she realizes she's missing something. She walks back to her desk, opens the top door, and grabs a ponytail holder she recently started stocking in there. She swiftly and deftly pulls her hair back into a messy bun. Maria likes to pull hair, and Cathryn had dealt with the painful end of that just last week. She wasn't going to make that mistake again.

Cathryn gets Maria from the group room, and as they make their way to the therapy room, a series of events begins to unfold that Cathryn can't help but glance upon as an onlooker, knowing that everything is about to get out of control very fast, and there's nothing she can do about it. It appeared as though one of the older kids on the unit had become emotionally dysregulated, and somehow lost control and the police were called to assist. Luckily, they did not see the officers arrest the child; however, one officer had hung around, likely taking statements from staff. Maria was seeing this too, and she wasn't handling it any better than Cathryn could expect her to.

Maria was referred to therapy after her father was detained and returned to Mexico. Maria, her mother, and her siblings were just returning home from school when ICE arrived. The officers held her and her family members and made them watch while searching the house for her father. She had not seen him since, though she had talked to him on the phone twice. It was no wonder seeing police officers often triggered Maria's emotional outbursts. As soon as she saw the officer she stopped in her tracks. Cathryn attempted to distract and reroute her, but it was no use. Maria's lower lip began to quiver as the tears were already forming. She dramatically flew to the wall like drawn by a magnet. Her tiny body slides down and slumps on the floor in a puddle of tears.

"I hate myself!" she yells to no one in particular.

The officers and staff glance down the hallway at the two of them. Cathryn gives the officer a half-hearted smile and then gives staff that look that suggests it's time to get the officer out of Maria's sight. This was becoming an all too often occurrence that Cathryn wasn't comfortable with. She remembers back when she started 10 years ago, and it didn't feel like they were calling the police all the time. But pressure from the state licensing body had given them few options for coping with aggressive behaviors in their environment. As the officer and staff leave down another hallway, Cathryn attempts the difficult task of helping Maria regulate.

"I wish I was dead. Just let me die."

"I would be really sad if you died, Maria."

"No you wouldn't. You wouldn't care. Nobody cares."

"Maria, why don't we keep walking to the playroom. Remember, we were going to play with the dollhouse today."

"I don't wanna. Leave me alone. Go away!"

Cathryn just sat with her. Giving her space, and really just wanting to cry with her. She couldn't imagine the pain of losing a parent that way, but this was just another day on the job for her. Cathryn had grown accustomed to not taking her patient's stories to heart, but she was finding Maria's particularly difficult to look past.

"Maria, did you get some sleep last night?"

"Only a little."

"What's a little?"

"I went to sleep when momma did and the clock said 1 o'clock. But then I had lots of nightmares so I looked out the window and waited until it got bright out."

"Did you have breakfast then?"

"No. I wasn't hungry."

"Would you like to go get a snack now? I heard the kitchen has yogurt and applesauce."

"No thank you. I'm never hungry anymore."

As soon as Cathryn returned to her office, she called Dr. Mussa. Dr. Mussa was the clinic's consulting psychiatrist. She doubted she'd get to speak with him, but they really needed to discuss medication for Maria. The family couldn't get into their primary doctor for over four more weeks, and Cathryn really felt Maria could benefit from an antidepressant. She heard the all too familiar voicemail greeting begin to play.

"Dr. Mussa, this is Cathryn Kabat calling again. I'm still waiting for a call back for a consultation regarding my patient Maria Gutierrez. Her symptoms of nightmares, not sleeping, and lack of appetite seem to be getting worse, and I'd like to consider the possibility of starting her on medication sooner rather than later."

Was he on vacation again? Cathryn's frustration was continually mounting with their psychiatry consult service. All of her kids were on some kind of psychiatric medication, and she felt they needed a better way to initiate prescriptions and monitor possible side effects. A 30-minute scheduled phone call once a week just wasn't doing the trick. "How do psychiatrists even treat patients without seeing them first?" she wondered to herself.

Brielle

Brielle walks onto the intensive outpatient wing to deliver Georgia's file back to Amanda, now that she has returned from inpatient. Brielle thinks back to her time on that unit before transferring to inpatient and feels that aching in her stomach that is all too common lately. She misses being here. She misses the support and encouragement, the hands-on training, and the feeling like she is able to help these children. Since her move to inpatient these feelings of support and usefulness have been few and far between.

Returning to inpatient, Brielle starts to wonder how she can begin to set up a more supportive and beneficial environment there, after all, that was her job now. She returns to her office with her head in her hands. She is able to see the things she would like to implement on the inpatient units to make it run more like IOP, but the weight and enormity of the changes feels overwhelming for one person to accomplish.

She walks down to the child unit to check and see how the patients were doing, because she knows the afternoon can be difficult for them with the staff transitions. As she heads down she hears the overhead page, "Code Green Unit 4," staff assistance needed on the child unit. She picks up the pace hoping to get there before other well-intentioned staff who will just inevitably make the situation worse. As she gets closer to the unit, she can hear a child screaming and the loud thuds of furniture hitting the floor. She can also hear the voices of multiple staff, trying their best to calm him down, but really just being distracting and offering too many options.

Brielle lets herself onto the unit and assesses the situation. Shantay is throwing chairs around day space and screaming "give me my snack you bitches." Brielle watches Nurse Jillian attempt to walk close enough to Shantay to take the chair away he was swinging around and she promptly gets hit in the side with the chair. Brielle looks at the other staff who have begun to

accumulate in response to the code. She looks at them and asks non-core staff to leave in order to remove attention from the situation. She then makes sure that someone is with the other kids in the group room. Finally, she recommends that all nurses and remaining staff move to behind the nurse's station for safety. At that time she says in a calm voice to Shantay, "Shantay, you look really angry to me. It sounds like you want a snack, but I don't feel safe helping you right now when you are throwing things around. When you are able to calm yourself down I'll be happy to talk to you about getting a snack."

Shantay continues screaming and kicking the door to the kitchen. Brielle encourages the staff to continue their work and ignore the outburst, doing her best to model this same behavior for them. Nurse Jillian recommends to Brielle that they turn on Netflix; this always helps Shantay calm down. Brielle contains her frustration with Nurse Jillian and suggests that this may not be the best idea. Within minutes Shantay has calmed down and is standing by the door with tears running down his face. Brielle walks out of the nurse's station towards Shantay, but continuing to maintain distance for safety if he were to escalate again.

"Shantay, you look sad to me. Is something wrong?"

"I miss my momma."

"Yeah. I can tell that's hard for you. It can be really difficult to spend so much time away from somebody. Has she come to visit you lately?"

"Yeah, she came last night and she's coming again tonight." Brielle notices that Shantay has stopped crying and he smiles when he talks about his mom coming to visit.

"Do you think you could help me pick up these chairs so we could sit down and talk some more?"

Brielle helps Shantay pick up the chairs and clean up the day space as they talk about his upcoming visit with his mother. Brielle reminds Shantay that when he becomes angry and aggressive, it makes people feel unsafe, and potentially interferes with a visit from his mother. They then discuss ways that Shantay can manage his anger when he is at home so he doesn't need to return to inpatient. By the time Brielle leaves, Shantay is able to return to group with his peers.

She heads over to the other child unit with the younger children. It's break time and many of them are jumping on the chairs and chasing each other down the hallway. The staff are standing off to the side with tired looks on their faces. She notices two children begin to fight with each other and wonders when the staff will step in. Once the fight escalates to physical aggression, with Jamie hitting Kaycee, Mr. Kevin jumps in and picks Jamie up by the waist and carries her to the quiet room. Once again, Brielle feels frustrated. Was physical intervention really necessary in this situation? She can hear Jamie continue to escalate in the quiet room until Mr. Kevin comes out and asks for help, wondering aloud why Jamie keeps throwing a fit with him. Brielle thinks to herself, "Maybe it's the way you came in and violated her space without trying to talk to her or verbally de-escalate her first," but Brielle doesn't say anything, because she feels as though she's said it all before and nobody is listening.

She returns to her office exhausted and defeated. She has been dealing with crises all day since the weekend. "Things are always worse after the weekend," she thinks to herself. With only fifteen minutes left until it is time for her to go home, Brielle tries to decide between spending her time coloring a picture to help wind herself down, or facing the ever mounting pile of tasks she has yet to complete. The pile seems never-ending and always growing, as she takes

out the markers and her coloring book. She wonders if tomorrow will be the day she actually quits.

Samantha

Boy, 9, Shot While Playing in Front Yard

City of Marshall police responded to a call of shots fired at 6:08pm Monday night near in the intersection of 68th Street and Ledgeview Lane in the Custer Park neighborhood. When they arrived, they found a nine year-old boy unresponsive in a nearby front yard with gunshot wounds in his upper thigh and lower abdomen. The boy's mother told police she was making dinner in the kitchen

when she heard the shots. She yelled for her son, and when he did not respond, she ran outside to find him laying in the yard. The boy was taken to a nearby hospital where he remains in stable condition. No suspects are in custody at this time. Anybody with any information about the shooting is urged to contact the City of Marshall tip line at 518-555-8924.

Samantha's breath quickened as she read the article. "I really hope that's not one of our kids," she thought to herself. It was getting so difficult for her to read or watch the news anymore, because she was always worried she'd see one of her kids, either as a victim or a perpetrator. She wished they'd just release his name so she'd know. Custer park wasn't far from where Samantha grew up, and just a few miles over from where she was living now. It was a rough neighborhood for kids to grow up.

Samantha wonders to herself how she got to be where she was. She wasn't all that different from these kids. What could she do to help them on the path towards success instead of the path towards violence they seemed doomed for, so her community would lead her to think. Marshall was not a great place to grow up Black in America. In fact, it was frequently cited as one of the worst cities in terms of outcomes for African American children. Samantha was the second in her family to graduate high school (her brother had graduated two years before her), and the first to attend and graduate college. She knew that many of her children, the kids in her

group, were looking up to her as a role model. While it added extra stress to an already stressful job, she was thankful to be someone they could relate to.

As she gets ready for the treatment team meeting, Samantha glances at the stack of fliers she been saving from her mail. Sitting on top was a flier for Bessel Van der Kolk's upcoming conference on the effects of trauma on the developing brain. Samantha had wanted to meet Bessel since first reading, Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society in her Master's level Trauma Counseling class. Unfortunately it was a 5-day conference, and she knew she'd never be able to get 5 consecutive days off work. Even if she could, she'd feel bad leaving her co-workers to pick up the slack. Samantha stifled a big yawn as she headed to the meeting. These long days and then late nights in classes and doing homework were really getting to her, but she needed to work to pay her way through her Master's program. Scratch that. She needed to work to pay for food and a place to live so she could get into massive loan debt during her Master's program. She knew she wasn't the only one, but the thought of student loans made her sick to her stomach, so she had promised herself long ago she wouldn't think about them. When she entered the field as a bright-eyed college graduate, she was convinced her Master's level salary would pay off her schooling in no time. Now that she'd been in the field awhile she realized the promise of Benjamins was something reserved for the elite, and she had no idea where people even found those jobs. However, she was certain that even if she found them, she would never love them as much as working with her kids. Call her crazy, but she loved this job. The kids that drove everyone nuts were her favorite. "Spunky" she called them.

Samantha took her seat next to nurse Jaqueline at the conference table. She was thankful for nurse Jacqui, because she knew how difficult other staff found it to work with their nurses.

Nurse Jacqui seemed made for this job. Full of smiles and patience, she never had a problem getting kids to take their medication. She was patient with parents as she described the uses and side effects of new medications and talked parents through their fears of starting their children on medication. Better yet, Jacqui and the team fit very well together and worked cohesively as a unit. Jacqui was frequently responding to calls for help and checking in on patients.

As Dr. Felecia began the meeting, Samantha noticed the group was smaller than usual. It was just herself, Callie, Amanda, Cathryn, Paige, and Adrian along with Dr. Felecia and Nurse Jacqui. None of the non-core staff were able to make it again. They begin by debriefing about an incident that had occurred the previous day with one of Adrian's patients. The patient had managed to steal Paige's badge while she was walking by in the hallway. The patient then used it to run out the exterior doors and into the street where Aaron had followed, grabbed him as a car was driving past, and carried him back into the building. Because there was a hold, it was necessary for them to complete a report that would be sent to the state facility licensing board for review. There was a somber tone in the room, because this was their second hold this year, and everyone knew that meant it was likely the state board would be coming for an inspection.

"Let's talk through what happened yesterday," Dr. Felecia started. "Where did it all start. Why was Maverick escalated in the first place?"

"It was time to start picking up for group, and he hadn't finished coloring his picture yet. I explained to him he needed to put it away to prepare for group. He said he needed to finish it before he could put it away. I didn't want to make him too angry, so I came over to start helping him. Suddenly, out of nowhere, he started screaming at me and throwing things and flipped the table."

"How did you respond to that?"

“I told him he couldn’t act like that in my room and I told him to get out.”

