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You Are Resilient: Trauma-Informed, Strengths-Based Treatment for Low-SES, Urban Youth

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CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

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has been approved by the
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Abstract

The focus in this review was to explore the benefits and optimal use of trauma-informed, strengths-based care for the therapeutic treatment of low-socioeconomic status (SES), urban youth. Specific focus was given to evidence-based research on the treatment of emotional and behavioral dysregulation among low-SES, urban youth. The review was guided by the following research questions: How can emotional and behavioral dysregulation be symptoms of trauma among low-SES, urban youth; What makes trauma-informed and strengths-based care optimal for the treatment of low-SES, urban youth with dysregulation; and What are clear guidelines for providing trauma-informed, strengths-based care to low-SES, urban youth with dysregulation. Emotional and behavioral dysregulation were defined and explored as symptoms of chronic stress and community trauma exposure (i.e., a traumatic stress response). The review included an exploration of protective factors and factors that contribute to traumatic stress responses and resilience. To fully conceptualize youth symptomology and provide thorough treatment guidelines, the review included an analysis of trauma-informed and strengths-based approaches as separate, yet complementary frameworks. This provided an opportunity to highlight supplementary theoretical traits and techniques from each approach that can uniquely benefit youth and their families who are affected by trauma. Treatment guidelines emphasize systemic needs with a focus on the importance of family growth and community support and include (a) engage in clinical preparation, (b) initiate a strong therapeutic alliance, (c) assess basic needs and community resources, (d) validate the trauma narrative, (e) empower systemic family change, (f) build strengths and reauthor the trauma narrative, and (g) establish and obtain unified goals.

YOU ARE RESILIENT: TRAUMA-INFORMED, STRENGTHS-BASED TREATMENT FOR LOW-SES, URBAN YOUTH

DEDICATION

I dedicate this work to urban youth and families, and to people of color who are met with social injustice and systemic adversity every day. You are resilient.

ACKNOWLEDGMENTS

Thank you to Dr. Christina Brown and the people who love me, challenge me, and believe in my work. To my husband and family.

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CHAPTER I: CLINICAL IMPACT OF URBAN LIVING

Years of research have shown young people who grow up in urban environments have a high risk of exposure to acute and chronic stress (Garbarino et al., 1992; Harris et al., 2012; Thomason et al., 2015). In the United States, more than half of urban youth are said to be living in poverty and are exposed to increased contextual stress, and thus they have a greater likelihood of serious physical and mental health problems across the lifespan (Harden et al., 2015). Common stressors associated with low-SES, urban living historically include substandard housing, a lack of basic resources (e.g., food), strained education, and limited access to medical care (Garbarino et al., 1992). Current research shows low-SES, urban living comes with increased exposure to neighborhood violence, strained caregiving relationships, and low social support systems (Black & Hoeft, 2015). Overall, research indicates multiple adversities can contribute to diminished emotional and behavioral regulation and increased PTS responses among urban youth.

Problem

The field of clinical psychology is growing in terms of the knowledge and application of evidence-based treatments to fit the many complex emotional, behavioral, and systemic needs of low-socioeconomic status (SES), urban youth and their families. Overall, researchers agree that trauma-informed care is crucial in treating most individuals (Bath, 2008; Bowie, 2013), particularly those who are affected by urban stressors and chronic adversity (Lucio & Nelson, 2016). However, more research is needed to highlight the impact of strengths-based care (SBC) to build insight into resilience qualities and social resources (Coulter, 2014; Drolet et al., 2007). The existing research lacks an emphasis on treatment guidelines that distinctly integrate trauma-

informed and strengths-based concepts to meet the emotional, behavioral, and systemic needs of low-SES, urban youth and their families.

Purpose

The focus in this review was to examine the impact of urban stressors and chronic adversity on the well-being of low-SES, urban youth and their family systems. In this review, emotional and behavioral dysregulation among low-SES, urban youth are identified as symptoms of traumatic stress as a result of exposures to chronic adversity and societal injustice. This review was designed to assess trauma-informed and strengths-based practices from distinct, yet complementary lenses. As well, the review involved a systemic family focus with the purpose of highlighting family involvement in treatment and unified growth to improve youth well-being. The review culminates in seven treatment guidelines that can be used to assist youth and their families in identifying and reshaping trauma narratives to include personal strengths, family and community support, and attainable goals for the future. Three primary research questions were posed:

1. How can emotional and behavioral dysregulation be symptoms of trauma among low-SES, urban youth?
2. What makes trauma-informed, strengths-based care optimal for the treatment of low-SES, urban youth with dysregulation?
3. What are clear guidelines for providing trauma-informed, strengths-based care to low-SES, urban youth with dysregulation?

Definitions

For the purposes of this review, the terms *youth*, *adolescents*, *young people*, and *young men/women* are used interchangeably and refer to individuals between the approximate ages of

12 and 21 years. The terms *inner-city* and *urban* are used interchangeably and refer to low-SES living areas that are densely populated and structurally over-developed. *Low-SES* is present throughout the discussion and refers to low social standing or class as measured by a combination of education, financial income, and employment status (Roberts & Rizzo, 2020). The term *trauma* is interchangeable with *adversity* and *chronic stress*. These terms refer to exposures to chronic poverty, racial/ethnic discrimination and disparity, community violence, and neighborhood disorganization. Last, *emotional and behavioral dysregulation* is also referred to as *emotional and behavioral distress/symptoms* and *traumatic stress response*. Emotional and behavioral dysregulation is characterized by unique clusters of posttraumatic stress symptoms (PTSS), including feelings of depression or hopelessness, anxiety, aggression, and acts of violence or delinquency.

Method

This review included only scholarly, peer-reviewed bodies of work. The majority of the studies collected were conducted between the years of 1989 and 2019 (e.g., Burnside & Gaylord-Harden, 2019; Coulter, 2014; Dil & Vuijk, 2012; Griffin et al., 2000; Harden et al., 2015; Henggeler et al., 1996; Schuck, 2005; Szapocznik et al., 1989; Vogel & Van Ham, 2018). Studies published prior to 2010 were used for historical context and to demonstrate growth in the research and clinical knowledge over time. With the exception of one study conducted with the Dutch population (Simmons et al., 2008), all direct studies took place within the United States. As well, a number of longitudinal analyses were cited, providing posttreatment results falling between 6 months and 8 years (Ludwig & Warren, 2009; Nanninga et al., 2016; Peterson et al., 2005; Szapocznik et al., 1989). Two scholarly practitioner reviews are included in Chapter 3 to provide general support for the historical and widespread efficacy of systemic care (Sydow et al.,

2013) and strengths-based therapy (Bond et al., 2013). In these sections, direct studies are also included as primary sources of research.

All studies provided empirical results on youth development and many were conducted specifically with urban youth living in high-population cities such as Chicago (Harden et al., 2015; Richards et al., 2015; Tobler et al., 2013; Williams et al., 2014), New York City (Fraenkel et al., 2009; Griffin et al., 2000), Detroit (Ceballo et al., 2003), Richmond (Sullivan et al., 2010), and Baltimore City (Copeland-Linder et al., 2011). To determine the most significant impacts of urban living, the majority of included studies contained a focus on low-SES communities and family systems. As well, search terms for collecting relevant articles and studies fell within four main categories: correlation between emotional and behavioral dysregulation and posttraumatic stress (PTS); contextual risk and protective factors affecting urban youth and family stress responses; psychological theories and interventions that fit urban youth and family needs; and trauma-informed, strengths-based, and systemic psychotherapy principles and approaches to care. Search engines used to collect scholarly, peer-reviewed articles included EBSCOhost Psychology Databases, APA PsycArticles, APA PsycInfo, and Google Scholar.

Clinical Impact of Urban Living

This section answers the first research question: How can emotional and behavioral dysregulation be symptoms of trauma among low-SES, urban youth? Information about the community and family distress low-SES, urban youth experience is provided. As well, this section provides psychoeducation on the traumatic stress response and symptoms of emotional, empathy, behavioral, and relational dysregulation that result from low-SES, urban stress. In the final section of this chapter, relevant treatment approaches are introduced to emphasize areas of

care important to address with this population. Treatment approaches within systemic care, trauma-informed care, and strengths-based care are discussed in greater depth in Chapter 3.

Community Distress

Youth raised in inner-city neighborhoods are exposed to a spectrum of violence (Youngstrom et al., 2003). In an early study, Youngstrom et al. (2003) assessed risk factors and problem behaviors among a group of urban high school students who were referred for mental health counseling. Results showed just 11 of the 320 participants had not been exposed to neighborhood violence. Of the remaining participants, 93.4% reported knowing at least one person victimized by a violent act, 79.3% had personally witnessed a violent act, and 48.7% had been the target of at least one violent act. Conclusively, the internalized and externalized symptoms presented by these youth were most correlated with exposures to community violence (Youngstrom et al., 2003).

Additional research (i.e., a large-scale population study; Finkelhor et al., 2009) generated similar findings. Finkelhor et al. (2009) found 61% of their urban youth participants had experienced one or more direct or witnessed acts of violence in a 1-year span, 46% had been personally victimized by a violent act, 25% had witnessed a violent act, and 10% had witnessed a violent act within their family. Overall, the majority of low-SES, urban youth were exposed to stress, including community and social violence. When research is designed to control for SES, it is evident that urban youth of color—Black and non-White, Hispanic—experience increased rates of acute and chronic stress as well as greater exposure to community violence in comparison to their White counterparts (Kessler & Neighbors, 1986; Turner & Lloyd, 1995).

Exposure to community violence is considered one of the highest predictors of internalized and externalized symptoms among urban youth, which commonly involve

depressive symptoms, PTS, aggression and violence, poor academic achievement, substance use, and exposure to abuse (Lambert et al., 2013). Community violence has also been shown to be correlated with anxiety symptoms (Cooley-Quille et al., 2001; Edleson, 1999; Fitzpatrick, 1993), with physiological reactions such as high blood pressure, hypervigilance, worry, social fears, and paranoia. Research shows the pairing of intense emotions and constricted or internalized processing can lead to explosive externalized responses, including aggression and violence (Sullivan et al., 2010). Based on the high rates of exposure to violence among urban youth and the impact of such exposures on the development of internalized and externalized symptoms, it is important to also consider the overall impact on emotional and behavioral regulation and stress management.