Samantha noticed Dr. Felecia take a brief pause before responding. “Okay. What happened next?”

“Aaron came and took him into the hallway. That’s where he took Paige’s keys.”

“I was just walking by and he pulled my badge right off from around my neck and ran away with it. I had no idea what I was supposed to do, so I just started yelling for help.”

“How did he get outside?”

“I keep my key card with my ID badge.”

So he ran outside...

“He was yelling and stuff saying, ‘You can’t fucking get me. You can’t fucking stop me.’ And he ran right into National Boulevard there, and there were cars coming everywhere so I just grabbed him.”

“We brought him in, in a hold? Who was all there?”

“It was me, Aaron, Amanda, and Jacqui.”

“What do you think we could have done differently to prevent the hold?”

“There was nothing we could do. He was running into the street and there were cars coming. We can’t just let him run into the street like that.”

“Now I just want to remind you we’re not supposed to go hands on outside the building. That’s no longer hospital property, and it can become a huge liability issue.”

“What were we supposed to do, let him get hit by a car?”

This wasn’t the first time staff had had this conversation, and it likely wouldn’t be the last. They’d been having similar conversations for years, since Samantha started at Marshall. It was easy to read the manuals and be trained exactly what to do, but situations never played out

exactly like the training manuals. Life just didn't work that way. She didn't blame administration for that. How could they possibly know what this work was like? But she also understood the frustration of needing to answer to people who didn't seem to understand the experiences of working with these children. Come to think of it, she couldn't remember the last time she had even seen any of them in the IOP building.

The meeting continued throughout the lunch hour. There always seemed to be more business to consider and patients to talk about than time in the day. The transportation vehicles started pulling up outside as a signal that it was time for the meeting to end. Samantha packed the remains of her lunch and headed towards her room. Kids came barreling down the hallway towards her. "We need to walk in the hallway," she said to them. As she walked through the door into her group room, she feels something hard bounce off her back.

"You're a fat ass," she hears one of her patients yell. She can feel the tears welling up in her eyes. Luckily Jacqui was right outside the door, one look and she knew Jacqui could tell she needed a quick break.

"Why don't you go grab some snacks from the break room. I can stay in here with the kids for a bit."

Thankful for the reprieve, Jacqui walked quickly to the break room, determined to get there before anybody noticed the tears. When she was first training for this job she remembers being told that kids are good at picking up on your greatest insecurity and using it to exploit you in their greatest time of weakness. It was something she had reminded herself of repeatedly since then. It always seemed like the kids were pointing out her biggest flaws that she was acutely aware of herself. But that reminder was always there. "It has nothing to do with you Samantha." It was just like the aggression she had learned to deal with on a daily basis. She was not the one

the kids were truly mad at. “Aggression only occurs in a safe space with trusted people,” she could hear Dr. Felecia saying in her mind. These kids were only reacting to the very real aggression and trauma they had experienced already in their short lives. She hadn’t even talked to the kids yet today when she’d had things thrown at her and been called a fat ass. “Man, that kid must’ve had a really rough morning.” She thought through her list of afternoon patients and what she imagined their home lives to be like based on their intake information. So much trauma, so much pain, so much violence. It could’ve been any of them. And just like that she was crying for a much different reason.

Aaron

Mr. Aaron heads to Dr. Felecia's office for his scheduled supervision time. There's been so much going on lately; he really needs help with some of the newer kids that have been giving him a difficult time. They also need to talk about the incident with Deonte where he went home and told his mother Mr. Aaron had twisted his arm and hurt him. Mr. Aaron remembers the day Deonte was talking about. It was a particularly difficult day and Deonte was very physically out of control breaking items, kicking the fire extinguisher box, and trying to punch staff as they walked by. Mr. Aaron is also very certain he never hurt Deonte. Of course Dr. Felecia was backing him up, but it has still been very stressful on him, and really other staff, because Dr. Felecia suggested Aaron not work with Deonte for a while. That just means whenever Deonte is struggling with inappropriate behaviors other staff members are taken away from their duties to help.

Just as they're about to get started, a call comes over the walkie about a fight between two kids in Samantha's room. Aaron glances at Dr. Felecia as he heads out that door. He knows that look of sympathy.

"We'll meet later. Maybe during lunch?"

He knows they won't meet later. There's never time.

Manager Meeting

Felecia heads to her much anticipated meeting with the management team. After thinking about it, she had decided to bring Cathryn, Amanda, Callie, and Samantha into the conversation. She had hoped Aaron would come, because she felt his input was also valuable, but he was busy getting caught up on notes from the morning group and suggested they go ahead without him. The group drove together to the administration building, discussing the ideas they were hoping to share.

They arrived at the building about three miles away from their own. The contrast couldn't be more apparent. New and modern, the administrators moved here in 2010 as the programs offered by Marshall Community Hospital expanded. That's also when they hired Charlie as their Clinical Director. Fresh out of Business School with an MBA, he was the best of the best everyone said. "He really knows how to run a business and has some fresh ideas that will help improve our profit margin." Ever since he arrived, things seemed to be changing at the hospital and everything seemed to be about money.

As they arrived in the conference room Charlie and the other board members were seated around the oval table. The seat at the head of the table was offered to Felecia, but it was apparent they weren't expecting anyone else to come. Cathryn and Amanda were able to grab chairs in the back of the room while Callie and Samantha were stuck leaning awkwardly against the wall.

"Well it looks like we have a full house here today," Charlie joked uncomfortably. "How about we get started?"

"Perhaps it would be helpful to do introductions, because I don't think everyone here is familiar with each other," Felecia offered, knowing for certain Charlie couldn't name any of her employees.

They went around the room, with the board curtly sharing their names and position titles. Felecia's staff shared a bit about their roles in IOP and how long they had been with the organization. After introductions, Charlie and the board opened the conspicuous looking binders in front of them.

“I see here that you currently employ 11 individuals on your treatment team. However, I also see that over the past fiscal year we've hired 20 different individuals to work on your unit. It looks like 10 people quit that year. Is that correct?”

Felecia began to think back, attempting to count in her head the staff that had come in and left over the past year. The number sounded a bit high, but she knew it was rhetorical. They clearly had come prepared with numbers and data. She was realizing too late that this was not meant to be a meeting of the minds, so to say.

“It looks like the median term of employment for staff on your unit is a very short 4 months, Felecia. As I mentioned in my e-mail, that's quite concerning to us.” Suits around the table began to nod their heads in agreement. “What's going on over there that you can't get people to stick around?”

Felecia needed to think carefully about how she was going to answer this question. She didn't need to look up, she could sense the frustration and concern from her staff. She thought back to the car ride over, where they talked about their concerns and brainstormed solution. Charlie may not be addressing them, but Felecia felt the responsibility to bring her staff into the conversation. After all, wasn't that why she had brought them in the first place? “Charlie, if I may, I think my staff have some valid concerns regarding their job duties and expectations and seem to have the best insight as to why we struggle with high turnover.”

“Well I suppose we have a little bit of time to hear from some people. But we need to keep it brief, because I have another meeting in an hour.”

Felecia felt like the air had been sucked out of her entire team. Suddenly they were all either giving her that “I told you so” glance or avoiding eye contact entirely. It was clear this wasn’t a brainstorming meeting, but a meeting where she would be reminded what was expected of her and told what to do once again. She wasn’t willing to go down without making her staff’s concerns heard, though. “I think my teams biggest concerns are not feeling safe and feeling undervalued. The lack of funding for efficient staff means we are constantly running understaffed, which creates more work for my staff, and in turn makes the environment inherently less safe. We are less able to watch all the kids and give them the individualized attention they need. We are asking them to do 50 hours of work some weeks and only paying them for 40, because they aren’t allowed to work overtime, but also aren’t allowed to leave work unfinished. We have policies and procedures that don’t seem to fit with the realities of our everyday jobs. For example, we just had our second hold this week, which we found to be necessary for the safety of one of our patients, but we’re afraid to even report that due to the backlash we expect to get. We need holds to keep patients safe, but we aren’t allowed to go hands-on, which makes our environment, patients, and staff less safe.”

“If your staff is feeling unsafe, then perhaps you need to consider the kids you are admitting.”

“What do you mean Charlie?”

“Perhaps Marshall Community is not the place for children that are violent.”

“Charlie, we are the only hospital within 250 miles that will admit children that are aggressive or on public insurance. If we don’t take them, who will?”

“Felecia, a second hold this year does not look good for us at all. We were already concerned with staff turnover, and now with state coming to intervene this is a big problem in our eyes. We’ve been waiting to say anything to you and would’ve preferred not to have this conversation with other staff present, but the board and I have considered cutting the early and middle childhood programs.”

“You want to close our unit?” one of her team members exclaimed. Felecia’s mind was spinning too much to even notice who it was. Likely all of them, because she was thinking the same.

“Frankly, child IOP just doesn’t make the money that our adult residential programs have been bringing in. In these days, private insurances are the big payers, and we’re considering not taking public insurance at all anymore. This is about money, Felecia, and your unit just isn’t making it.”

“These kids need help Charlie. If we don’t help them, nobody will, and we will just see them again as adults when it might be too late. We know that early intervention is the key to the best possible outcomes.”

“That isn’t our problem Felecia.”

It was clear this conversation was over, and Felecia wasn’t sure she could bite her tongue any further. She and her team left sullen and deflated, fearing for the future of their program and their children.

Felecia

Felecia returns to her office feeling defeated. She glances at her growing spreadsheet of referrals and waitlisted kids. She realized she never followed up on Zion's referral. She picked up the phone,

“Hi, Ms. Adams? This is Dr. Felecia from Marshall Community Hospital. How are you doing tonight.?”

“I just wanted to let you know that I received Zion's referral. Unfortunately we are not going to be able to accept her into our IOP program at this time. I'd be happy to provide you with a list of other community referrals if you'd like.”

Chapter V

The previous chapter was a novella, which presented the main themes found through interviews with participants. We met Dr. Felecia, the psychologist and unit manager of an intensive outpatient program that served young children with aggressive behaviors. We also met various members of her staff, including group leaders and counselors. Through these stories, we saw what typical days in this line of work look like, as reported by participants. In this chapter, I will review the codes and themes that emerged from participant interviews and explain how these were interwoven into the novella and how they fit with and diverge from the research presented in chapter II.

This grounded theory qualitative study sought to understand the experiences of mental health professionals who work with aggressive young children. It examined the questions, “What experiences do mental health professionals have that help or hinder them from providing daily care to aggressive young children?” and “How do organizational aspects affect a mental health professional’s ability to provide care to aggressive young children?” The purpose was to understand the personal and organizational resiliency strategies which help mental health workers to continue to provide high-quality daily care to these children and develop a theory of persistence in mental health work with aggressive children.

As mentioned in the previous chapters, these research questions were centered around the theories of counselor burnout/resiliency, as well as the ecological model of aggression. The theories of burnout and resiliency suggest that mental health professionals face high levels of everyday workplace stress that frequently lead to burnout. Burnout is characterized by emotional exhaustion, cynical attitudes, personal unhappiness, codependence on coworkers, boredom, frequent job changes, low morale, poor job attendance, substance use, and somatic concerns, all

of which interfere with an individual's ability to complete their job satisfactorily (Freudenberger, 1974). Lee, Cho, Kissinger, and Ogle (2010) propose that all mental health professionals experience burnout occasionally. Successful attempts to identify and cope with burnout are suggested to be integral to resiliency, (Crants, 2013) whereas individuals who do not or cannot cope with their feelings of burnout often become ineffective at their job or leave their position. Factors thought to promote resilience include engagement, meaningfulness, subjective well-being, positive emotions, and proactive coping (Crants, 2013). Previous research has implicated both personal and environmental factors in professional resiliency including balancing one's personal and professional life, engaging in enjoyable activities, high-quality, professional supervision, and formal and informal debriefing following critical episodes (Hunter & Schofield, 2006).

McAdams and Foster (1999) proposed an ecological model of aggression that suggests aggression occurs as a response to one's environment. Aggression is conceptualized as a coping response when one is unable to meet the demands of the environment. Therefore, personal characteristics cannot be blamed for aggression, but environmental demands must be considered. Some organizational changes thought to reduce the likelihood of aggression include increased knowledge and training, self-awareness, reduced access to weapons, increased access to exits, establishment of clear expectations for staff and patients, and providing as much autonomy as possible to patients.

Before we consider the themes uncovered from interviews about working with aggressive young children, we should first consider a primary premise of this research question: that working with young children who are aggressive is qualitatively different from working with older children who are aggressive. Interviews with research participants suggest this is the case.

“I feel sad that they are so young and that their behaviors have escalated to this at such a young age. And what has happened to them that has caused them to act this way. Because at 9 or under, you didn’t get that way without some bad things-90% of the time, maybe 95% of the time, you didn’t get that way without bad things happening in your life or a combination of bad situations occurring.”

“[What’s hard] is working with all the aggressiveness. Especially with the young kids. With the really little kids it’s like our emotional response is different. It’s harder. They just seem more infantile. So you want to be more nurturing and positive and it’s just so hard to see them so out of control. Nobody wants to do the CPI on a young child that’s had trauma. And then there’s just that there’s some parts of a child’s life you have no control over. Like, you can give families and schools the information, but then the kid goes home and maybe their family doesn’t follow through and there’s nothing you can do about that.”

“I think just from observing the staff interactions from more internalizing teens, their aggression tends to be more verbal or self-harm rather than outwards towards others. The staff are more engaged with those teens and it doesn’t seem as high of staff turnover. Our more externalizing patients tend to be younger patients. I think that is really draining on the staff to constantly have to redirect those behaviors and I see more turnover with those staff.”

What experiences do mental health professionals have that help or hinder them from providing daily care to aggressive young children?

Lee, Cho, Kissinger, and Ogle (2010) suggest all mental health workers experience stress as part of the job, and this was echoed by the participants of the current study. All participants mentioned that verbal and physical aggression occur daily in their programs. Examples of physical aggression include hitting, kicking, throwing objects, spitting, and breaking things.

Examples of verbal aggression include swearing and threatening other patients and staff. Each participant was able to identify times they had experienced burnout in their career, many of whom gave examples from their current job position. However, most were also able to identify strategies to cope with the daily stressors of working in the mental health field, and specifically working with aggressive children. Two main personal and professional themes emerged as directly related to resiliency for professionals working with aggressive children: “Ability to Conceptualize and Treatment Plan Effectively,” and “Our Savior Complex.”

Ability to Conceptualize and Treatment Plan Effectively

One of the primary ways mental health professionals cope with aggressive behaviors in the work place, and the most frequently mentioned theme in interviews for this research project was the ability to conceptualize and treatment plan effectively. This involves “Understanding the Origins of Behavior,” “Don’t Take it Personally,” “Therapeutic Models,” and “Trauma Informed Care.”

Understanding the origins of behavior means knowing the patient’s history and understanding that aggression is often deeply ingrained in this historical context. This context helps providers understand why a child acts aggressively as well as elicits empathy for the patient. According to participants, the primary reasons patients are thought to act aggressively include trauma, communication skills deficits, learned behaviors, and feeling out of control of their environment. One participant, when asked why she believed children act aggressively, stated, “Well I think what comes to mind is they’re trying to get some need met. And obviously they don’t have any other ways of trying to get that need met other than being aggressive.”

Another participant, responding to the same question, stated, “...to get out their emotions; to get

out their point of view. They can't verbalize what they are feeling. They don't have the words so it's easier to act out physically and the results are more immediate with physical aggression."

Once treatment providers understand the origins of a child's aggressive behavior, they can "stop taking it personally." Not Taking it Personally requires a general understanding that the aggressive behavior of a patient may be directed towards a staff member, but it is not caused by that staff member. Not taking it personally, at it's core, requires the professional to adequately self-reflect and recognize their own personal limits, recognize when they're experiencing countertransference, and working towards not allowing countertransference to interfere in patient care.

"I try to remove myself [from the situation]. I think that I don't take it personally when they're being aggressive towards me. I obviously can see they're really struggling in that moment," said one research participant.

"You learn to take things less personally so now you can easily kind of just shrug your shoulders and 'oh yeah that happened' you know, and I don't know, kind of brush it off a little bit more. I mean, there are still them patients that I've had really good therapeutic relationships with you know that have become aggressive towards me even now, and that stings a little bit more, but you still kind of learn that it's really not about you. They're here for a reason and they probably really don't want to hurt you," stated another.

When we consider the skill of self-reflection as necessary to not taking it personally, that means that individuals need to be aware of their own countertransference that occasionally occurs when a child becomes aggressive. One psychologist suggested that all individuals are likely to experience countertransference at some time or another with these patients and their ability and willingness to self-reflect was, to her, a key component in an employee being

successful at their job. When asked what she believes makes an employee successful at dealing with aggressive children she responded, "...being open about their comfort level so that we can practice some scenarios to help group their skills in areas that they are uncomfortable. Knowing that some kids' behaviors may trigger them and being open and honest about that and willing to learn and grow in their skills."

Additionally, self-reflection was a skill only mentioned by doctoral level mental health staff, and it was suggested that self-reflection is typically a skill learned at the graduate level. Individuals that have gone through graduate level mental health course work will recognize the shift in education, where the undergraduate level typically focuses on learning facts and theory, and the graduate level focuses more on self-reflection and practical skills development and application. For this reason, it makes sense that supervisors see graduate level individuals as more able to engage in self-reflection related to their reactions to aggressive children. Additionally, some psychologists discussed ways that the skill of self-reflection can be developed and fostered in all levels of staff. One Master's level supervisor was discussing crisis intervention training and explained,

One thing that's unique to this level of care and in this state is that not everyone needs a Master's degree to work in this level of care. So we have people here with Bachelor's degrees or whatever. And I feel like there's a lot you learn at the Master's level. Especially like, self-awareness and self-reflection. I feel like the people who haven't gone on to get a Master's lack some of that self-awareness and need the training more frequently. Because the training helps with some of that self-reflection. Like, sometimes you need to look at yourself and, we're still humans and we still lose our shit sometimes. You don't have to crucify yourself. But you need to look at what happened and what you can do different next time and move on.

Although McAdams and Foster (1999) suggest self-reflection to fit under an ecological approach to coping with aggression in the workplace, participants in this research study spoke

about it more as an individual and person-specific skill that guards against burnout. This cannot really be separated from the fact that self-reflection is needed to respond appropriately when a child acts aggressively towards a staff member. For this reason, self-reflection and “Not Taking it Personally” is likely an ecological factor as well as a resiliency factor.

Once staff are able to conceptualize the patient and understand the origins of behavior, they should put this knowledge into practice to form and execute an individualized treatment plan. When asked what “Theoretical Models” they follow, participants said things such as “Cognitive Behavioral Therapy,” “Trauma Informed Care” and “a little bit of everything.” Two interesting observations emerged from these responses. If we think back to participants’ conceptualizations of patients’ aggression as a coming from trauma, skills deficits, feelings out of control of their environment, and learned behaviors, we would expect therapy to consist primarily of skills training and behavioral interventions. This brings up an idea mentioned frequently by one participant; there is a difference between being helpful and being therapeutic. She illustrated this concept by saying,

[At my other job]* the staff appear to come from more of a skill deficit approach as looking at the patient as acting out-as not having skills and see it as a learning opportunity to model what else they could do. Again, they don’t take kids acting out as personally. They try to separate that. They really take the time to deescalate before they would do hands on. [At my new job]* the staff tend to act more reactive than proactive, and if they see someone acting out they will try to calm them down in the moment as quickly as they can. I mean they do try to offer them coping skills but try to move them out of the milieu, not necessarily because it’s the most effective but because it’s the best in the moment. That’s what I see. It’s not the best-it’s the most effective in the moment but not therapeutic. I don’t see it as trying to be cruel but more not understanding therapeutic techniques.

A second inconsistency that appeared across many interviews was regarding the concept of “Trauma-Informed Care.” Many individuals noted their theory of treatment as Trauma-

Informed Care. However, trauma-informed care is not a standalone treatment model, and, when asked what it meant, many participants struggled to verbalize what it was. This is concerning because, if you propose your main theory of treatment is trauma-informed care, but you don't truly understand trauma informed care, what are you actually doing?

Consider the case of Anthony as presented in Callie's chapter in the novella. We know from previous novella chapters that Anthony has a history of foster home placements and was removed from the care of his biological mother due to significant abuse and neglect. Individuals in foster care typically have few possessions, and usually when they move from home to home, the possessions they do have can get lost or taken away. When Callie asked him to put his toy away, that request may have been difficult for Anthony, because single objects are often times more valuable to kids in foster care. Setting the limit and following through is a primary standard in typical treatment with aggressive children. However, when we consider the words used by Callie, which may be no different than is taught in training, we see she says "Okay, this toy is mine now." Some children may understand that this is a temporary thing. The toy will be returned at the end of the day. However, for Anthony, who is used to items being taken away frequently and forever, this may remind him of his frequent moves between foster home placements and may have elicited a trauma response. Callie responds, again, in what may seem like a typical response, "When I hear you talk like that it makes me not want to talk to you." The purpose of such a response is to help the child understand the natural consequences of their actions and recognize the asocial behavior of yelling and cursing. However, due to Anthony's history, he is likely to feel rejected by Callie when she makes a statement like this, further escalating the behavior.

This example illustrates how trauma-informed care might be considered within the IOP environment. Care providers should begin to examine their language and behavior and understand how that might affect the children they work with and unintentionally trigger traumatic responses. The core concept is making a shift from wondering, “What is wrong with you?” to “What happened to you.” Another important part of trauma-informed care is understanding that it’s individual to the patient. A treatment team can’t simply say they’re trauma informed because they understand the impacts of trauma and what it looks like in their patients. Trauma-informed care means understanding the backgrounds, behaviors, and coping skills of each of our patients and working to minimize situations and environments that may elicit a traumatic reaction. One participant with an advanced knowledge of trauma-informed care, when asked how trauma-informed care affects treatment with patients stated,

I really think it’s a lot about information gathering. Like, we can be really quick to jump to trauma and trauma informed care, but I think we need more info to know if that’s what is needed in this situation. We need to consider why they are here. Was there trauma? The sooner we know that the better and to make sure we aren’t unintentionally activating the child. I think people really need to be educated on what trauma is in general and how it may present. And experienced vs. vicarious trauma. And complex traumas. There are various types of trauma. Like was there neglect? Were they removed from the home? It’s important to assess the current family system and the impact trauma may have had on the system and its function in various situations. And using trauma informed care means we think about how to respond. You have to be aware of your positioning and when it’s appropriate to use physical touch. It helps us to navigate dysregulated moments and know how to bring them back. Like do we use distraction or soothing?

Let’s consider the situation presented in Cathryn’s chapter with her patient, Maria. In this instance, the police had been called to the unit to assist with restraining another patient. After speaking with participants in this study, it appeared police contact with the unit is a relatively

frequent occurrence, as staff feel that is the only way they are able to cope with aggressive behaviors due to expectations from the state that they not use hands-on restraints. To avoid repercussions by the state, staff avoid physically restraining patients when they become violent. Instead, the situation gets turned over to law enforcement. However, numerous patients have had contact with law enforcement in various capacities, but for many patients these have not been positive interactions. The mere presence of law enforcement on the unit may elicit a traumatic response and further escalate the behavior, feeding into that cycle of aggression.

Our Savior Complex

Another theme related to counselor burnout and resiliency mentioned in this research study was “Our Savior Complex.” Our savior complex refers to the employee’s need to save or protect another person, either patients or staff. This came in various forms: a staff wanting to save an aggressive patient, staff wanting to save other patients around the aggressive patient, and managers wanting to save their staff from harm.

The most frequent form of this code was staff mentioning wanting to save the aggressive child in some way.

Okay. It’s bad but I actually like the bad kids. I do. I really really do. Like, I don’t like them once they are always hitting, but I think once you start teaching them how to, you know, show or display their feelings in a different way... But I like the horrible kids for whatever reason, and sometimes I do, in all honesty, and it’s bad, I know, but I kind of favor them over the not so bad kids. You want to tend more to the people who are really on task, but the bad ones, like if I can just get you...Because I think that no one wants the bad kid, so it’s like every environment I go to, no one wants me. It’s always the same. So it’s the same cycle. So I’m like, okay, I’m going to want you.

Interestingly, many unit managers spoke about new and young staff starting with high motivation to help and change patients’ lives, which managers felt to be out of proportion to the

limits of the work done in IOP. One manager, who also supervises therapy practicum students, explained it as,

Doing this work for so long, I think I came in, like so many people, with rose-colored glasses. Like, 'I can just sit down and fix things.' I felt that way for the first year or so and it took a while to get more real-world about what I was doing. I needed to get taken down a notch or two. Like these practicum students come in and right away they're like, 'why won't they tell me everything? Why won't they talk to me?' But that's not realistic. And if they did, that would suggest something totally different.

Another individual described his goals in the safety of various individuals when a patient is being aggressive as, "My main goal is to keep the client safe. Then keep myself safe, and then keep the other clients safe. The client is above ourselves." Literally suggesting he considers the client's safety more important than his own.

Managers spoke frequently about believing that the transition from "rose-colored glasses" to more realistic expectations to be necessary to persistence in the field. Interestingly though, they also frequently mentioned their own need to "save" their staff from patients' aggressive behaviors.

If we have a kiddo that's really aggressive here I try to do my best to be there. We haven't had one in awhile that been super aggressive. But, if I hear that there are walkie calls about someone being aggressive, I try to be there. I try to be the main person with the most aggressive kids, because I feel like this protective factor for my staff; like I don't want them to get burned out because I know that they're also in group all the time with the kids and working with the kids when you're out of group. And I know how an aggressive kid can cause burnout even faster sort of because that is more draining to deal with, so I try to be there a lot more often when we have someone who's really aggressive and try to take the primary kind of role of managing that as much as I can.