Family Distress

Research has historically shown the main contributor to youth psychosocial development is caregiver attachment. Bowlby's (1969) attachment theory is based on the idea of secure and insecure parent–child attachment styles. A secure attachment derives from caregiver reliability, sensitivity, love, warmth, and ability to provide. The secure child typically experiences their needs for safety and comfort being met. An insecure attachment results from caregiver inconsistency and limited or stress-inducing interactions. The insecure child experiences unmet needs and difficulty thriving in their emotional and behavioral development. Bowlby (1977) noted children with insecure attachment styles are more likely to "experience emotional distress and personal disturbances such as anxiety, depression, and emotional detachment" (p. 127).

Dodge et al. (1994) highlighted the unique strains low-SES, urban environments place on family systemic functioning and parent–child attachments (Stolbach et al., 2013). Research indicates there is a tendency for separation, divorce, and parental psychopathology within urban

communities as a result of the cumulative stress of financial strain, lack of social support, and proximity to substance use and criminal activity (Stolbach et al., 2013).

In 2012, Dil and Vuijk conducted a study to assess rates of disorders presented by youth patients in an urban emergency psychiatric facility. Results showed 11%—45% of the youth had behavioral disorders, 15%—33% had mood disorders, 17%—28% had anxiety disorders, and 10%—13% were diagnosed with a psychotic disorder. In addition, 70% of participants and their parents reported strained caregiver–youth attachments. Last, Dil and Vuijk (2012) compiled a list of presenting problems among the youth patients and found aggression was most frequent, followed by parent neglect, suicidal ideation, exposure to abuse, running away, and homelessness.

Overall, residing within a low-SES, urban environment comes with many stressors, including financial and social strain, that have an impact on caregiver–youth attachment. Moreover, exposure to poverty, violence, and familial stress has been suggested to contribute to emotional and behavioral dysregulation among youth. The next section provides information on the traumatic stress response (TSR) in relation to emotional and behavioral dysregulation among low-SES, urban youth. Following, emotional dysregulation and behavioral dysregulation are individually explored as symptomology of trauma.

Traumatic Stress Response

Researchers have concluded young people with chronic exposure to trauma and life stress, including neighborhood disorganization and community violence, are at a significant risk for emotional and behavioral problems (e.g., Chan & Yeung, 2009; Cicchetti & Toth, 2005; Kearney et al., 2010; Lynch, 2003; Yates et al., 2003). The American Psychiatric Association (1994) has historically defined psychological trauma as exposure to extreme stress that is

experienced as life-threatening or compromising to the integrity of oneself or loved ones. According to Janoff-Bulman (1992), traumatic experiences challenge three moral assumptions: the world is benevolent, the world is meaningful, and the self is worthy. Roth and Newman (1991) added a fourth assumption, that people are trustworthy and worth relating to. Thus, experiences of adversity distort core notions about oneself and the world and generate developmental dissonance among youth.

Research refers to the significant reaction to trauma and adversity as a traumatic stress response (TSR; Thompson & Massat, 2005). A TSR that persists beyond the traumatic events is then considered a posttraumatic stress response or symptom (PTSS). In diagnosable cases, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., *DSM–5*) indicates symptoms of trauma that persist for an extended amount of time meet criteria for posttraumatic stress disorder (PTSD; American Psychiatric Association, 2013). Research generally highlights that young people who are exposed to trauma and chronic adversity experience feelings of rage, shame, and betrayal and might exhibit behaviors such as sexual activity, school truancy, substance misuse, and delinquency (Becker et al., 2011; Forrest-Bank et al., 2014; Middlebrooks & Audage, 2007). Thompson and Massat (2005) noted low-SES, urban families experience high rates of PTS in relation to community violence exposure. Similar to adults, young people in the study exhibited PTSS, including social withdrawal and hypervigilance. In a more recent study, Copeland-Linder et al. (2011) found environmental stressors, including community violence, neighborhood disorder, and racial discrimination, to be associated with behavioral aggression and substance misuse among eighth grade male participants up to 2 years later. Among female participants, environmental stressors were correlated with increased substance misuse up to 2 years later. This

research supports that PTSS is common among urban youth and manifests in unique ways in response to community stress.

Research has confirmed “there is an intimate connection between traumatizing behaviors and the social conditions which support them” (Bloom & Reichert, 1998, p. 17). Understanding the relationship between environmental context and youth and family experiences is one key to generating growth and change. Assessment and conceptualization of emotional and behavioral dysregulation among low-SES, urban youth must occur within the context of community stress and PTSS. This is particularly true for youth of color and urban youth, who are exposed to the highest rates of chronic and acute stress (Levy & Johnson, 2019; Mohammad et al., 2015; Stolbach et al., 2013).

Emotional Dysregulation

Research shows emotional regulation and adequate emotional communication abilities facilitate healthy social interactions and the capability for positive relationships with one’s environment (Sullivan et al., 2010). However, interruptions to the development of emotional regulation can generate emotional distress and difficulties building relationships with others. Among urban youth, interruptions to developmental might include community violence, death or loss of loved others, and financial hardship.

Research indicates emotional experiences and regulation skills derive from neurological interactions within the prefrontal cortex and subcortical regions, which involve the amygdala (Morawetz et al., 2017). Regulation abilities within the prefrontal cortex and amygdala are particularly essential for controlling anxiety and fear responses (Ishikawa et al., 2015). In youth, exposure to chronic stress can easily generate hyperarousal and lead to changes in the prefrontal cortex–amygdala circuitry (Evans & Kim, 2013). McCoy et al. (2016) noted individuals who are

exposed to trauma might experience neurological changes that include selective attention toward negative stimuli and hyperaroused appraisal of threat.

In 2015, Ishikawa et al. conducted a study to evaluate the influence of stress on childhood and preadolescent stages, and later emotionally stimulated behaviors and activities within the prefrontal cortex and amygdala. The researchers observed rats within compliance of the Japanese federal law. Young rats were exposed to early separation from parent rats as well as unpredictable stress exposures, such as forced swimming in cold and warm water every 10 to 15 minutes, immobilization for 15 minutes, and exposure to cold stress at random. After maturation, rats performed open-field and maze tests. During testing, procedures were used to measure prefrontal cortex and amygdala activity (i.e., immunohistochemistry; electrophysiology).

Results from the study showed early life stress increased anxiety and fear behaviors and altered adult functioning in stressed rats (i.e., loss of mobility and rearing movement, less frequent grooming, and longer durations of freezing on open-field and maze courses; Ishikawa et al., 2015). Measures of prefrontal cortex and amygdala activity highlighted specific imbalances in neurological communication within the right medial prefrontal cortex (mPFC), right basolateral amygdala (BLA), and central amygdala (CeA). In general, rats demonstrated hypoactivity in the prefrontal cortex and hyperactivity in the amygdala. If applied to human neurodevelopment, these results indicate stress exposures in pre-adult life led to developmental changes in the brain that increase threat responding and decrease effective regulation skills.

Overall, low-SES, urban youth face traumas and exposures to community stress that can affect brain development and emotional regulation circuitry. Exposures to adversity in younger years increase the likelihood of strain on emotional coping and heightened threat responding. Symptoms among youth are known to include anxiety, depression, anger, and agitation (Cole et

al., 1994; McCoy et al., 2016; Sullivan et al., 2010), as well as externalized behaviors such as aggression, impulsivity, hyperactivity, and oppositionality (Cole et al., 1994).

Empathy Dysregulation

Empathy is defined as the ability to respond to the affect and psychological state of another person (Zahn Waxler & Radke-Yarrow, 1990). Schreiber (1992) proposed that impaired empathy in adolescents largely results from biological and social risk factors that impede the development of self- and other-awareness. A primary risk factor that influences self- and other-awareness is exposure to chronic stress and trauma in childhood (Sams & Truscott, 2004). Jensen and Howard (1999) stated urban youth are exposed to chronic stressors in the form of domestic, community, and media violence that directly affect emotional regulation and the development of empathy.

In a historical study, Sams and Truscott (2004) assessed 41 adolescent males across five schools within the Buffalo Public School District. Racial and ethnic demographics were as follows: 68% Black, African American; 12% White, Hispanic; 12% White, non-Hispanic; 5% White, Native American; and 2% "Multiracial." Participants included a group of non-urban students and a group of urban students who had been suspended or disciplined for at least one in-school violent offense across the past year. Students completed measures of empathy, use of violence, and exposure to community violence.

Results showed urban students demonstrated only slightly lower empathy in comparison to non-urban students (Sams & Truscott, 2004). However, 98% of urban students were involved in at least one violent offense in their lifetime, 80% reported exposures to violence within their community, 75% heard gunshots in their neighborhood, and 40% knew someone who had been robbed or stabbed. Overall, however, there were no significant differences in empathy across

urban and non-urban youth. This was found to be true regardless of high rates of exposure to community violence and personal engagement in violence among urban youth, suggesting empathy capabilities were not affected by adverse experiences.

Another study conducted by Stone and Dover (2007) also involved looking at the impact of social context on attitude and empathy development among adolescent boys ages 12 to 17. The researchers suggested the adolescent attitude is influenced by many factors, such as SES, living with or without biological caregivers, attachment style, caregiver–caregiver violence, caregiver–child violence, community violence, and peer violence. Participants included 73 youth residents from two detention and rehabilitation centers in a Midwestern state; 74% of the participants were White, non-Hispanic and 11% were Black, African American. Residents were evaluated on attachment dynamics, exposures to violence, and level of empathy.

Results showed empathy regulation, exposure to caregiver–caregiver violence, and living without biological caregivers directly mediated pro-violence and aggressive attitudes among the youth (Stone & Dover, 2007). Exposure to community violence also proved to have an indirect influence on pro-violence attitudes, dependent on empathy regulation. Last, residents with low empathy who were exposed to caregiver–caregiver violence were found to be most likely to demonstrate pro-violence and aggressive attitudes. Overall, results indicate empathy regulation functions as a prerequisite to adolescent attitudes toward violence and aggression. Youth with lower empathy skills may be more susceptible to the impact of social stress and more likely to take on pro-violence and aggressive attitudes.