They don't seem to recognize the inherent irony in their impulse to save and protect their staff, when they expect their staff to transition out of that role towards patients.

This need to save patients that seems to prominently present in early career professionals in the field was often discussed as part of a bigger career life cycle presented by seasoned supervisors. They stated that they often see individuals come into the field with an air of naivete in regards to their expectations of clients and the job role. As time goes on, this discrepancy between their “Expectations vs Reality” results in the professional remaining in the field but adjusting their expectations, or becoming burnt out and leaving the field entirely (See Figure 1.5). As shown in Figure 1.5, the two things participants proposed to mediate the relationship between Expectations vs Reality and persistence/desistence, are Intrinsic Interest in Working with the Population and Passion for Learning.

This interviewer spoke with supervisors in charge of hiring new mental health professionals to work on their unit. All hiring individuals agreed, “I don’t think you can be prepared. Like, people can tell you about this, and it’s not until you are here and you actually see it and experience it that you really understand. I don’t think anyone outside of here really understands what we do and the stress we are under.” Thus, it doesn’t seem anyone can be prepared coming into this type of work. So, when asked what they looked for in new employees, they stated they look for people who have an intrinsic interest in working with children as well as a passion for learning. One supervisor stated, when asked what she looks for in hiring new staff, “Some of it is their history and experience. But also their body language when talking about kids. Where do they want to go from here? Is this their passion or are they looking for a job? What’s their investment level? And really just their ego strength.” Another supervisor was asked if she believes education is related to an employee’s comfort and success in working with aggressive children. She replied, “No. I don’t think it’s so much about education. Like, we have some social workers here that struggle and therapists. But we have an [employee]* that has a bachelor’s

degree in a field not even related but he's really motivated to learn and he does really good. So I think it's more about being open to grow and learn."

Finally, one last personal skill was discussed as a way for individuals to protect themselves when working with aggressive children. This was the only code that differed based on how experienced someone was in the field, with only individuals working in the field more than 8 years mentioning it: "Disengagement." Disengagement was described as "checking out," "detaching," or "becoming immune to client problems." Quotes by participants better explain this phenomenon.

"I like to check out, and I'm like 'Whatever. Let me just get you out. Then we can go back to sailing on the water and looking at the gray skies and the sun, and feel the breeze so...'" spoken by a counselor with 8 years experience in the field.

"Personally, I'm a little colder to some client issues. I'm less attached to clients, which can be good in some ways. It's just like, when you hear the same client stories over and over, I'm not as shocked by it. I think I was more invested in the beginning. But now I focus more on how I can help instead of actually taking in the experience," said a program director working in the field for 20 years.

"I didn't kind of have this tough exterior at the time I guess... Well after being here for almost 10 years getting hit and kicked it kind of just seems like part of the job now, and I almost built up this immunity to it. And you learn to take things less personally so now you can just easily kind of just shrug your shoulders and 'oh yeah that happened you know and, I don't know, kind of brush it off a little bit more... I kind of think that I have toughened up and I have a tougher interior too. So, I am a little bit more immune to having the really strong and sad angry

feelings about it, because this is something that happens. I just have become used to it I guess. Which I don't think is a good thing," says a social worker.

The previous quote, spoken by a social worker of ten years brings up an interesting thought. Is disengaging a good thing? Disengaging appears to be a coping mechanism used by individuals who persist past the period of disillusionment due to expectations vs reality as mentioned in figure 1.5. However, Freudenberger, the first person to discuss the concept of burnout, suggested that ultimate catalyst of burnout to be devotion to a cause, belief or relationship that failed to bring about the expected reward (Freudenberger & Richelson, 1980). This suggests that, if all individuals come into the field with unrealistic expectations, they are also hopping on the fast track to burnout when their expectations are not met. Furthermore, Lee, Cho, Kissinger and Ogle (2010) as well as Marner (2008) both suggest depersonalization of clients to be a characteristic of counselors experiencing burnout. However, after speaking with these professionals and hearing about their passion for their job and their patients, it didn't appear that these individuals would be those that others would identify as experiencing burnout. Actually, quite the opposite, they seemed quite resilient. Perhaps this is due to the protection of other factors proposed by Marner (2008) such as cognitive empathy (Understanding the Origins of Behavior) and putting the client's experience in perspective (Not taking it personally). The mediating factors between depersonalization and burnout/resiliency deserve continued consideration in future research.

As we can see, the "Ability to Conceptualize and Treatment Plan Effectively" as well as "Our Savior Complex" appear to be two main themes that help mental health professionals provide daily quality care to aggressive young children. Next, we will examine the organizational aspects that affect the ability of mental health professionals to provide quality care

to aggressive young children use the ecological framework presented by McAdams and Foster (1999).

How do organizational aspects affect a mental health professional's ability to provide care to aggressive young children?

When viewing aggression as an ecological problem, McAdams and Foster (1999) suggest that organizational approaches can be helpful in the treatment of aggressive behaviors in young children. This approach examines the factors in the environment that lead to aggression and works to change those factors. It suggests that, for those who work with aggressive young children, certain organizational changes can be made to reduce the occurrence of violent episodes in the workplace. Some of these suggested changes include increased knowledge and training, self-awareness, reduced access to weapons, increased access to exits, establishment of clear expectations for staff and patients, and providing as much autonomy as possible to patients. In the current research, 4 main themes were identified as organizational aspects that affect an individual's ability to work productively with aggressive children. These four themes are, "Logistics," "Career Opportunities," "Effective Multidisciplinary Teams," and "The Role of Management."

Logistics

Previous sections focused on personal characteristics of individuals who work with aggressive children that help or hinder them from providing quality care to aggressive young children. Following sections will focus on characteristics of managements and organizations that support the individuals providing this care. However, this section will focus on the themes of "Logistics" which refers to technical aspects of the job and environment that get in the way of

providing patient care. The logistical aspects mentioned in this section include “Not Enough Staff,” and “Aesthetics.”

Not enough staff was something mentioned frequently throughout interviews from group leaders all the way up to psychological unit manager. This concern makes sense, as this study’s main foundation is high staff turnover in the field, and Hunter and Schofield (2006) assert that manageable caseloads are required to mitigate counselor burnout. There are various ways in which a lack of staff affects other employees, but the primary way is that covering for other staff results in more work to do, longer work hours, and less down time. We’ve already examined the emotional effects of working with aggressive young children. However, when units are not fully staffed, the child to staff ratio increases, resulting in an even higher emotional, mental, and physical investment.

Not enough staff may be a result of frequent staff turnover but can also occur as a more time-limited event when staff take vacations or are out sick. One manager, when asked what she thought could make her team more successful or productive stated, “More staff members. More people to help staff members avoid burning out. Having a small team has its benefits, but also has its drawbacks. So, if someone isn’t available, if they’re sick or on vacation or something, the rest of the team has to pick up that work.” In this sense, intensive outpatient units are not like outpatient care in that, if a provider is out sick, their appointments and groups are still expected to run and another professional is needed to step in for them while also completing their own work that day. The researcher followed up that response, wondering if that reliance on others to cover for them impacts people’s decisions to take sick days or vacation days. She responded, “No not really. We are all very close here so we sort of expect patterns of vacations and know what’s important to each other so we know when to expect someone will be on vacation. And if

we know we have something coming up we know others will be covering for us, so we'll try to think ahead and think, 'How can I help that person out? Will they need a day off or some help with something?' I do think we are less likely to call in sick when you know that means someone else will have to pick up your work."

A second logistical code mentioned by at least half of this study's participants was "Aesthetics," which refers to physical aspects of the building or unit on which employees are working. Some aesthetic concerns individuals had regarded the colors of the walls, the layout of the unit, and the overall cheerfulness of the unit. One participant compared a previous location they worked with as compared to their new location. She shared how she felt the setup of her previous unit was more functional, because intensive outpatient and inpatient programs were all in the same building, which made transfer of care safer and easier. It's not uncommon for aggressive young patients to transfer between inpatient and intensive outpatient levels of care to address ongoing mental health and physical safety and stability concerns. At her new location, the IOP and inpatient buildings were no longer connected and required crossing a busy street. In her old location, she could walk her patient upstairs to the inpatient unit, but at her new location, she did not feel safe doing so. "When you need to send a child to inpatient you have to cross [Main]* Street right there. And that's a busy street and kids can just go running down a busy street. And so more times than not, I'm going to call the police to take a kid across the street, because if they're dysregulated they're clearly not safe enough to walk across the street."

Another aesthetic concern mentioned by participants at two different locations included the color of the walls. While some may not consider the color of a setting, there is some evidence that colors can have small effects on mood. One participant spoke specifically about the "drabness" of the walls and her concern that it brought mood down. Another individual in a

different setting was concerned that the drab color of the walls may create an unwelcoming environment when patients arrive, which is concerning, because aesthetics such as this are likely to be one of the first things new patients and their families notice when entering the building.

Other aesthetical concerns include a general lack of space required for staff to engage in necessary activities for themselves as well as their patients. This includes places for staff to put their personal things and computer space for completing required patient notes. It also includes indoor space for physical activities. One participant mentioned concerns with building aesthetics. When asked to elaborate, she addressed all of these issues.

We recently moved into this new building. It was supposed to be bigger, but really it was the same size. So we don't have enough offices and our group leaders don't even have an office. They're using a shelf in the file closet. And just more of those sensory things. Our location is not trauma-informed at all. Even the colors. Like, they chose these colors and they're just so drab. And I was thinking the other day that one of our group rooms doesn't even have windows. It just needs a new layout and floor plan and more physical space. And a self-care space for staff to feel rejuvenated. And exercise or gym space, because we have a parking lot and some grassy area we use for capture the flag and other group events, but an indoor space would be nice.

All of these are ideas to consider when designing a space most appropriate for client care and organizational function.

Career Opportunities

Moving into the theme of "Career Opportunities" we begin to explore things that mental health workers identify that their organizations do that are helpful or get in the way of providing care. This begins the section in which specific factors in which managers can intervene to best support their employees are mentioned. These factors include, "Glass Ceiling," "Pay," "Training," and "Diversity."

Multiple individuals discussed their progression in the organization, as they transitioned from a lower level mental health role to a higher level role. Many started as a group leader and were able to transition into a social worker or counselor position as these positions opened up. Conversely, for many of these individuals, social worker or counselor is the highest level position attainable within these organizations. “Frankly, there’s limited growth here.” This glass ceiling leaves little availability for intrinsic motivation to succeed and striving for continued growth if there’s nowhere left to go. When we consider the previous and following codes of passion for education and intrinsic motivation, individuals who feel there is no future direction for their job are less likely to feel fulfilled in their careers. For this reason, the next code will focus on mediators that affect motivation for a job with limited growth.

The first code, mentioned frequently, was “pay.” Specifically, the lack of pay. Many individuals, especially at the group leader level, mentioned needing to have multiple jobs to afford to live on their own, or continuing to live at home with their parents, because their current pay didn’t afford them the opportunity to live on their own.

When asked why she believes individuals leave the job or field, one psychologist replied, “I think really because it’s not high paying, but it’s high stress. The amount of stress and work does not get matched by the pay... We struggle to find [mental health workers] here and I feel like it shouldn’t be that way with all the colleges in this town, and all you need is a Bachelor’s degree in whatever. Not even necessarily psychology or social work. But it’s the pay. Why work here doing this when you could get paid as much at McDonald’s?” This suggests that, not only is the pay very low, but the job stress and demands are very high, making the lack of pay unworthwhile.

This is echoed by another individual with her Master's Degree, currently working as a program coordinator. When asked what she likes least about her job, she replied,

Really the money. I think with making less money I just feel like I'm not getting my investment back. Like, I spent all this time and money in school, but I'm not getting paid for all that time and money. I mean, this is a specialty area, you think it would pay more. But I know Bachelor's level people making more than I do, and that just doesn't feel right. I mean, I just moved out of my parent's house at 29. Not at all what I expected. And I can only afford to do that because I got a really great deal and I sell on Poshmark, and I bartend, and I sell Norwex. I'm just constantly trying to hustle...I've had some really candid conversations with my supervisors about how non-competitive the pay is and how we could improve staff retention by making the pay more competitive. Right now I don't think anyone has stayed really over 10 years before moving on.

When asked how management responded to that, she said, "Well we have a lot of locations and they will say, 'Well we've had staff with us for over 15 years that have never gotten a raise and they're happy as a clam' but I've never met them. And maybe it's because they're in rural areas with less opportunities or something, but here in the city people are going to leave."