The above studies indicate more research is needed to determine the impact of low-SES, urban living and exposure to community violence on empathy regulation and the development of emotional and behavioral dysregulation among youth. It appears empathy regulation is most

affected by social and community stressors when levels are already low or compromised. In these cases, difficulty effectively using empathy contributes to emotional and behavioral dysregulation in light of chronic stress, as becoming aggressive or violent may be less avoided and seen as a viable option.

Behavioral Dysregulation

Though research shows low-SES, urban youth face many social and neighborhood stressors, including exposure to racial disparities and community violence (Andrews et al., 2015; Richards et al., 2015), society is quick to view poor behaviors as antisocial and delinquent with little consideration of the overarching impact of trauma. Research has shown young people who face chronic adversity experience changes in brain functioning and emotional regulation (McCoy et al., 2016). Research also shows youth who struggle with emotional management (e.g., expressive reluctance, emotional overexpression) are most capable of externalizing anger and engaging in aggression (Sullivan et al., 2010). Zeman et al. (2002) found positive correlations among emotional expression, difficulty moderating anger, and aggressive behaviors among a sample of urban youth. Their research confirmed that behavioral dysregulation is a response to emotional dysregulation, particularly among youth who struggle with the management of negative emotions (Zeman et al., 2002).

Researchers have begun to evaluate behavioral dysregulation as context-specific, with consideration of the environmental factors that affect youth functioning (Cleek et al., 2012; Harden et al., 2015; Sullivan et al., 2010). Sullivan et al. conducted a study in 2010 with a sample of 358 middle school-aged youth from Richmond, Virginia. Of the sample, 92% were Black, African American and 46% were young men. As well, 61% of the youth resided in high-poverty neighborhoods. Neighborhood demographics included high levels of violence, low-

income housing, and high levels of crime relative to other areas of the city. Youth were evaluated on degree of physical aggression, relational aggression (i.e., non-physical aggression in relationships), emotional expression reluctance, and emotional regulation abilities.

Results showed 75% of the sample participated in at least one physically or relationally aggressive act within the month prior to the study (Sullivan et al., 2010). Moreover, 39% of young women and 56% of young men reported participating in multiple acts of aggression within the prior month. Particularly for young men, increased emotional expression and difficulties regulating anger were correlated with increased physical aggression. For young women, increased emotional expression and difficulties regulating anger were correlated with increased relational aggression. Sullivan et al. (2010) suggested acts of relational aggression were most common among young women because of an innate orientation toward interpersonal connection (e.g., relationship maintenance), rather than interpersonal status (e.g., dominance), which is most common among young men.

Overall, research supports the notion that behavioral dysregulation is common among youth residing in low-income, high crime, and high violence neighborhoods. Dysregulation is also consistently correlated with difficulties in emotional expression and anger moderation that are exacerbated by traumatic experiences (Zeman et al., 2002). Last, research shows young men and young women express behavioral dysregulation in differing forms—young men are more likely to engage in physical aggression, whereas young women are more likely to engage in relational aggression (Sullivan et al., 2010).

Relational Dysregulation

Researchers are evaluating relational aggression as an alternative, yet primary expression of behavioral dysregulation among youth (e.g., Sullivan et al., 2010). Relational aggression

refers to behaviors that foster negative interactions with others or inflict harm onto others through relationship dynamics (Crick & Grotpeter, 1995). Examples of relational aggression include threats to withdraw from a relationship, enforcement of specific demands, exclusion of others from group activities, and participation in social rumors or gossip (Crick et al., 2006). Sullivan et al. (2010) highlighted the impact of context on aggression and dysregulated behaviors among youth and suggested neighborhood stress and strained emotional responding are main contributors to relational aggression.

Research shows relational aggression occurs at high rates among adolescents because of their developmental focus on recreational time, peer interactions, and peer influence (Prinstein et al., 2001). This conclusion might also indicate youth with emotional dysregulation commonly express themselves through relational aggression, not only physical aggression. Similar to physical aggression, however, relational aggression derives from ineffective emotional expression and moderation of negative emotions (Sullivan et al., 2010; Zeman et al., 2002). Thus, relational aggression is a primary outlet for emotional distress among youth facing adversity (Crick & Grotpeter, 1995; Crick et al., 2006; Crick et al., 1999).

Summary of Clinical Impact

Low-SES, urban youth and their families reside within living conditions that can have a significant impact on their emotional and behavioral health and overall family functioning (Vogel & Van Ham, 2018). Research shows low-SES, urban youth are exposed to numerous and chronic stressors, most common of which is community violence. These youth have a high likelihood of not only witnessing community violence, but becoming personally victimized by violence (Finkelhor et al., 2009). In particular, young Black men experience the highest rates of community violence exposure across SES, race, and gender (Kessler & Neighbors, 1986;

Richards et al., 2015; Turner & Lloyd, 1995). Overall, exposure to violence and other stressors make low-SES, urban youth susceptible to traumatic stress responding and posttraumatic symptoms. Symptoms of traumatic stress are commonly expressed by youth as emotional and behavioral dysregulation, including problems with anger, aggression, and delinquent behaviors (Sullivan et al., 2010; Zeman et al., 2002).

Professionals are in need of therapeutic treatment guidelines that approach emotional and behavioral dysregulation as a natural response to chronic adversity and family strain. Low-SES, urban youth and families need care that takes into consideration their community and social context, history of trauma and adversity, and access to strengths and resources. The next sections contain reviews of three main approaches to therapeutic treatment for low-SES, urban youth: systemic, trauma-informed, and strengths-based.

Relevant Treatment Approaches

This section provides a brief introduction to treatment approaches that will he discussed in Chapter 3.

Researchers have not identified many specific modalities for treating urban youth or youth with a classification of emotional and behavioral dysregulation. A thread of studies identified therapy modalities to treat urban youth who demonstrate substance use issues (e.g., Eisman et al., 2018; Lardier, 2019; Lardier et al., 2018). Additionally, many studies have focused on caring for at-risk youth in residential and inpatient mental health programs (e.g., Bryson et al., 2017; Makki et al., 2018; Meagher et al., 2013). However, there is a gap in psychotherapeutic recommendations for low-SES, urban youth in outpatient care settings.

In 1998, Bloom and Reichert created the Peaceful Posse Model for the psychological treatment of urban youth. This model remains applicable today as interventions are focused

around three key processes: mentoring (i.e., connecting youth with a caring adult to foster trust and self-expression), healing (i.e., engaging youth in opportunities to focus on the holistic nature of their feelings and actions), and strengthening of self-concept (i.e., guiding youth through introspection and encouragement to correct and redevelop self-esteem and individuality).

In consideration of best practice for meeting all the needs of low-SES, urban families in treatment, the therapist must adopt an integrated approach. As environmental context is a main factor in care, a systemic approach with a focus on neighborhood influence, social relationships, and family dynamics will be important. Because trauma exposure is likely, the therapist must maintain a trauma-informed approach to ensure safety and develop validation and empowerment. Last, treatment is only effective when it instills hope into clients. Thus, youth and families will thrive from a strengths-based approach with focus on personal and family strengths, social support, and community resources.

Systemic Care

In terms of providing treatment to youth with emotional and behavioral dysregulation and their families, systemic family therapy is an evidence-based approach that has been deemed effective in improving family and social support around change (Cleek et al., 2012; Szapocznik & Hervis, 2020). Structural family therapy (Minuchin, 1974) is a form of systemic family therapy that has been studied in application with urban youth and found to be beneficial in treatment for risky behaviors, including drug and alcohol misuse, antisocial peer affiliation, and unsafe sexual activities (Jessor & Jessor, 1977). The goal within structural family therapy is to aid families in recognizing that the strongest and most enduring force in youth development is the family structure. As well, structural family therapy and other systemic family therapies are

used to educate families about the positive impact of changes in poor or lacking family interactions on youth development (Szapocznik et al., 2012).

Research indicates most families who present to mental health treatment in urban communities struggle with multiple environmental and sociocultural stressors (Cleek et al., 2012). Thus, treatment should include a focus on and support of basic living needs and household and community functioning. According to Simmons et al. (2008), the primary ways in which therapists can support urban families include locating services within the community to meet primary needs (e.g., food supply, housing), accessing services in a primary language, embracing and using family and community values, providing motivational interventions to encourage engagement and commitment to services, and providing structured treatment activities that relate to family values.

To add, research shows youth and families who have faced chronic stressors and community obstacles also expect barriers in treatment, which commonly affects their initial participation in therapy and commitment to services. Nanninga et al. (2016) conducted a study on the types of barriers urban youth and families expect to encounter in therapy and their associated characteristics. The researchers used data from a community sample of 666 youth and their families who are receiving psychosocial treatment within a Dutch urbanized region.

Assessment measures focused on expectations of life obstacles and stressors (i.e., limited transportation, other children in the home, other activity obligations, health concerns, conflict with a significant other), treatment demands and issues (i.e., unrealistic cost and duration, no voice in treatment, confusion around treatment information), irrelevance of treatment (i.e., no need or relevance of treatment, introduction of new or greater life problems), and having a problematic relationship with the therapist (i.e., poor therapeutic alliance, little support from the

therapist; Nanninga et al., 2016). Assessment focused on child characteristics including age, gender, ethnicity (i.e., Dutch, non-Dutch), psychosocial problems (i.e., emotional symptoms, conduct problems, hyperactivity and inattention, peer problems), and family characteristics including educational level and family composition (i.e., number of parents in household). Last, youth and families were evaluated on participation in psychiatric or psychological services within the past 6 months.

Results from the study showed the majority of the parents (63.6%) and a higher majority of the urban youth (83.9%) expected one or more barriers to seeking or engaging in treatment. The most common expectation was that treatment would be irrelevant, followed by the potential for a problematic relationship with the therapist and that the family and adolescent might face unrealistic treatment demands (Nanninga et al., 2016). Some might believe expectations of problems in the therapeutic relationship may relate to experiences of social violence, disparity, and discrimination. For urban families facing poverty and financial stressors, expectations included difficulty with transportation and scheduling of weekly sessions, and treatment payments being outside of their financial budget. Nanninga et al. (2016) suggested it is important to assess youth and family expectations to understand environmental influence and barriers to care. Overall, systemic care is an essential piece of providing treatment to youth and families, particularly those who are exposed to chronic community stressors and are experiencing symptoms of distress.

Trauma-Informed Care

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) indicates the trauma-informed care (TIC) approach emphasizes the

> widespread impact of trauma and understands potential paths to recovery . . . recognizes the signs and symptoms of trauma in clients, families, staff, and others involved in the system . . . responds by fully integrating knowledge about trauma into policies, procedures, and practices . . . and seeks to actively resist traumatization. (p. 9)

The TIC framework does not endorse standardized interventions but relies on the ethical and moral value of remaining trauma-informed in all settings and with all clients to prevent further harm (Lucio & Nelson, 2016). The TIC framework also encompasses six major concepts to include across services: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, and cultural and historical consideration (including gender; SAMHSA, 2014).

Trauma-informed practice is supported by results from the Adverse Childhood Experiences (ACE) Study conducted by Felitti et al. (1998). The original ACE Study included a retrospective analysis of more than 17,000 adults who were previous medical patients at the Kaiser Permanente San Diego Health Appraisal Clinic. Adults were mailed ACE surveys to obtain information on exposure to child abuse and household dysfunction. Survey questions about exposure to child abuse were evaluated within three categories: physical, psychological, and contact-sexual. Survey questions about exposure to household dysfunction were evaluated within four categories: substance abuse, mental illness, violent treatment of mother-figure, and criminal behavior.

ACE surveys were measured alongside health appraisal questionnaires used at the clinic to gather information on medical history, lab results, and other physical findings (e.g., smoking/drinking behaviors, depressed mood, suicide attempts, disease conditions; Felitti et al., 1998). Results showed more than half of the sample was exposed to one or more adverse

experiences, with a small percentage exposed to four or more. Exposure to one or more adverse experiences also increased feelings of anxiety, anger, and depression that led to maladaptive coping. The prevalence of smoking, obesity, physical inactivity, depressed mood, and suicide attempts increased as the number of ACEs increased. As well, the prevalence of alcoholism, use of illicit drugs, injection of illicit drugs, high lifetime number of sexual partners, and history of sexually transmitted diseased increased as adverse experiences increased. Last, individuals with four or more exposures to adversity were likely to develop poor physical health, including diabetes, chronic bronchitis, emphysema, skeletal fractures, hepatitis, jaundice, and poor self-related health. Overall, the ACE Study (Felitti et al., 1998) contributed greatly to TIC by confirming that many youth and families experience long-term effects of trauma.

In conclusion, TIC involves therapy that is sensitive to youth and families who have traumatic experiences and chronic stress. TIC is beneficial in treatment for low-SES, urban families as the majority are exposed to community violence, neighborhood dysfunction, and discrimination and racial disparity and thus need treatment that focuses on surrounding resources and resilience capabilities (Riebschleger et al., 2015).

Strengths-Based Care

Strengths-based care (SBC) is said to measure "emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers and adults; enhance ability to deal with adversity and stress; and promote personal, social, and academic development" (Epstein & Sharma, 1998, p. 3). Most importantly, the foundational belief within SBC is that all individuals possess innate strengths (Weick et al., 1989).

SBC has a positive reputation for maintaining youth participation and motivation toward change in treatment (Harris et al., 2012). Researchers have suggested that though there are many approaches to treatment for youth, most fail to account for community context and empowerment and resiliency factors (Harden et al., 2015). SBC also includes a heavy focus on parent engagement as a means to provide support and encouragement for change. Parents participate in therapy to learn methods for encouraging youth identity development and acknowledging resilience and strengths (Drolet et al., 2007).

Solution-focused brief therapy (SFBT) is a form of SBC that has been found to be effective in treating youth who have unstable emotions, risky behaviors, and poor self-concept (Coulter, 2014). SFBT involves a focus on personal resources as strengths and resilience skills for coping with adversity (Bond et al., 2013). SFBT and other strengths-based modalities are used to engage youth through empowerment interventions and building motivation toward positive identity development (Travis & Leech, 2014). Research shows urban youth particularly benefit from strengths-building and positive reinforcement in treatment as these interventions increase the propensity for resilience, management of stress, and ability to obtain social support (Folk et al., 2014).

Overall, SBC goes beyond a focus on presenting problems to a focus on strengths, including personal resources, family support, community resources, and social opportunities. Research shows youth with emotional and behavioral dysregulation do not benefit from deficit-based, problem-centered therapies; rather, they thrive from value being placed on what they and their families have done well in order to create solutions to adversity (Coulter, 2014; Drolet et al., 2007).

Summary of Treatment Approaches

There are various approaches to serving young people and their families in therapy; however, few function with a primary consideration of community context and household needs in the manner that low-SES, urban youth and families need (Harden et al., 2015; Riebschleger et al., 2015).

This review reflects an integrated approach to providing guidelines of care for low-SES, urban youth. First, the systemic approach is considered to involve the whole family in treatment and build support around united goals, including emotional and behavioral coping (Minuchin, 1974; Simmons et al., 2008). Second, the trauma-informed approach is highlighted to capture the sensitivity and role of trauma in youth and family narratives and provide space for emotional healing (Felitti et al., 1998; Lucio & Nelson, 2016). Last, a strengths-based perspective is used to help youth and families identify resilience factors and resources for coping (Coulter, 2014; Drolet et al., 2007).

Conclusion

This chapter was intended to address the first research question: How can emotional and behavioral dysregulation be symptoms of trauma among low-SES, urban youth? The chapter included a discussion of the chronic stressors and traumatic experiences that are most common to low-SES, urban youth and families, including community violence (Finkelhor et al., 2009; Youngstrom et al., 2003) and family distress (Dil & Vuijk, 2012) in response to financial strain, lack of social support, and proximity to substance use and criminal activity (Stolbach et al., 2013).

This chapter highlighted the notion that exposure to chronic adversity increases the chances for low-SES, urban youth to develop mood and behavioral dysregulation as a traumatic

stress response. Emotional dysregulation develops when a young brain is exposed to chronic stress and disruptions occur in the prefrontal cortex–amygdala circuitry (Evans & Kim, 2013). Thus, the brain is likely to engage in increased attention or hypervigilance toward negative and threat-inducing stimuli (McCoy et al., 2016). Behavioral dysregulation is induced as a response to emotional dysregulation, including poor management of negative emotions, leading to the externalization of fear, anger, and sadness through aggression and delinquent behaviors (Sullivan et al., 2010).

Many urban youth across the United States are labeled with emotional and behavioral disorder (EBD) as a categorization for the emotional and behavioral dysregulation witnessed within the school system that often qualifies students for learning accommodations and segregated classroom experiences (Walker et al., 2013). In order to avoid misdiagnoses of EBD and improve holistic care for urban youth, it is important to grasp the psychosocial context of symptoms of distress, including exposures to trauma and resilience factors. Thus, the integration of systemic care, TIC, and SBC enables the focus to be on the presenting problem as well as the family and community systems, narratives of trauma, and strengths and supportive resources.

CHAPTER II: RESILIENCE AND CONTRIBUTING FACTORS

The current chapter continues the focus on the first research question: How can emotional and behavioral dysregulation be symptoms of trauma among low-SES, urban youth? It highlights risk factors that contribute to increased exposures to violence and the consequential symptoms of emotional and behavioral distress (e.g., hopelessness, aggression, delinquency). In addition, the chapter highlights protective factors that contribute to low-SES, urban youth resilience against daily risks. Protective factors are noted as areas of strength that decrease emotional and behavioral distress in response to adversity and increase goal-orientation and hope for the future. First, resilience theory is explored and defined in the context of low-SES, urban youth and their families.

Resilience Theory

The term resilience is used to refer to both healthy functioning after exposure to trauma as well as the capacity to successfully adapt to multiple exposures to trauma over time (Luthar et al., 2000; Masten, 2007, 2011). Research shows many youth and individuals who experience trauma or violence exhibit healthy long-term functioning and resilience (Grych et al., 2015). If not careful, clinicians can bypass resilience factors in looking to understand the negative impacts of childhood adversity.

Resilience theory highlights the idea that resilience is a process of healing and growth rather than a cluster of characteristics of strength (Khanlou & Wray, 2014). Kelly (1968) indicated the resilience process has four main mechanisms: adaptation—learning to cope with the system and vice versa; cycling of resources—defining, using, creating, conserving, and transforming coping skills within a given setting; interdependence—all elements of a system

having an effect on and being affected by one another; and succession—being in a state of flux and requiring strategic contextual and historical approaches.

The process of resilience is also captured across multiple levels and systems. Shaw et al. (2016) used Bronfenbrenner's (1979) construct of systems to categorize resilience across interrelated contexts. First, resilience is influenced by a primary system based on individual patterns of activities, personal roles, and personal relationships. Resilience is also influenced by a secondary system that includes relationships between multiple primary systems. Within the third system, individuals do not have active roles but resilience is influenced by connections between primary and secondary systems. Finally, resilience occurs within a universal or larger system based on overarching patterns of culture and subculture, belief system, and ideology (Shaw et al., 2016).

Overall, resilience is a unique and multifaceted process that involves more than just individual strengths (Peterson, 2006; Peterson et al., 2005), as it requires an ability to adapt, establish new resources, moderate the impact of systemic interdependence, and maintain the use of coping and resources over time (Grych et al., 2015). Resilience theory also integrates concepts from positive psychology (Peterson, 2006; Peterson et al., 2005; White & Epston, 1990), including the notion of posttraumatic growth (Rutter, 2012), which supports that healthy and resilient outcomes can occur because of exposure to stress and trauma, not only despite these exposures (Jirek & Saunders, 2018). According to Tedeschi and Calhoun (2004), highly stressful life experiences can lead to positive changes in an individual's view of the self, the world, and relationships.

In order to gain a complete understanding of youth and family functioning, both risk and protective factors are considered within positive psychology as contributing to traumatic stress as

well as resilience. Research has shown resilience reflects a balance among exposure to adversity, appraisal of the situation, coping response, present strengths and resources (i.e., self-regulation skills, interpersonal skills, meaning-making skills; supportive relationships, environmental supports), and psychological health (i.e., well-being, affect, competencies, symptoms; Grych et al., 2015). To add, research has consistently indicated adolescence is a developmental period characterized by rapid cognitive and social growth, as well as modifications to mental processes including moral reasoning, judgment, decision-making, social perspective-taking, and emotional regulation (Bluth et al., 2018; Steinberg, 2005). From a resilience perspective, youth have a window of opportunity during which to develop coping and internal strengths, or character strengths (Peterson, 2006; Peterson et al., 2005), that attach to their identity and remain with them into adulthood (Roeser & Pinela, 2014).