Thinking back to our novella, the group leaders Samantha, Callie, and Adrian all discuss job openings within other organizations. Callie has a short internal debate with herself about considering the alternate job Samantha shares with them due to the increase in pay. However, she also thinks about how much she enjoys her job and the kids she works with. This dissonance between enjoying the work but desiring more pay appears to be a frequent struggle for all levels of staff in IOP. This suggests that for some individuals leaving their positions, they are doing so not because of the work demands, but because of the lack of pay. When the pay doesn't match the amount of work required, employees may feel undervalued by management. This will be considered further in an upcoming section.

Training was a code mentioned in various capacities throughout this research study. This echoes McAdams and Foster's (1999) assertion that training can affect the organization in a way

that helps individuals better work with aggressive patients. Specific de-escalation training and other specific types of training were asked about and mentioned. The two most common types of training mentioned were de-escalation training and trauma-informed care training. Trauma-informed care was discussed previously. Based on the findings regarding the lack of understanding of what trauma-informed care is and how they implement it, the desire for additional trauma-informed care training is likely a crucial one. In terms of de-escalation training, a few different types were mentioned, crisis-consultants group, (CCG), The Mandt System, and crisis prevention institute (CPI). These trainings are administered either “in-house” or by outside consulting groups. The way training is administered is an important consideration. Some participants mentioned liking in-house training, because “we really know each other here, and lots of our staff have been here awhile, so we can get rid of the verbal de-escalation piece. Like, we’ve been doing that 15 years, of course you know how to verbally deescalate. We don’t need to focus on that, because we know how to do it.” Organizations should have some reservations regarding this attitude, however, because the next thing this individual stated was, “I think it’s nice to have the refresher and reminder. I also think it helps to add confidence immediately after the training and being reminded how to do this. It’s also nice to teach the younger staff how to handle the behaviors.” While staff may feel that the verbal de-escalation piece of training is wasted time, the purpose is to cut down on hands-on de-escalation, which organizations and state licensing bodies would like to eliminate. Additionally, while seasoned staff may feel they have a good grasp on how to verbally de-escalate, this participant herself admitted that the refresher increases confidence in experienced employees and is the way in which new employees learn these skills. If in-house trainers remove this part of the curriculum, they are removing a primary way in which new staff learn and practice these necessary skills. A

different employee specifically mentioned how the verbal de-escalation phase is her favorite part of training and what she finds most helpful. “I think the verbal part has helped me. Even though I say what I am supposed to say, what I am taught to say. I just know how to approach things in a different manner or what-not...I mean, really that’s what we’re doing lot of the time. I mean that’s the majority, not the majority, a lot of our interactions are, it’s all about managing it and de-escalating it and verbally de-escalating before this gets further. So offering coping skills and offering anything that will help you to be able to regulate so that the behaviors don’t escalate.”

Additionally, some staff members mentioned feeling as if their organizations wanted or expected them to attend and complete training but did not provide opportunities or time to do so. One participant, when asked if there was additional information she wanted to share, focused specifically on her desire for additional training opportunities and time to participate in those. “I think the main thing is training. There’s not a lot here. We had lots of opportunities for training at [my old job]. Like, we could go on the computer and register for all these training opportunities. But here, it’s like I have to have my [continuing education hours]* completed by the end of July, [for the organization]* but they don’t offer anything. Where am I supposed to get that? In my free time? I don’t have time for that. More professional development and continuing education.”

The training opportunities that participants found most helpful were “on the job” and informal training opportunities, specifically shadowing de-escalations with aggressive patients. Some employees didn’t feel they’d had enough on-the-job training. This was especially true for individuals who had already been working in the organization but in a different position or capacity. “So, I was [working in a different role]* before here so I didn’t have to do the formal training. I just shadowed for a few days and then they were like, ‘here’s your caseload.’”

Managers and supervisors often mentioned how “comfort” was a key to managing aggressive patient behaviors. As a result, exposure to aggressive behaviors and de-escalations completed by experienced staff are considered vital to new staff training. One individual, who started out at a lower level in the organizations and progressed to the psychologist level, reflected back on her initial training and stated the most helpful thing for her was watching the psychologists model different ways to help clients de-escalate. Behaviorism tells us that modeling is often a key component to learning, so it may be helpful for managers and supervisors to provide as many shadowing and modeling opportunities as possible.

A final code was the most frequently identifies as a protective factor that participants enjoyed most about their job. In fact, every professional, when asked what they liked most about their job, answered the same thing, the “Diversity.” Specifically, they most enjoyed the diversity of job tasks and challenges. Answers to “What do you enjoy most about your job?” include,

“I like the diversity of kids and the days and the dynamics; every day is different, every kid is different, every situation is different. You can’t be like, ‘one-size-fits-all.’ You’re never like...you’re always thinking and being creative and ‘what will work?’”

“I like the level of care and the variation. Like everything changes every day and it’s always different.”

“It’s hard to say what a typical day would look like, because every day...what I love about this job is every day is different.”

Career theories suggest that a desire for job task diversity and lack of regular routine is an individual career interest not shared by all employees. For this reason, managers may find it helpful to look for employees who valued work place and work task diversity.

Effective Multidisciplinary Teams

Individuals who work in formal mental health settings should easily recognize the need to work as part of an “Effective Multidisciplinary Team.” When interviewed about their multidisciplinary teams, members of the team included group leaders, social workers, psychologists, counselors, psychiatrists, nurses, and occasionally occupational therapists.” Notably, not a single person mentioned that program business manager as a member of the team. The reason it’s likely necessary to consider the manager as part of the multi-disciplinary team is further elaborated upon in the epilogue. Things important to an effective multi-disciplinary team include “Passion for Work and Learning,” “Cohesive Goals,” and “Communication.”

Passion for work and learning was further discussed in the preceding section about personal characteristics that help individuals provide quality care to aggressive children. The reason it’s also relevant to the multi-disciplinary team aspect, is because a lack of passion for the work appears to negatively impact team morale. One participant focused on the differences between working at her old job, where she felt like part of a successful team that managed aggressive patient behaviors, and her new job where she felt a lack of staff cohesion and difficulty managing aggressive behaviors.

Over [at my old job]* it seems like people enter there because they want to enter into a career in mental health so they take a lot of opportunities for learning. It’s a smaller department and the staff have really worked to be a strong team. So they work cohesively together. [Here] there’s a lot larger department. I see more variety in educational background and I think many people come into this department more because this is a job they got, not necessarily looking to stay in mental health for a career. So it doesn’t seem they are as eager to take things as learning opportunities. More just trying to get through a day and because there are so many more staff the team aspect isn’t as strong. And as across interdisciplinary teams and within positions people vary. If they can work together they’re stronger. It’s almost [here] working from a historical medical model, so trying to change that to more of an interdisciplinary team has been a stronger and harder obstacle to overcome.

As mentioned in the final sentence of the previous quote, it's also important for the multidisciplinary team to have cohesive goals. A benefit of a multidisciplinary team is having multiple perspectives through which to view a patient's behaviors and struggles. However, the various disciplines also have various educational and personal backgrounds that affect their understanding of patients' behaviors and different goals for treating patient concerns. If the professional goals have competing outcomes, working together can be difficult and may require professional compromise. For example, the medical model discussed in the previous quote is the model in which medications are seen as necessary to managing strong and disruptive emotions. Therapy and counseling is seen as secondary. For counselors and psychologists, they are likely to see this backwards and believe medication is a secondary adjunct to effective psychotherapy. For this reason, effective communication is necessary for an effective multidisciplinary team.

Communication appeared to be the largest factor that determined if people felt their team was successful or unsuccessful.

"I think, just my time, I think it's awesome. I think we are all on one accord as far as redirection, as far as communicating with one another. If I said something like, the follow-through, because I think a lot of times that would be the hardest part. If you say something to one kid and then someone else says something to the same kid. But I think we are awesome at just being on one accord with our consequences and just keeping that line of communication open. I think we are awesome...I think the major thing is just being on one accord. I think the disconnect is when everyone thinks that they have the answer and that everyone wants to put their two cents in. But if you are all on one accord and not giving in to these kids, [placing] boundaries and actually keeping them, then that's when you're going to get compliance."

Another participant discussed how lack of communication can interfere with patient care. She specifically discussed the help of team members that work on her unit, but not specifically on her team. When asked how she feels staff work together to managed the behaviors of

aggressive children she said, “Not so awesome, because I think they mean well but because you don’t understand the dynamics of what we are trying to teach, your meaning well is like kind of derailing what we are trying to implement and it doesn’t work. So thank you for meaning well, but I want you to mean well only in your mind and heart, don’t actually do it. Like, no so it’s not always the best because it goes against what we are trying to actually teach or what we just said.”

Other participants mentioned not feeling heard by staff when communicating about therapeutic or patient-specific concerns and said this was the most difficult part of her job. What’s difficult is “staff’s openness and willingness to understand that there are things that they don’t know and there are more effective and therapeutic ways when interacting with a patient. A lack of some people’s openness and willingness to want to change and do better is the most frustrating part of the job, because it makes me really sad to think of a patient not receiving the best care they can.”

Passion for work and learning, cohesive goals, and communication are all aspects of a cohesive team that need to be fostered by an effective manager. This final section will focus on the role of management, specifically ways that participants view managers and ways management can work to better support their staff on the front lines of providing care to aggressive children.

The Role of Management

This section started by asking “How do organizational aspects affect a mental health professional’s ability to provide care to aggressive young children?” While all the previous subsections focused on organizational aspects affecting their ability to provide appropriate care, this section will focus directly on managerial aspects that support or discourage employees from persisting in their job. Readers are directed to the “Manager Meeting” chapter of the novella for

some more specific recommendations regarding what participants thought would be helpful in the execution of their jobs.

First, it's important to note that the length of this section should not necessarily be considered relative to its importance to employees. It was interesting to the research team how infrequently any concerns with management were ever addressed, even when asked about them directly. Anecdotally, it doesn't seem possible to find anyone who has no complaints about their jobs, thus it seems unlikely that that every single participant is 100% satisfied with their relationship with their organization's managers. Instead, some small hints suggested feeling unheard, not respected, or not understood were shared. Additionally, in this section, management does not refer to the on unit psychological or counseling manager but a separate organizational manager.

This lack of talking about management in general suggested a general desire to not doubt the skills or vision of management. For example, one participant discussed feeling that de-escalation training was ineffective, but also stated that she was unsure if it was ineffective, "sometimes every blue moon it helps. I mean, there's a reason it's researched so it works to a degree, I believe." Further, she stated, "I think a lot of times the people who make the rules, they don't deal with the kids. So the reality of what they teach and the reality of how the kids are, they don't co-exist." It may be important to note that this particular participant has already submitted her notice of leaving her job prior to the completion of this interview, which may have affected her willingness to doubt management. Additionally, very few participants were willing to be audio-recorded and asked multiple times how their information would be safeguarded to be sure their managers did not find out they had participated in this study or find out what was said. Because very few individuals had anything negative to say about their position, managers, or

organization, it left the researcher to wonder why such an excessive degree of concern was placed on confidentiality aspects.

Another interesting management aspect observed by the researcher was the availability, or lack thereof, of the program manager. In fact, of all programs that participated in this research study, not a single one had a program manager whose office resided in the same building as the treatment unit or program. One participant, when asked what she believed her manager could do to better support her and her team suggested, “Not just going there when it’s not acute. Go when it’s more acute...when patients really struggle and are harder for the staff.” This suggests that the manager rarely visits the unit and that the manager doesn’t truly understand the struggles unit staff encounters. This need for accessibility was discussed in Hunter and Schofield (2006) who found that, after difficult counseling sessions or critical incidents, staff would want to debrief with managers.

Finally, we must consider why some individuals chose not to participate in this study. Most notably, the only male participant that agreed to participate, did so with quite a bit of reservation, and was called out of the interview after less than five minutes. He never returned or returned communication from the researcher. Additionally, direct line staff, or mental health technicians also refused interviews, despite being asked. Notably, direct line staff is the position in which most male mental health staff work. Through informal discussions with male line staff, it has been suggested that they avoided participating in this research study, because they were afraid of judgment from the researcher about how they conceptualized and managed aggressive behaviors, as well as concerns regarding confidentiality. This researcher finds men and line staff to be crucial to the care of aggressive young children, as they are typically the staff with the most

direct client contact. For this reason, Mr. Aaron is a vital role in the previously presented novella despite his “voice” not being present.

Overall, participants suggested a general belief that there was no reason to question management or offer suggestions, because their suggestions wouldn't matter or their sentiments would fall on deaf ears. For example, refer back to a previous participant quote in which she suggested employees needed higher pay to remain with the organization and her concerns were minimized and dismissed. Furthermore, as discussed in the epilogue, management has moved so far as to suggest unit managers no longer accept aggressive children into treatment or closing programs entirely.

The Conditional Matrix

It was mentioned previously that the program manager should be considered as part of the multi-disciplinary team. The manager plays a role in the treatment of children, although primarily indirectly. To better understand how the role of the manager and managerial goals fit and conflict with the roles of other team members, we will consider our conditional matrix. Strauss and Corbin's (1998) conditional matrix, as described in Chapter III, considers the micro- and macro-level implications of research questions being considered. In this sense, we will consider the conditional matrix exploring the various treatment and behavioral goals of the team working with aggressive individuals. Refer for Figure 1.6 for a visual representation of the conditional matrix.