Bluth et al. (2018) suggested self-compassion is an internal process that develops when youth become more aware of their thoughts and emotions and helps in maintaining a balance between a perspective of adversity and common humanity. Resilience and self-compassion among youth include working toward a rational evaluation of the impact of trauma and understanding individual hardships as a shared experience. Bluth et al. studied a sample of 1,057 adolescents to determine the impact of self-compassion on resilience, curiosity, and exploration. Curiosity and exploration were defined as typical youth experiences, including actively seeking out new experiences and taking risks. Results showed self-compassion was positively associated with both resilience and curiosity. Also, self-compassion was found to be a significant character strength among youth that generated the opportunity for resilience and the ability to embrace novel situations.

Overall, research has shown resilience is a process common to urban youth and develops across exposures to both risk and protective factors (Khanlou & Wray, 2014; Shaw et al., 2016). In the next sections, common risk and protective factors among low-SES, urban youth and families are identified and discussed in depth. Protective factors are known to contribute to resilience, and risk factors are considered as contributing to posttraumatic growth (Grych et al., 2015; Rutter, 2012).

Risk Factors

Risk factors include places, people, situations, and behaviors that directly contribute to individual harm or health impairment (Sams & Truscott, 2004). There are many risk factors and unique daily challenges that affect urban youth, their families, and their communities. The focus in this section is on risk factors, including racial and ethnic disparity and discrimination, poverty and neighborhood disorganization, and community violence.

Racial and Ethnic Disparity

With regard to racial and ethnic representation in the United States, research indicates Black families and families of color are consistently and disproportionately represented within low-SES, urbanized communities (Bell & Jenkins, 1993; Centers for Disease Control and Prevention, 2006; Copeland-Linder et al., 2011). Schuck (2005) conducted a study to assess the racial disparity of Black youth represented within the child welfare system in Florida. The researchers used data obtained by Florida's Department of Children and Family (DCF) and Child Protective Services (CPS) between the years of 1998–2001 (U.S. Department of Health and Human Services, 2003). Data were also collected from the 2000 census (U.S. Census Bureau, 2003) to determine the relationships between poverty, urbanization, single-parent (i.e., female-headed) household, and placement of youth in the welfare system.

Results showed Black families experienced significantly higher rates of exposure to poverty—including concentrated poverty (i.e., urbanization)—and living within single-parent households as compared to White families (Schuck, 2005). These high rates of exposure to adversity also correlated with higher rates of DCF reports among Black families compared to White families. However, data indicated county verification and substantiation of evidence of maltreatment from these reports were low among Black families and high among White families (Schuck, 2005). Thus, findings indicate Black youth and families are overrepresented at county and state levels (i.e., child welfare system) as a result of poor social expectations based on proximity to poverty and strains on the nuclear family system.

In general, research shows Black and Hispanic individuals in the United States experience increased rates of trauma and adversity in comparison to White, non-Hispanic individuals (Andrews et al., 2015; Harden et al., 2015). In 2008, the U.S. Department of Justice found Black individuals had significantly more experiences of community violence and victimization by violence compared to their White counterparts.

Andrews et al. (2015) examined racial and ethnic factors related to trauma exposure in correlation with symptoms of posttraumatic stress and depression. The researchers gathered information through structured interviews with 3,312 youth and their parents that measured experiences of polyvictimization (i.e., two or more experiences of physical, sexual assault; physical, sexual abuse; non-assaultive events; witnessing of violence in the home, community, or at school), posttraumatic stress and depressive symptoms, and demographic information.

Results showed Black and Hispanic youth experienced increased rates of polyvictimization compared to White youth. As well, Black and Hispanic youth reported slightly higher rates of posttraumatic stress and depressive symptoms. Andrews et al. (2015) noted that

though there was a small difference between symptomology across races, the difference was accounted for by experiences of polyvictimization among Black and Hispanic youth. Last, the impact of polyvictimization was present for youth across low-, middle-, and high-income households; however, posttraumatic stress and depressive symptoms were most profound among youth in low-income families.

Overall, as racial and ethnic minorities, Black and Hispanic urban youth face an increased likelihood of exposure to impoverished living conditions and changes to family structure. These experiences, in turn, increase their chances of exposure to adversity, including polyvictimization, and residual symptoms of traumatic stress and depression (Bornstein & Bradley, 2014). Disparity in the representation of youth of color in low-SES, urban environments contributes to the influx of traumatic experiences and posttraumatic symptoms across Black and Hispanic youth.

Racial and Ethnic Discrimination

Black individuals and individuals of color experience regular racial and ethnic discrimination and associated distress. To add, researchers agree that Black youth and youth of color are at particular risk for more frequent, targeted discrimination in comparison to their White peers (Copeland-Linder et al., 2011; Greene et al., 2006; Seaton et al., 2008; Sellers et al., 2006).

Jirek and Saunders (2018) evaluated 45 urban young people to determine ability to thrive and engagement in posttraumatic growth as influenced by trauma history, major sub-trauma events (e.g., parent divorce or legal separation, victim of non-violent crime), chronic stress, sexual harassment, discrimination (i.e., based on personal or social identity, race or ethnicity, gender or sexual orientation), and cumulative adversity.

Results showed Black and Hispanic individuals experienced significantly more discrimination than their White counterparts (Jirek & Sanders, 2018). As well, Black and Hispanic individuals experienced chronic life stress at significantly higher rates than White individuals. The most common stressors included residing in a home or neighborhood described as noisy, dirty, polluted, and overpopulated and having a history of conflict or poor relationships with parents. In this study (Jirek & Sanders, 2018), a significant correlation was not determined between race, ethnicity, and cumulative adversity because of the small sample size. However, it was ultimately suggested that Black and Hispanic people experience more discrimination and chronic stress than others as a result of racial and ethnic differences.

Copeland-Linder et al. (2011) considered racial discrimination toward urban youth of color to be an attack on their identity during a pivotal time in their psychosocial development. In 2011, they examined the cumulative effect of discrimination and contextual stressors on Black youth and their engagement in risk-behaviors over time. They conducted a longitudinal study in which they evaluated 500 Black, African American youth in the eighth grade who attended various schools across Baltimore City. Each year for 3 years, students, parents, and teachers were assessed for the presence of discrimination, contextual stressors (i.e., neighborhood disorder, community violence), protective factors (i.e., self-worth, academic competence, parental monitoring), and youth risk-behaviors (i.e., aggression within school setting, substance use in past year).

Results were interpreted with a focus on gender differences and similarities. Results showed exposure to racial discrimination, neighborhood disorder, and community violence had a cumulative, significant effect on increased aggression over time among young men. Neighborhood disorder and community violence were also significantly correlated with

increased substance use among young men and women over time. Overall, results from the Copeland-Linder et al. (2011) study support that racial discrimination paired with contextual stressors contributes to increased risk-behaviors and aggression among urban youth over time. The finding that young men were more likely than young women to engage in increased aggression over time may align with suggestions that young men generally demonstrate more overt physical signs of aggression whereas young women tend to exhibit aggression through relational means (Sullivan et al., 2010).

In a final study, Tobler et al. (2013) evaluated a group of 2,490 Chicago youth, the majority of whom were Black, followed by Hispanic and White. Data were collected in multiple waves to measure perceived racial and ethnic discrimination—including frequency and intensity—and association with risk-behaviors such as alcohol and cannabis use, physical aggression, delinquent acts (e.g., stealing, skipping school, major conflict with parents), victimization (i.e., being threatened of intentionally injured by another person), suicidal ideation, and sexual behavior. Tobler et al. found 73% of their sample of Chicago youth had experienced some type of racial or ethnic discrimination over the course of 1 year; 42% of these youth had experiences that were considered “somewhat” and “very disturbing” in nature.

Tobler et al. (2013) found youth who had experienced racial and ethnic discrimination to any degree over the course of 1 year were at an increased risk for negative outcomes in mood and behaviors regardless of race, ethnicity, or gender. As well, any exposure to discrimination increased the risk for future victimization and depressive symptoms. Results showed increased frequency of exposure to discrimination was significantly associated with physical aggression, delinquency, suicidal ideation, and greater sexual concerns (e.g., more lifetime partners).

In conclusion, youth who are exposed to chronic life stressors in addition to discrimination face increased chances of engagement in aggression, delinquent behaviors, personal victimization, and depressive symptoms (e.g., suicidal thinking). In further consideration, Black youth and youth of color are exposed to heightened discrimination and adversity, particularly when residing in low-SES, urban environments.

Poverty and Neighborhood Disorganization

Over time, researchers have become more attuned to the understanding of social context in the etiology of adolescent problems (e.g., Dotterer & Lowe, 2011; Nair et al., 2013). Current research has shown urbanized communities in the United States are exposed to an unequal distribution of physical, economic, and social resources based on systemic determination of community disorganization or sustainability (Copeland-Linder et al., 2011; Vogel & Van Ham, 2018).

As low-SES communities often demonstrate high levels of neighborhood disorganization, they are subjected to perpetual disadvantage through fewer resources and limited access to a wider range of support (Lucio & Nelson, 2016). Low-SES, urban communities are said to typically experience disparities in housing, income, and education, which are then associated with high rates of criminal activity, violence, and impoverishment among a majority of households (Vogel et al., 2015; Vogel & Van Ham, 2018). Studies have shown families living among these disparities report at least twice as many experiences of stressful life events and higher rates of victimization and witnessing of violence in comparison to families in affluent communities (Sullivan et al., 2007).

In 2018, Vogel and Van Ham evaluated the relationship between youth residing in low-SES, urban communities and behaviors of impulsivity and aggression. The study was

longitudinal and involved 12,935 participants. Youth, parents, and teachers completed surveys to measure youth impulsivity and violent behaviors, as well as neighborhood SES-related disadvantage (i.e., receiving welfare, living below poverty, unemployment, living as a "female-headed" home). The researchers also measured demographic information, including race (55% White, 20% Black, 17% Hispanic, 8% Other), age, sex, and whether the youth resided in a one- or two-parent household.