The matrix consists of five concurrent circles with the patient at the center. Treatment staff surrounds the patient, which consists of mental health staff and medical staff. Next is management of those staff. The following circle is the patient's immediate environment, including their family and their school. Finally, society is the outermost circle. Each of these

circles consists of people with their own goals, which may or may not fit with the goals of others within the matrix.

We've already explored the goals of the patient, which are to gain control over their environment and to express a need, which they may do through aggression. Treatment staff include both medical and mental health staff. Medical staff focus on the medical and medication management of aggressive behaviors. Mental health staff focus on counseling and mental health treatment of aggressive behaviors by teaching adaptive skills and appropriate communication of emotions. Surrounding the medical and mental health treatment staff is management. As mentioned in the epilogue, the goals of management seem two-fold: supporting their treatment staff and making money for the organization. Beyond management is the immediate environment of the patient, which typically consists of family and school. School's typical goal for treatment of patients is to manage aggressive behaviors so patient can appropriately participate in school. The family's goal can be varied: either the management of aggressive behaviors at home, or the placation of sources such as school who are requiring treatment. The final circle is society, which typically requires the management of aggression, because aggression is not supported by the societal constructs in which we live. Thus, while the goal of many is the management of aggressive behaviors, it is not the primary goal of all. The epilogue further demonstrates how the conflicting goal of making money required by management directly conflicts with patient care and management of aggressive behaviors.

Limitations and Recommendations for Future Research

This grounded theory research study was an exploratory study to examine the experiences of individuals who work with aggressive young children. The goal was to better understand what personal and organizational factors lead to increased performance and persistence in

professionals who experience daily aggression from the clients they work with. While qualitative research has many benefits, especially in regards to the current research question, it can also present some limitations. Specifically, qualitative research allows us to understand the experiences as understood by research participations. However, it doesn't not allow us to make causal inferences about the relationships between constructs and variables. Future research should focus on the variables outlined in the discussion section of this study to determine the strength of their relationship with variables such as professional persistence, compassion fatigue, burnout, and patient outcomes. Specifically, this dissertation uncovered various themes professionals identified as related to positive career outcomes. Further research can take these themes, such as supervisor availability, building aesthetics, and reasonable workloads, and develop a measurement tool to compare these variables to existing scales of burnout or patient outcomes.

Additionally, this research can be used as a springboard for mental health organizations looking to do program evaluations and determine the effectiveness of treatment they're providing. The results from this study can be used as a model against which to measure various organizational factors that are proposed to be related to better professional and client outcomes. The results can also be used to identify areas an organization may wish to target in hiring or management performance to better support their employees in the difficult work they do.

This research specifically interviewed mental health professionals, primarily counselors and psychologists. Future research would benefit from interviews with other members of the multidisciplinary team, including psychiatrists, nurses, and mental health direct care staff. All but one participant was female and all but one individual was Caucasian, which is somewhat representative of the professionals working this this age group. Interviewing a more diverse

group of professionals may find similarities or differences among professionals of various backgrounds. The hope is to further this line of research to best support professionals of all background who work with aggressive children.

Summary and Conclusions

This grounded theory qualitative study sought to understand the experiences of mental health professionals who work with aggressive young children. It examined the questions, “What experiences do mental health professionals have that help or hinder them from providing daily care to aggressive young children?” and “How do organizational aspects affect a mental health professional’s ability to provide care to aggressive young children?” The purpose was to understand the personal and organizational resiliency strategies which help mental health workers to continue to provide high-quality daily care to these children and develop a theory of persistence in mental health work with aggressive children.

The paper started with a general orientation to the research project. Chapter II examined the background research related to the treatment of aggressive behaviors in children. This chapter also introduced the concepts of burnout and resiliency and the ecological model of aggression. Chapter III proposed a research study to examine the experiences of individuals who work with aggressive young children. The results of this study were presented as a novella in Chapter IV. The current chapter, Chapter V, discussed the themes and codes found in the research to answer the questions, “What experiences do mental health professionals have that help or hinder them from providing daily care to aggressive young children?” and “How do organizational aspects affect a mental health professional’s ability to provide care to aggressive young children?”

The experiences mental health professionals have that help or hinder them from providing daily quality care to aggressive young children include The Ability to Conceptualize

and Treatment Plan Effectively as well as Our Savior Complex. The organizational aspects that affect a mental health professional's ability to provide care to aggressive young children include Logistics, Career Opportunities, Effective Multidisciplinary Teams, and The Role of Management.

Chapter VI

Epilogue: Some Final Thoughts

As a researcher, I have been collecting data for this dissertation over a period of approximately 15 months. During that time, out of the five intensive outpatient programs I worked with to conduct interviews and gather data, two of them closed their programs for children under the age of 9. This appears to be a relatively new, but likely to persist, phenomenon in the work of treatment for aggressive young children. Those programs that still exist are becoming less willing to admit children with aggressive behaviors, as they are not being given the tools and space to appropriately deal with these behaviors. When children act aggressively, the hands-on de-escalation training that is required for providers on a daily basis is not allowed to be utilized. This has resulted in programs frequently calling law enforcement to address the aggression. The result is mounting tension between law enforcement and IOP programs, as well as the potential further traumatization of patients. This was something I, as a researcher and professional in the field, struggled with when preparing this final project. I was left feeling as if my project no longer mattered. In five years will anyone care how to help staff work with aggressive young children? Will aggressive young children even be able to get treatment at that time?

When engaging in frank discussions with various staff about this lack of support for IOP programming for young children, a somewhat interesting revelation came to light. As mentioned in the previous chapter, the managers of most (perhaps all?) IOP programs, spend the majority of their time in private offices off site, rarely interacting with program staff and patients. However, a quick search engine query will show you that these managers often have an M.BA, and few, if any, have formal training in the mental health field. Business managers are wonderfully trained

in how to run a business and make money. Unfortunately, the mental health sector is not about making money, especially in this time of managed care.

If we think of the Business Manger as another member of the multi-disciplinary team, we consider that they may have goals different than our own. In fact, the Business Manger's goal is to make the most money possible for the business. Not surprisingly, there's not much money in the treatment of young children. They often need longer terms of care, they're often paid through public state insurance at the lowest possible rate, and aggressive behaviors are a large liability to the company. However, one must consider an alternate reason young patients are not profitable: the earlier you intervene with children, the more likely they are to get better and stay better. When you consider that mental health "businesses" may actually profit more by patients not getting better, concerning questions start to arise. Now, this isn't saying that youth IOP programs don't make money. They just don't seem to make ENOUGH money to compete with other, more profitable, mental health programs, such as residential alcohol and drug rehabilitation programs. Additionally, as presented in Chapter II, there are long-term benefits to treating aggressive behaviors in young children include reduced drug and alcohol abuse and decreased incarceration rates. While these things are beneficial to the community, they do not directly benefit the organization.

Let's return to a previous stated fact that the majority of young children in treatment are on public state insurance. The reason for this is that a majority of young children in treatment are in, or have been in the foster care system or are currently involved with social services or are living in poverty. We previously discussed in Chapter V that most young children in treatment have experienced trauma, and it's likely safe to assume that almost all kids in foster care have experienced some level of trauma. Many are removed from their homes due to abuse and

neglect. Experience in the field has shown that some continue to experience abuse and neglect in their new foster homes. We also know that abuse can lead to aggressive behaviors through behavioral modeling and behavioral reinforcement. Thus, many of these children exhibit aggressive behavior because that is what was taught to them from a young age, or that is how they learned to survive at home. It is not the fault of these children that they struggle with aggressive behaviors. Many of them simply don't know any differently; they have those skills deficits mentioned in Chapter V. Now, as a mental healthcare system, we are telling them they don't deserve treatment and we aren't going to provide it to them. They are too aggressive to be managed in outpatient care. Schools are kicking them out because they can't manage the behaviors. Those programs that still take young children are increasingly not taking aggressive children, due to state and managerial expectations. And so these abused and neglected kids are being abused and neglected by the mental health care system and told they are unworthy of treatment. It's probably not a far stretch to assume that, for some of them, their first form of regular therapeutic contact will be within the correctional system. This is system trauma.

So here we are at a crossroads. The people in charge of making decisions about mental health programming for aggressive young children are trained and expected to make decisions that are the most profitable for the organizations. Aggressive young children are the least profitable. It is my opinion that young children are also the most deserving of treatment, as they are often in need not due to their own actions but the actions of those around them. To me, as a mental health professional, the answer is simple. Everyone deserves treatment. The unfortunate fact, and the one I continue to struggle with as I write this, is that I can't make the treatment of young children more profitable. So somehow we need to reconcile the need for children to get treatment with the desire of managers to make money; and unfortunately I can't make anyone

care about these kids if they don't. And as long as money comes first, these kids will be left behind.

I'll leave you with a final participant quote.

“Okay the kid is aggressive. They learned it. That’s what they are used to and sometimes it’s just like you said. Nobody wants them and somebody needs to want them. And that’s what I see myself doing. Like, nobody wants you. I’ll like you.”

Figure 1.1

The Chappell di Martino Model of Workplace Aggression

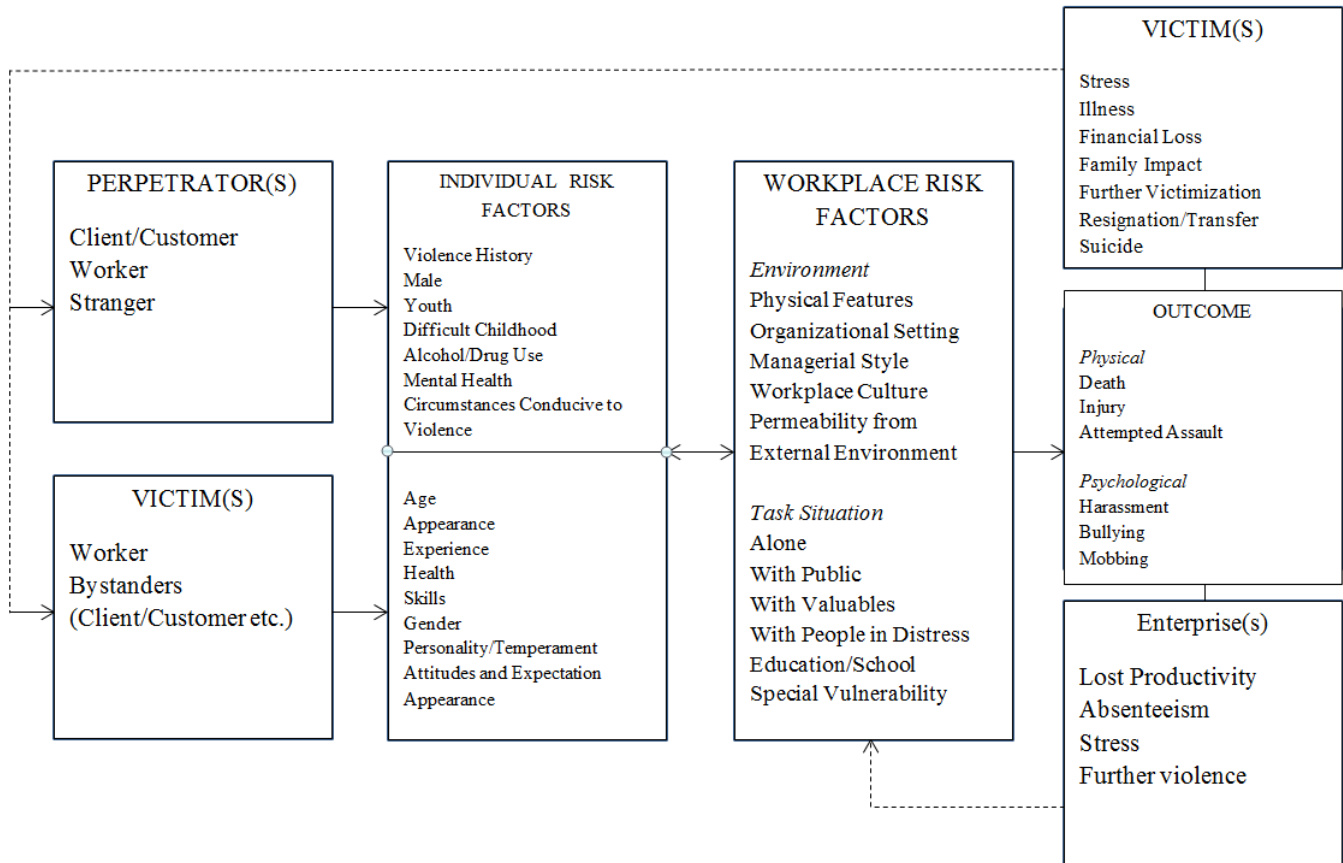


Figure 1.2

Potential Interview Questions for Research Participants Based on Participant Role, Research Question, and Corresponding Theoretical Base