Results from Vogel and Van Ham's (2018) research showed youth living in low-SES neighborhoods and with a predisposition to behave impulsively were significantly more likely to act out in violence and aggression than were youth without a predisposition for impulsivity. As well, when comparing youth impulsivity and behavioral disposition across disadvantaged and affluent communities, results showed the relationship between the two was more salient among youth living in low-SES neighborhoods. Thus, impulsive low-SES youth were found to be more likely than impulsive middle- and high-SES youth to engage in aggression. Results indicated 81% of youth endorsed there being a significant relationship between their impulsivity and experiences of neighborhood disadvantage, 16% of this relationship was accounted for by a high concentration of impulsive youth within low-SES communities. Overall, findings support that levels of impulsivity and engagement in aggression are high among low-SES, urban youth as a result of the impact of poverty and disadvantage. As well, the research showed there is an overrepresentation of impulsive and high-risk individuals in disadvantaged communities (Vogel & Van Ham, 2018).

Historically, research has shown low-SES, urban communities lack informal social control, which, in turn, contributes to increased disorganization and engagement in violence and criminal activity (Lynam et al., 2000). Though this may be true, research also shows families

living in impoverishment face a number of disadvantages that contribute to disorganization, including single-parent households and unemployment, which can detract from a young person's access to appropriate socialization from their family and ability to learn skills for anger and aggression regulation (Wikstrom & Sampson, 2003). Roche et al. (2003) conducted a study to measure the relationship between adolescent emerging independence and aggressive mood and behaviors. The researchers made a valuable point that adolescence is a developmental period during which young people experience increased unsupervised time with peers, take on adult-like responsibilities, and make important contributions to the family. However, the value placed on youth independence and developmental well-being varies based on sociodemographic upbringing and demands on the family. The Roche et al. study included a sample of 516 Baltimore City youth (79% Black, 20% White, 1% Other) who were measured on levels of aggression (e.g., frequency of physical fights within the last 12 months), number of independent roles (i.e., family roles, peer roles, and work roles), demographics (i.e., race/ethnicity, single-parent or kin household, family income), and social context (i.e., parent-monitoring, deviant peer affiliations, neighborhood violence).

Results from the study showed participants with issues with anger and aggression across their adolescence also reported less parent-monitoring, greater exposure to neighborhood violence, affiliation with deviant peers, frequent working, and involvement in peer roles (e.g., dating, partying) in their earlier adolescence (i.e., ages 12 and 13 years; Roche et al., 2003). Through a post-hoc analysis, results also showed engagement in independent roles involved affiliation with deviant peer groups and exposure to neighborhood violence occurring at higher rates among youth in disadvantaged neighborhoods than among youth in affluent neighborhoods. In particular, low-SES youth experienced decreased parent-monitoring and engaged in greater

independent family roles, which included taking care of younger siblings, preparing meals, and completing household chores.

Youth in low-SES communities who engaged in work as well as independent family roles were found to demonstrate less aggression than those who engaged in one or the other (Roche et al., 2003). The researchers suggested increases in aggression among youth with only independent family roles are influenced by an inability to take on peer and work roles for various reasons (e.g., too young, fear for youth's safety). To add, increases in aggression among youth who solely worked might represent those who have less family-centered goals or engagement, and therefore focus on maintaining personal security through monetary fulfillment (Roche et al., 2003).

Overall, Roche et al. (2003) highlighted the importance of emerging independence and social roles in moderating anger and aggression among low-SES, urban youth. In general, this research supports the idea that social context and residing within an environment with a lack of community support and limited access to resources places significant strain on family functioning and adolescent development. Household financial struggles and limited social supports contribute to low parent-monitoring and higher independent roles among youth, increasing their likelihood of exposure to violence and poor peer affiliation (Roche et al., 2003). As well, disadvantaged communities are prone to disorganization and violence because of an overrepresentation of high-risk individuals in these areas (Vogel & Van Ham, 2018). Thus, this overrepresentation increases rates of exposure to and engagement in violence and aggression.

Community Violence

Community violence has been defined as direct victimization or witnessing of violent acts in a neighborhood or community (Cooley-Quille et al., 1995). In 1998, Bloom and Reichert

provided the following rates of community violence exposure among low-SES, urban youth: 74% witnessed a violent act, 48% had been hurt directly by some form of violence, 81% knew someone hurt by gun violence, and 75% knew someone hurt by some other form of violence. Currently, studies indicate over 80% (50%–96%) of urban youth are exposed to chronic community violence (Copeland-Linder et al., 2011; Tummala-Narra et al., 2014).

Anderson (1999) stated, "Of all the problems besetting the poor inner-city Black community, none is more pressing than that of interpersonal violence" (p. 32). Gradually, researchers have placed more focus on the significant relationship between urban living and heightened violence exposure among youth of color. In one study, Richards et al. (2015) measured daily exposures of community violence among 169 low-SES, Black adolescents across Chicago neighborhoods. Youth were longitudinally assessed over a 3-year span. Participants completed daily diary entries with detailed descriptions of violence exposures based on categories: type of community violence (e.g., fighting with pushing, kicking, or punching; getting stabbed or shot; witnessing a gun being shot; hiding because of a shooting), time of day, location (i.e., home, school, public), who committed the act, and who was victimized. Participants also completed questionnaires and engaged in weekly evaluations to measure average exposures.

Results showed low-income, Black Chicago youth experienced about one daily exposure to community violence, equating to approximately six exposures each week (Richards et al., 2015). Exposures peaked before and mostly after school hours, between 3 p.m. and 8 p.m. On average, the sample endorsed moderate exposures to community victimization followed by moderate exposures to witnessing violence, severe exposures to witnessing violence, and severe exposures to victimization. For young men, violence exposures most often occurred within a

public setting, followed by occurrences within school and home settings. For young women, violence exposures occurred most frequently within the school setting followed by occurrences within public and home settings. The most common types of exposure to community violence included someone dealing drugs, someone being arrested, someone threatening to hurt or hurting someone else, someone getting robbed, and hiding because of a shooting. The most common types of exposure to school violence included someone threatening to hurt or hurting someone else; fighting that involved pushing, slapping, kicking, or punching; someone carrying a gun or knife; and someone threatening to shoot or stab someone else. Finally, the most common type of exposure to home violence included yelling; no other types were identified within the study. Overall, Richards et al. (2015) concluded low-SES, urban youth and youth of color experience a significant degree of community violence manifesting across public, school, and home settings.

Exposures to community violence as a young person has been linked to various emotional symptoms, including depression, anger, anxiety, and posttraumatic stress (Cooley-Quille et al., 2001). As well, youth exposed to community violence have been found to demonstrate behavioral symptoms, including social withdrawal, aggression, and violence (Sullivan et al., 2010; Zeman et al., 2002). In a 2019 study conducted by Burnside and Gaylord-Harden, incarcerated young men were assessed to determine the relationships among community violence, feelings of hopelessness, and delinquent behaviors. Researchers have many hypotheses for the cause of hopelessness among urban youth. Some include witnessing and victimization of violence (So et al., 2015), low achievement expectations (Joiner & Wagner, 1995), and anticipation of poor quality of life (Bolland, 2003).

The sample in the Burnside and Gaylord-Harden (2019) study included 831 incarcerated youth in Philadelphia and Phoenix between the ages of 14 and 17 years. Of the sample, 52%

were Black, 42% were Hispanic, and 6% were "Other." Youth were evaluated for frequency and intensity of exposures to community violence as well as reported feelings of hope toward the future (i.e., aspirations and expectations for future work, family, and legal goals) and engagement in delinquent behaviors (e.g., carried a gun). Last, youth were measured on amount of incarceration time (i.e., time within a controlled setting). Results showed there was statistically significant relationship between feelings of hopelessness in early adolescence and later witnessing of community violence. As well, a strong relationship was determined between feelings of hopelessness and engagement in delinquent behaviors, which also mediated later exposures to community violence. Finally, community victimization in early adolescence was predictive of later engagement in delinquent behaviors.

Overall, research has confirmed that low-SES, urban youth, particularly those of color, are routinely exposed to community violence (Burnside & Gaylord-Harden, 2019; Richards et al., 2015). This community violence is predictive of emotional distress and behavioral symptoms among low-SES, urban youth. Moreover, the emotional distress caused by urban living increases the chances of community violence exposure (Burnside & Gaylord-Harden, 2019).

Summary of Risk Factors

Overall, experiences of racial and ethnic disparity and discrimination, poverty and neighborhood disorganization, and community violence are considered risk factors that affect the well-being of low-SES, urban youth. Racial disparity and discrimination are risk factors that relate to the high rates of Black families and families of color being segregated into low-SES, urban communities (Andrews et al., 2015; Schuck, 2005) and experiencing chronic societal and interpersonal pressures, prejudice, and violence exposure (Copeland-Linder et al., 2011; Jirek & Saunders, 2018; Tobler et al., 2013). Poverty and neighborhood disorganization are factors that

contribute to family distress and household strain, generated by changes in parent-monitoring, youth roles, and community affiliations (Roche et al., 2003; Vogel & Van Ham, 2018). Finally, community violence is a significant risk factor for youth well-being related to chronic exposures to violence, aggression, and criminal activity across settings (Burnside & Gaylord-Harden, 2019; Richards et al., 2015). All components highlighted above have a negative influence on family functioning and youth emotional and behavioral development. Next, protective factors are explored.

Protective Factors

Protective factors are resources that promote resilience and reduce risk and the negative impact of stress (Copeland-Linder et al., 2011). The impact of protective factors includes fewer mental health concerns and functional impairments among youth and families exposed to chronic adversity (Kisiel et al., 2017). In this section, protective factors specific to low-SES, urban youth are discussed. Through this discussion, the relationship between increased resilience and decreased emotional and behavioral concerns is identified. Protective factors include racial and ethnic identity, parent-monitoring and communication, and school and academic interest.

Racial and Ethnic Identity

In particular to low-SES, urban youth of color, having a positive and insightful sense of racial and ethnic identity is critical for resilience toward community-based risk (e.g., M. A. Zimmerman et al., 2013). Racial and ethnic identity influences the ability to navigate stereotyping and prejudice and confront differences in cultural norms and values between people groups (Phinney et al., 1990).