Research Question	Type of Participant	Theoretical Base	Examples of Potential Interview Questions
<p>“What experiences do mental health professionals have that help or hinder them from providing daily care to aggressive young children?”</p>	Line Staff	Ecological Framework	<p>“How often would you estimate that you work with aggressive children?”</p> <p>“How do other employees or staff members react when a child is acting aggressively towards you or others?”</p> <p>“How many children do you work with daily? How many would you estimate are aggressive children?”</p> <p>“Why do you believe children act aggressively?”</p>
		Burnout/Resiliency	<p>“How many years have you worked in the social service field?”</p> <p>“Tell me about some ways that a child has acted aggressively towards you.”</p> <p>”How would you describe your feelings when a child is acting aggressively towards you?”</p> <p>”How would you describe your feelings and reactions following an aggressive incident?”</p> <p>“What do you feel helps you to deal with aggressive children?”</p>
	Counselors/Social Workers	Ecological Framework	<p>“How often would you estimate that you work with aggressive children?”</p> <p>“How do other employees or staff members react when a child is acting aggressively towards you or others?”</p> <p>“How many children do you work with daily? How many would you estimate are</p>

			aggressive children?" "Why do you believe children act aggressively?"
		Burnout/Resiliency	"How many years have you worked in the social service field?" "Tell me about some ways that a child has acted aggressively towards you." "How would you describe your feelings when a child is acting aggressively towards you?" "How would you describe your feelings and reactions following an aggressive incident?" "What do you feel helps you to deal with aggressive children?"
	Psychologists	Ecological Framework	"How often would you estimate that you work with aggressive children?" "How do other employees or staff members react when a child is acting aggressively towards you or others?" "How many children do you work with daily? How many would you estimate are aggressive children?" "Why do you believe children act aggressively?"
		Burnout/Resiliency	"How many years have you worked in the social service field?" "What do you feel helps you to deal with aggressive children?"
	Managers	Ecological Framework	"How often would you estimate that you work with aggressive children?" "How do other employees or staff members react when a child is acting aggressively towards you or others?"

			<p>“What do you feel helps you to deal with aggressive children?”</p> <p>“How many children do you work with daily? How many would you estimate are aggressive children?”</p> <p>“Why do you believe children act aggressively?”</p>
		Burnout/Resiliency	<p>“How many years have you worked in the social service field?”</p>
	Nurses	Ecological Framework	<p>“How often would you estimate that you work with aggressive children?”</p> <p>“How do other employees or staff members react when a child is acting aggressively towards you or others?”</p> <p>“How many children do you work with daily? How many would you estimate are aggressive children?”</p> <p>“Why do you believe children act aggressively?”</p>
		Burnout/Resiliency	<p>“How many years have you worked in the social service field?”</p> <p>“Tell me about some ways that a child has acted aggressively towards you.”</p> <p>”How would you describe your feelings when a child is acting aggressively towards you?”</p> <p>”How would you describe your feelings and reactions following an aggressive incident?”</p> <p>“What do you feel helps you to deal with aggressive children?”</p>
“How do organizational aspects affect a mental	Line Staff	Ecological Framework	<p>”What do you think other employees or staff members could do to help individuals that work with aggressive</p>

health professional's ability to provide care to aggressive young children?			children?" "What policies does your organization have for responding to aggression in children?" "Do you believe that your workplace is a safe place to work?" "Do you believe that, overall, your workplace is effective in managing the aggressive behaviors of children?"
		Burnout/Resiliency	"How would you describe the supervision you receive to work with aggressive children?" "What aspects of your job make it easier to work with aggressive children?" "What do you think your organization could do differently to better support the work that you do with aggressive children?"
	Counselors/Social Workers	Ecological Framework	"What do you think other employees or staff members could do to help individuals that work with aggressive children?" "What policies does your organization have for responding to aggression in children?" "Do you believe that your workplace is a safe place to work?" "Do you believe that, overall, your workplace is effective in managing the aggressive behaviors of children?"
		Burnout/Resiliency	"How would you describe the supervision you receive to work with aggressive children?" "What aspects of your job make it easier to work with

			<p>aggressive children?"</p> <p>"What do you think your organization could do differently to better support the work that you do with aggressive children?"</p>
	Psychologists	Ecological Framework	<p>"What do you think other employees or staff members could do to help individuals that work with aggressive children?"</p> <p>"What policies does your organization have for responding to aggression in children?"</p> <p>"Do you believe that your workplace is a safe place to work?"</p> <p>"Do you believe that, overall, your workplace is effective in managing the aggressive behaviors of children?"</p>
		Burnout/Resiliency	<p>"How would you describe the supervision you provide to work with aggressive children?"</p> <p>"What do you think your organization could do differently to better support individuals that work with aggressive children?"</p>
	Managers	Ecological Framework	<p>"What do you think other employees or staff members could do to help individuals that work with aggressive children?"</p> <p>"What policies does your organization have for responding to aggression in children?"</p> <p>"Do you believe that your workplace is a safe place to work?"</p> <p>"Do you believe that, overall, your workplace is effective in managing the aggressive</p>

			behaviors of children?"
		Burnout/Resiliency	<p>"How would you describe the supervision you provide to work with aggressive children?"</p> <p>"What do you think your organization could do differently to better support individuals that work with aggressive children?"</p>
	Nurses	Ecological Framework	<p>"What do you think other employees or staff members could do to help individuals that work with aggressive children?"</p> <p>"What policies does your organization have for responding to aggression in children?"</p> <p>"Do you believe that your workplace is a safe place to work?"</p> <p>"Do you believe that, overall, your workplace is effective in managing the aggressive behaviors of children?"</p>
		Burnout/Resiliency	<p>"How would you describe the supervision you receive to work with aggressive children?"</p> <p>"What aspects of your job make it easier to work with aggressive children?"</p> <p>"What do you think your organization could do differently to better support the work that you do with aggressive children?"</p>

Figure 1.3

Differences Between Traditional Glaserian Grounded Theory and Evolved Grounded Theory

	Glaserian Grounded Theory	Evolved Grounded Theory
Creators	Barney Glaser and Anselm Strauss originally in 1967; Currently only Barney Glaser	Anselm Strauss and Juliet Corbin in 1998
Research Paradigm	Positivism	Constructivism
Views on Objectivity	True Grounded Theory research must rely on objectivity on the part of the researcher	Complete researcher objectivity is impossible, but objectivity of research can be increased through the use of the research team
Use of Literature Reviews	Glaser does not believe in the use of Literature Reviews prior to conducting research, as it may taint the researcher's objectivity	Strauss and Corbin believe the Literature Review can be used to inform the data collection process
Data Analysis Procedures	2 Step Model of Data Analysis <ul style="list-style-type: none">• Substantive Coding• Theoretical Coding	3 Step Model of Data Analysis <ul style="list-style-type: none">• Open Coding• Axial Coding• Selective Coding
Conditional Matrix	Used	Not Used

Commonalities between Traditional Glaserian Grounded Theory and Evolved Grounded Theory

- The name Grounded Theory explains the process by which theories are originated as grounded in the data
- Theory grounded in the data is believed to be more likely to resemble reality
- Grounded theories can be useful for bridging the gap between research and practice
- Use of Theoretical Sampling

Figure 1.4

Typical Organizational Structure and Roles of Individuals Working in Inpatient and Intensive Outpatient Settings

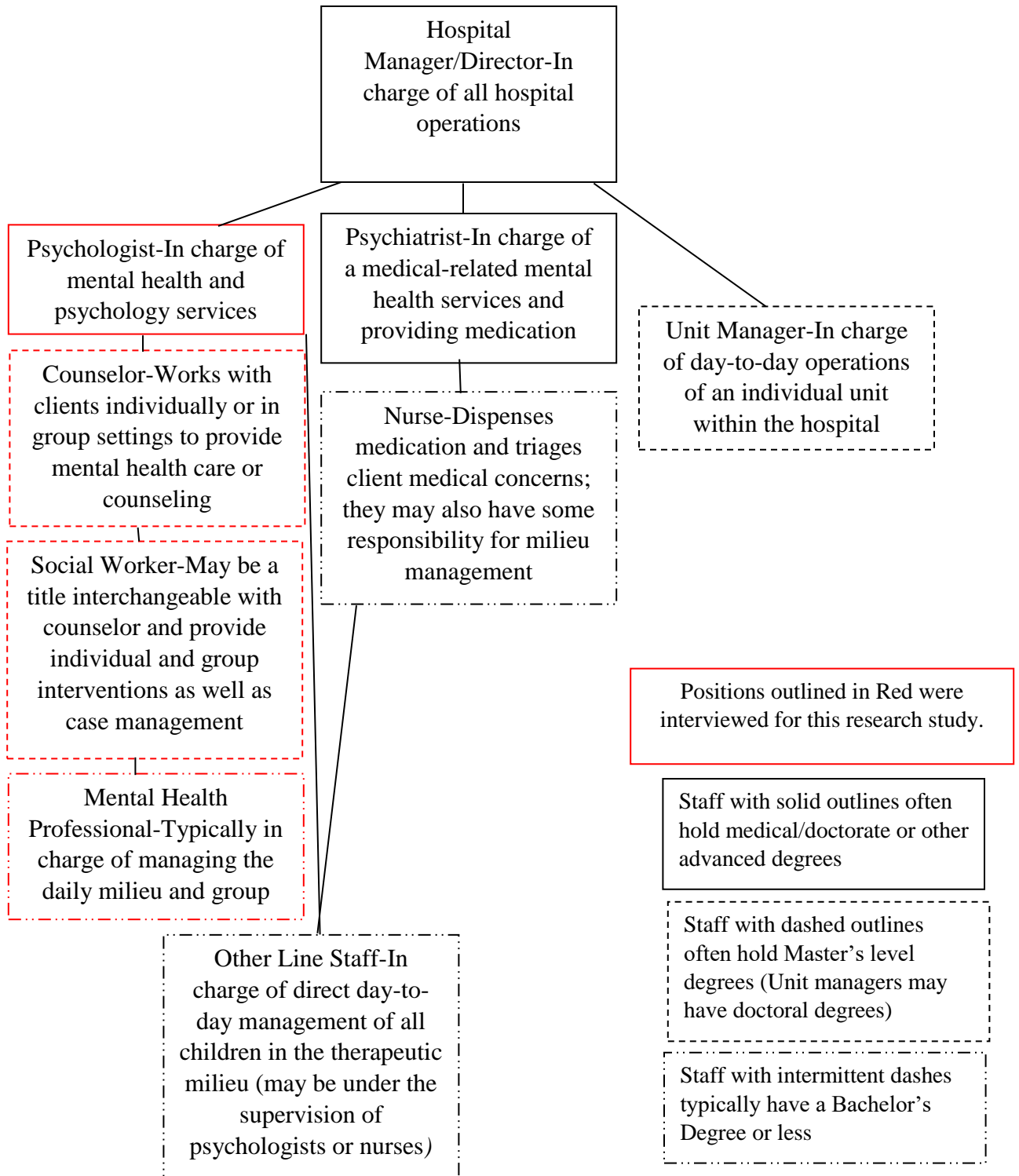


Figure 1.5

The “Expectations vs. Reality” Model of Career Development for Early Career Professionals working with Aggressive Children