Williams et al. (2014) conducted a longitudinal study to measure racial and ethnic identity as a moderator between adverse experiences and youth antisocial behaviors across time.

The original sample included 341 middle school youth in Chicago who were annually evaluated on antisocial and delinquent behaviors (e.g., violence toward others, stealing), criminal arrests and charges, and contextual stressors (i.e., discrimination, family stress, violence). Last, youth were evaluated on their sense of racial and ethnic identity within two categories: identity affirmation and identity achievement. Identity affirmation referred to a positive sense of belonging and pride in one's race and ethnicity. Identity achievement included high exploration, awareness, and accomplishment within one's racial and ethnic group.

Results showed strong racial identity had mixed moderating effects on the relationship between contextual stress and youth dysregulation. Identity affirmation was identified as a protective factor against family and household stress (e.g., financial strain, single-parent strain). Identity achievement, however, had an adverse effect on emotional and behaviors and a correlation with increased distress in response to discrimination. Williams et al. (2014) inferred that increased distress was a result of heightened awareness of and therefore sensitivity to discrimination. Among the total sample, distress in response to discrimination commonly led to antisocial behaviors and trauma responses (e.g., destructive of property, violent when provoked). Though the study had mixed findings on the protective benefits of racial/ethnic identity among urban youth, it is common understanding that connection to one's racial/ethnic identity contributes to meaning-making and is reflective of maturity and insight that can be drawn upon in times of stress (Lee et al., 2011).

Other researchers have suggested racial identity is both a risk and protective factor for urban youth. Tummala-Narra et al. (2014) conducted a study with 522 youth residing in a northeastern city. The sample was 25% Asian, 25% White, 13% Black, 12% Multiracial, 11% Hispanic/Latino, 1% Middle Eastern, and 9% "Other." Youth and teachers completed surveys

pertaining to youth exposures to violence; symptoms of posttraumatic stress, depression, and anxiety; ethnic identity; and help-seeking behaviors. Results showed exposure to violence and symptoms of posttraumatic stress varied across races and ethnicities. Identity proved to be a buffer within the overall context of violence exposure. Identity moderated the relationship between exposures to school violence and symptoms of posttraumatic stress, anxiety, and depression. However, it did not moderate the relationship between posttraumatic stress symptoms and violence exposures within the community or home. As well, racial and ethnic identity did not moderate the impact of violence exposure among Black youth within any setting. Researchers correlated this finding with the unique frequency and intensity of exposure to contextual stressors among Black people.

In conclusion, studies have shown racial and ethnic identity play mixed roles as protective factors for low-SES, urban youth. For Black youth and youth of color, racial and ethnic identity may have an adverse effect on functioning as a result of an increased awareness of discrimination and emotional and behavioral reactions (Williams et al., 2014). As well, Black youth face routine community stressors that, in turn, are thought to reduce the protective ability of racial and ethnic identity (Tummala-Narra et al., 2014). Thus, additional protective factors are necessary to maintain emotional and behavioral regulation.

Parent-Monitoring and Communication

Historical research indicates parental monitoring can decrease the impact of community violence and substance use exposure on urban youth (Kliewer et al., 2006). However, it is most influential among youth and families who are experiencing low levels of stress (Ceballo et al., 2003).

Ceballo et al. (2003) assessed parent-monitoring as a moderator between community violence exposure and symptoms of depression and hopelessness. The sample included 147 middle school youth from a low-SES neighborhood in Detroit. Racial demographics were predominately Hispanic, followed by White, Black, and youth labeled as "Other." Youth were evaluated on exposures to trauma, parent-monitoring, and symptoms of depression and hopelessness. All youth reported high rates of violence exposure within their neighborhood, with a subsequent increase in symptoms of depression. However, youth who reported consistent parent-monitoring also reported less personal victimization and witnessing of violence, as well as decreased symptoms of depression and hopelessness. Thus, parent-monitoring demonstrated some potential to buffer exposure to violence and related distress among low-SES, urban communities.

In another study, Griffin et al. (2000) examined the relationships between parent-monitoring and youth substance use, delinquent behaviors, and aggression. The sample included 228 middle school youth (88% Black, 2% Hispanic, 2% Asian, 1% White, 7% Multiracial) who attended two public schools in New York City. Parents were assessed on knowledge of their youth's whereabouts after school hours, whereabouts during the weekend, weekend activities, peer group affiliation, and peer group activities. Parents were also evaluated on how often they had discussions with their youth about plans for the day, schoolwork, drug-related topics, and violence-related topics. Last, parents were asked how often they checked their youth's homework, ate dinner with them, and spent unsupervised time with them.

Results showed substance use among the sample was low, whereas delinquent behaviors and aggression were high (Griffin et al., 2000). Youth reported engaging in the following behaviors over the course of 1 year: 17% vandalized property at school, 33% shoplifted, 39%

picked a fight, and 41% fought someone when provoked. As well, young men endorsed higher rates of aggression compared to young women, and rates of aggression were higher among youth in single-parent homes versus two-parent homes. Parents reported engaging in parent-monitoring as follows: 94% discussed schoolwork several times per week, 69% discussed daily concerns, 67% discussed daily plans, 63% discussed violence-related topics, and 50% discussed drug-related topics.

Results also showed parent-monitoring correlated with lower delinquent behaviors and substance use among youth (Griffin et al., 2000). In particular, parents eating dinner with their youth was correlated with significant decreases in aggression among young women and youth residing in single-parent homes. It was suggested that this activity might have provided the routine communication, structure, and stability that these groups desired or needed. On the other hand, parents eating dinner with their youth was correlated with increased delinquent behaviors among young men and two-parent households. The researchers indicated a personal history of poor behaviors and parent response patterns likely contributed to youth perceptions of this activity as undesirable or overwhelming. Overall, the efficacy of parent-monitoring across the studies (Ceballo et al., 2003; Griffin et al., 2000) appeared to be strongly based on parent–child relationship and nature of daily communication.

Forehand and Jones (2002) added that parenting style (i.e., authoritative, authoritarian, permissive, neglectful) and communication significantly affect the protective nature of parent-monitoring. Authoritative parenting is a communication style that involves a balanced practice of support and warmth, with clearly defined family expectations and discipline (i.e., high response; high demand; Baumrind, 1971). Thus, Forehand and Jones (2002) proposed authoritative parenting is the healthiest approach to building effective parent–child relationships and

boundaries for parent-monitoring. Overall, authoritative parenting can be used to promote the building of strengths and cohesion within the family (Darling & Steinberg, 1993).

Forehand and Jones (2002) conducted a longitudinal study to evaluate the stability of authoritative parenting within a sample of 124 Black families from New Orleans. Family participants consisted of mother–child dyads recruited from five public schools within low-SES neighborhoods. Mothers and youth were evaluated on exposures to community violence and patterns of authoritative parenting across a 2-year span. Results showed parent-monitoring and parent warmth as components of authoritative parenting were most significant among mothers and daughters versus mothers and sons. Results also showed authoritative parenting remained stable over time among the total sample, though independent parenting styles and communication altered. In particular, parent warmth and parent-monitoring decreased over time for many mothers. Forehand and Jones, however, suggested this parent response was natural as it related to increased youth independence and peer affiliation over time. Thus, as youth age parents have fewer opportunities to provide monitoring and warmth. Regardless, no youth in the study who received authoritative parenting experienced significant increases in problem behaviors over time. Authoritative parenting had a positive and stable impact on youth behaviors over time despite diminished parenting opportunities.

Overall, authoritative parenting appears to serve as a protective factor with a manifesting impact on youth development over time. Thus, the current implementation of parent-monitoring and communication with youth has long-term effects on emotional and behavioral development.

School and Academic Interest

Commitment to learning and positive school interactions (e.g., good peer relationships, teacher–student working alliance) are considered significant protective factors for all youth and

urban youth, in particular (Frey et al., 2011). Research has indicated youth generally thrive in school environments that include high expectations for learning, opportunities for involvement in the classroom, and support and care from authority figures (Comer, 1985).

In 2009, Ludwig and Warren evaluated the interactions between school protective factors and psychosocial outcomes among urban youth who were exposed to community violence. The researchers studied 175 adolescent students across two urban high schools in a northeastern city. All students lived in low-SES neighborhoods and attended regular education classes. The majority of the participants were of color (i.e., 35% Black, 36% Hispanic, and 13% Asian). Youth were measured on exposures to community violence, identification with school (i.e., sense of belongingness and value in educational outcomes), teacher support (i.e., expressing interest, being helpful, conveying high expectations and positive regard), psychosocial functioning (i.e., emotions and behaviors), and feelings of hope (i.e., goal-directed thinking, goals for the future). Results showed feelings of hope significantly moderated the effects of community violence by lowering emotional and behavioral symptoms. As well, increased identification with school and perceived teacher support contributed to increased feelings of hope and therefore also moderated the emotional and behavioral symptoms of community violence. The study showed students with moderate and high exposures to community violence were less responsive to school protective factors. Overall, this supports that urban students with heightened school identification and perceived teacher support are likely to experience feelings of hope that have the potential to lower emotional and behavioral distress and mitigate the impact of community violence.

As noted in the previous study (Ludwig & Warren, 2009), school and academic involvement can serve as a protective factor among urban youth. However, effectiveness fluctuates depending on a young person's level of trauma exposure and current distress. A

longitudinal study conducted by Morales (2010) placed focus on the concept of "academic resilience," capitalizing on the capability of many urban youth to develop personal and academic success despite adversity (Morales & Trotman, 2004, p. 4). The sample included 50 low-SES students of color who were considered to be academically resilient, 24% of whom were considered "gifted" learners. Participants were assessed across 8 years to determine the impact of academic success on their psychosocial functioning throughout high school and college. Overall, results showed youth significantly benefited from having a supportive and trustworthy mentor relationship with a teacher or other school-based adult.

Results showed 94% of the youth were willing to "class jump" or shift to higher-education courses and 72% reported having a relationship with a school mentor that influenced such willingness (Morales, 2010). As well, 86% of the youth developed increased future orientation over time, which was also correlated with having a school mentor. Though anxiety toward the future also increased across high school and college, these students were likely to engage in resilience and seek out counsel from their school mentor as needed. Youth described mentors as caring adults who were encouraging, empathetic, supportive, firm, and trustworthy. Mentors were also described as teachers and other adults who acknowledged youth ambivalence and normalized the process of academic achievement. Many students indicated their mentor provided a sense of racial and ethnic translation and encouragement to persevere through cultural and educational obstacles.