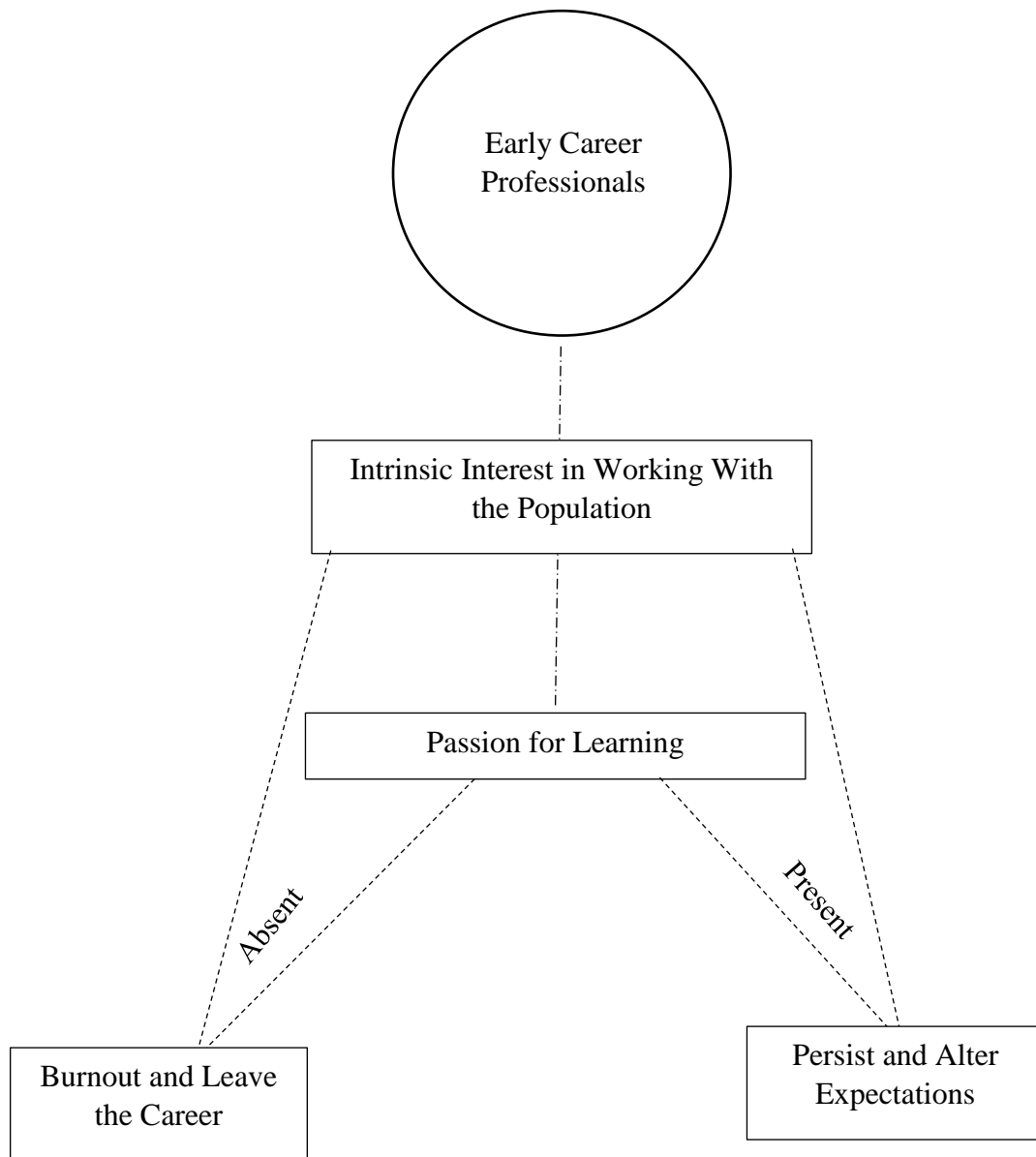
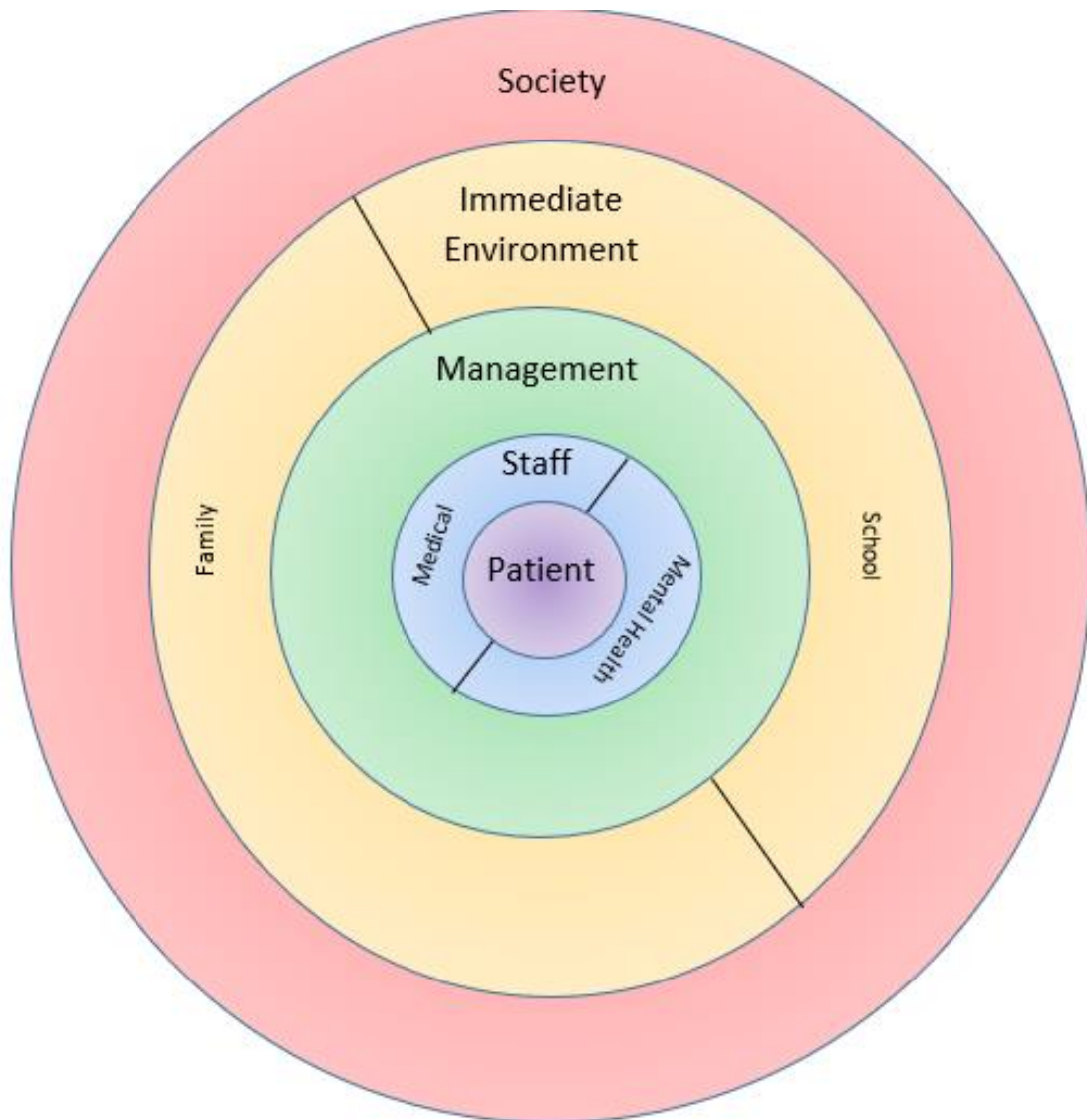


Figure 1.6

The Conditional Matrix of Goals of Teams Working with Patients with Aggressive Behaviors



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Academic Background

Doctor of Philosophy Student, University of Wisconsin-Milwaukee, Milwaukee, WI

Concentration: Counseling Psychology

Dissertation: When Children Hurt You: Examining the Experiences of Clinicians Who Work With Aggressive Young Children

Master of Science Degree, University of Wisconsin-Milwaukee, Milwaukee, WI (*May 2014*)

Concentration: Community Counseling

Bachelor of Arts Degree, Ripon College, Ripon, WI (*May 2011*)

Major: Psychology

Minor: Sociology

Thesis: Social Facilitation Theory: Effects of Experimenter Familiarity, Task Type, and Sex

Licenses and Certifications

- Licensed Professional Counselor in Training (2015-present)

Work Experience

- **Psychology Student Intern:** Wisconsin Department of Corrections (2018-present)
Facilitated high- and average-risk sex offender treatment groups, as well as completed psychological assessment batteries, risk assessments for sex offenders, and provided consultation to various correctional providers
- **Practicum Student:** Taycheedah Correctional Institution (2016-2018)
Provided individual, group, and crisis counseling to female correctional inmates as well as conducting intake diagnostic assessments, providing suicide prevention training to employees, and completing psychological assessments by referral.
- **Adjunct Lecturer:** Marquette University (2016)
Taught courses in educational research and research design and evaluation to Master's level students.
- **Psychological Assistant:** Rogers Memorial Hospital (2016-2017)
Completed intake psychological assessments and program development and evaluation for the intensive outpatient and inpatient settings with children and adolescents.
- **Practicum Student:** St. Rose Youth and Family Center (2016)
Completed cognitive and personality psychological assessments on new female residents.

- **Teaching Assistant:** University of Wisconsin Milwaukee (2014-2016)
Taught entry level undergraduate courses in career planning as well as motivation and college success strategies.
- **Practicum Student:** Rogers Memorial Hospital (2014-2016)
Provided group and individual counseling to children ages 3-8 and 16-18 in the intensive outpatient setting.
- **Tutor:** Tutor.com, Online (2013-2014)
Tutored students online in Research Design and Statistics.
- **Practicum Student:** The Youth and Family Project, Inc. (2013-2014)
Coordinated to local school districts to provide individual counseling to students by referral, as well as group counseling in the juvenile detention facility.
- **Crisis Intervention Counselor:** Friends of Abused Families (2011-2014)
Answered the local domestic violence and sexual assault hotline, as well as provided support to residents living in the shelter.
- **Psychology Intern:** Solutions Center (2010)
Provided case management to homeless individuals and sexual assault survivors living in the shelter.
- **Research Assistant:** Cognition Lab, Ripon College (2009-2011)
Conducted research on cognition as part of a professor's research team.
- **Tutor:** Psychology Tutor, Ripon College (2008-2011)
Tutored various subjects including Introduction to Psychology, Research Design and Statistics, Introduction to Philosophy, and Introduction to Sociology
- **Tutor:** Ripon Middle School, Ripon, WI (2007-2009)
Provided after school tutoring support and mentoring to student in the after school program.

Volunteer Work

- Elected as Vice President of Counseling Psychology Student Association (2015-2016)
- Participated yearly in the NAMI walk for the Greater Milwaukee Area (2013-present)
- Elected as Co-President of Counseling Student Organization (2013-2014)
- Served as a Graduate Student Representative to the Student Non-Academic Misconduct Hearing Committee (2012-2013)
- Organized first fundraiser for Prevent Child Abuse America at Ripon College (2008)
- Raised Money for the A-T Foundation (2008-2010)
- Participated in the Memory Walk for Alzheimers (2010)
- Raised Money for ASTOP (2010)
- Organized National Eating Disorder Awareness Week at Ripon College (2009)

Extracurricular

- Member of Coalition for Justice (2016-2017)
- Member of Counseling Psychology Student Association (2014-2018)
 - Vice President (2015-2016)
- Member of Golden Key Honor Society (2012-2013)
- Member of Counseling Student Organization (2012-2014)
 - Co-President (2013-2014)
- Member of UWM Non-Academic Misconduct Hearing Committee (2012-2013)
- Member of UWM Academic Misconduct Hearing Committee (2012-2013)
- Member of Psi Chi (2008-2011)
- Member of Sociology Club (2009-2011)

Honors and Awards

- Distinguished Tutor Award (2011)
- Member of Psi Chi (2008-2011)
- First Generation College Student
- Graduated Magna Cum Laude with Psychology Honors (2011)
- Member of Golden Key Honor Society (2012-2013)
- Student Success Teaching Award (2014)

Research Interests

- Effectiveness of therapy for CSEM offenders
- Correlates to inmate treatment and recidivism
- Affective experiences of therapists working with aggressive children
- Treatment modalities for trauma and aggression with young children
- Aspects of teaching efficacy
- Effects of teacher evaluation on classroom performance

Publications

Madsen, M. (2019). *When children hurt you: Examining the experiences of clinicians who work with aggressive young children.*

Manuscripts in Progress

Madsen, M. (in progress). *Multicultural taboo: Examining what is presented and ignored in doctoral level Clinical and Counseling Psychology Multicultural courses.*

Alomá, A., Lira, E., DePratt, T., Leon, E., **Madsen, M.**, Powless, M., Rouse-Arndt, L., Sapp, M. (in progress). *The Use of Hypnosis to Help American Indians Quit Smoking.*

Professional Conference Presentations

Rineck, L., **Madsen, M.** (NADE 2016). *Using a Co-Requisite Model for Integrating Math Study Skills into Developmental Mathematics.*

Sapp, M. **Madsen, M.**, DePratt, T., Aloma, A., & Rouse, L. M. (APA 2015). *Hypnosis and postmodernism: Multicultural applications.*

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Sapp, M., DePratt, T., Leon, E., Lira, Ernesto, Aloma, A., **Del Ponte, M.** Quant, M.B., & Hunt, J. (APA 2014). *Hypnosis, automaticity, and African American college students.*

Aloma, A., DePratt, Leon, E., Lira, E., **Del Ponte, M.**, Arndt, L., Rouse, L., Sapp, M., & Powless, M.W. (APA 2014). *Development of a culturally tailored smoking cessation hypnosis script for an American Indian Community.*

Arndt, L.M., Powless, M., Sapp, M., Aloma, A., Lira, E., DePratt, T., Quant, M.B., & **Del Ponte, M.** (APA 2013). *Smoking cessation using hypnosis in a Native American Sample.*

Hunt, J., Alomá, A., Lira, E., DePratt, T., Quant, M., **Del Ponte, M.**, Sapp, M. (APA 2013). *Integrating Hypnosis into Early Intervention and Screening of Injured Trauma Survivors*

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