Academically resilient students also had personal and family strengths that contributed to their school interest and achievement. Morales (2010) categorized youth personal strengths into three categories: 90% had strong work ethic, 94% had high self-esteem, and 92% had strong internal locus of control. In addition, results showed having a good sense of racial identity and

family pride had a significant impact on the maintenance of academic resilience over time. Youth reported a strong parent relationship, including the application of parent modeling and expectations, was largely impactful on their resilience. A majority of the sample attended schools outside of their local community. This was the result of parents' intentional efforts to achieve better education for their youth and maximize their opportunities for success. Within the sample, 62% of parents made transportation sacrifices, 70% routinely checked homework, 80% encouraged daily reading, and 72% provided constant praise around academic achievement.

Overall, school and academic interest is a major contributor to youth resilience. Among low-SES, urban youth, commitment to school has the potential to increase feelings of hope and orientation toward the future and decrease emotional and behavioral distress (Ludwig & Warren, 2009; Morales, 2010). As well, engagement and achievement in school provides youth with opportunities to grow in personal strengths, make achievements, receive support and guidance from mentors, and make their community and family proud (Morales, 2010).

Summary of Protective Factors

Though low-SES, urban youth face high risks and chronic stressors, research highlights protective factors and strengths that contribute to resilience (e.g., Forehand & Jones, 2002; Morales, 2010; Williams et al., 2014).

Though racial and ethnic identity exacerbates discrimination-related distress among some youth, it is protective among other youth and within various settings (i.e., home, school; Tummala-Narra et al., 2014; Williams et al., 2014). To add, parent-monitoring and communication are protective factors that have a positive influence on youth emotional and behavioral development (Ceballo et al., 2003; Griffin et al., 2000), but only when the parent–youth relationship is secure and the parent uses an authoritative parenting approach (Forehand &

Jones, 2002). Last, school and academic interest serves as a protective factor in that academic achievement and support increase feelings of hope, pride, and orientation toward the future (Ludwig & Warren, 2009; Morales, 2010).

All components highlighted above have a positive influence on family functioning and youth emotional and behavioral development. Protective factors are essential for the development of resilience despite adversity.

Conclusion

There are many risk factors and protective factors that contribute to emotional and behavioral development among low-SES, urban youth. This chapter was used to address the first research question: How can emotional and behavioral dysregulation be symptoms of trauma among low-SES, urban youth? This question was answered by first defining resilience theory and identifying its prevalence among urban youth. Resilience is defined as a process of healing and growth (Khanlou & Wray, 2014) that occurs across systems and exposures to protective and risk factors (Shaw et al., 2016).

The discussion moved to major risk factors that low-SES, urban youth face and that contribute to symptoms of posttraumatic stress such as depression, anger, aggression, violence, and delinquent behaviors. From a contextual lens, this chapter highlighted the impact of racial and ethnic disparity (e.g., Andrews et al., 2015), racial and ethnic discrimination (e.g., Copeland-Linder et al., 2011), poverty and neighborhood disorganization (e.g., Vogel & Van Ham, 2018), and community violence (e.g., Burnside & Gaylord-Harden, 2019) on emotional and behavioral functioning among low-SES, urban youth.

Third, in addition to risk factors, the chapter made note of protective factors among low-SES, urban youth. Protective factors do not contribute to emotional and behavioral

dysregulation, but function as moderators of the impact of trauma and assets to resilience. Contextual protective factors included racial and ethnic identity (e.g., Williams et al., 2014), parent-monitoring and communication (e.g., Ceballo et al., 2003), and school and academic interest (e.g., Morales, 2010). In many situations, these factors demonstrate the potential to lessen emotional and behavioral distress and increase feelings of affirmation, support, and hope.

In conclusion, trauma exposure and chronic stress play significant roles in the development of emotional and behavioral regulation among low-SES, urban youth. Though exposure to risk can lead to posttraumatic growth (Rutter, 2012), in many situations it first contributes to distress and dysregulation. Thus, protective factors must be highlighted and used to combat trauma symptoms and build resilience. Best practice principles for the psychotherapeutic treatment of low-SES, urban youth should incorporate their stories of trauma as well as elements of strength, support, and resources.

CHAPTER III: EFFECTIVE TREATMENT AND INTERVENTIONS

The focus in this chapter is on the second research question: What makes trauma-informed, strengths-based care optimal for the treatment of low-SES, urban youth with dysregulation? To start, the chapter is based on a systemic perspective of care, highlighting principles from systemic and structural family therapies. The structural family perspective is important to address, as the family system is the primary system of functioning for all youth (Minuchin, 1974).

The chapter moves to an identification of foundational principles of trauma-informed care (TIC). Narrative therapy is proposed as an optimal approach that provides youth with validation of their trauma narrative and the safety they need to engage in the reauthoring and overcoming of obstacles (Shapiro & Ross, 2002). Finally, strengths-based care (SBC) is explored in depth. In particular, solution-focused brief therapy (SFBT) is highlighted as most effective to engage youth and families in new perspectives of adversity and focus on strengths and goals (Corcoran, 2002).

Systemic Care

Systemic care is applied through an understanding of theoretical principles, rather than therapeutic technique (Edwards, 2019). Bronfenbrenner (1979) noted a systemic approach to therapy alters the clinical conceptualization from focus on the individual as the problem, to the enactment of the problem across multiple individuals and subsystems (Minuchin, 1974). Minuchin (1974) added that systemic care involves the recognition of behaviors as occurring within the context of reciprocal and bidirectional relationships. Thus, the clinician's goal is to understand problem behaviors as serving one or more purposes within multiple systems and as adaptive depending on maintenance and reciprocation in relationships. In combination with

therapy, systemic clinicians are expected to support low-SES, urban families in engaging in community activities, accessing resources to meet basic needs, and developing realistic and attainable goals (Simmons et al., 2008).

In 2013, Sydow et al. conducted a scholarly review in which they evaluated 47 randomized controlled trials (RCTs) across the United States, Europe, and China to determine the efficacy of systemic care for treating children and adolescents with symptoms of attention-deficit/hyperactivity disorder (ADHD), conduct disorder, substance use disorders, and behavioral disorders. The RCTs included samples of youth who participated in family, group, and multi-family group treatments, all facets of systemic care. RCT participants exhibited a range of externalizing symptoms, including impulsive and delinquent behaviors, aggression and violence toward others, and substance use.

In eight of 20 trials that contained a focus on treatment of youth with conduct issues and delinquent behaviors, systemic care was not shown to be superior to alternative treatment (i.e., juvenile probation) for improving present youth mental health (Sydow et al., 2013). However, in these treatment trials, systemic treatment was found to be effective at posttreatment (6 to 12 months) in comparison to individual treatment via improvements in family relationships and family functioning. As well, rates of criminal activity, time spent incarcerated, and risk of incarceration were markedly reduced for the youth in these trials (Borduin et al., 1995; Borduin et al., 2009; Butler et al., 2011; Ogden & Halliday-Boykins, 2004; Olsson, 2010; Sundell et al., 2008; Timmons-Mitchell et al., 2006; Wells & Egan, 1988). Overall, systemic care was deemed non-harmful to youth and families (Sydow et al., 2013) and found to have lasting positive effects of up to 22.9 years posttreatment (Sawyer & Borduin, 2011). Thus, results support that group,

family, and multi-family groups are effective in building family relationships and diminishing youth criminal activity and legal involvement.

Systemic Family Therapy

Systemic family therapy (SFT) is based on the core belief that human beings are elements that form relationships with one another and build stability over time through invisible boundaries and expectations (Cottrell & Boston, 2002). Interactions within a family are therefore on a feedback loop, which maintains and is maintained by relational input and output. Systemic theorists (e.g., Fonagy et al., 2002) have suggested that in treatment, improvements within a family system are measured based on the use of services and changes to interactional symptoms and adaptations.

Henggeler et al. (1996) conducted a historical study to evaluate the efficacy of SFT in treating urban young criminal offenders and their families. Study participants included 57 youth with behavior problems who received SFT, 23 youth with behavior problems who received non-systemic therapy, and 44 youth with no behavior problems who did not receive therapy. SFT involved addressing problem behaviors as multidimensional, noting times when interactions between the youth and their community (e.g., school, neighborhood) were more detrimental than with their family. Family dynamics were addressed with special attention to dominance hierarchy, parent–child relationships, and sibling relationships.

Pre- and posttreatment measures were used to evaluate family affect (i.e., acceptance, warmth, affection, verbal aggression), conflict (i.e., cooperation versus hostility), and dominance (i.e., relative power and influence). Results showed SFT was effective in reducing maladaptive behaviors and improving family dynamics among young criminal offenders (Henggeler et al., 1996). Parent–partner relationships and parent–youth relationships were greater in warmth and

affection at posttreatment. At posttreatment, youth also demonstrated increased involvement in family discussions and parents reported decreased youth misconduct, anxious withdrawal, immature behaviors, and poor peer associations. These changes were not observed among youth and families who participated in non-systemic therapies. To the contrary, many of these parent–youth relationships worsened and deteriorated by posttreatment evaluation.

Various SFT techniques and goals were shared in Henggeler et al.'s (1996) study. All methods were noted as dependent on youth and family characteristics and relationships within the community. First, it is the clinician's role to incorporate psychoeducation and teachings on authoritative parenting into treatment. Second, youth and families must be provided with new opportunities to grow and practice skills in emotional awareness, social responsibility, and earning privileges. To alter aggressive or poor communication within a family, techniques can include the use of meaning-making to reframe hostile interactions, emphasis of positive feelings between family members, rearranging interactions to facilitate safety and mutual respect, and encouraging participation in community activities. Therapeutic goals can also broadly include establishing the youth's relationship with a caring adult, developing adequate support from that caring adult, and applying learned skills within the environment.

Overall, research shows effective treatment for youth involves their family and community. In particular, youth with aggression and other behavioral concerns benefit from treatment focused on changing relationship boundaries and expectations to provide opportunities for new patterns of interaction (Henggeler et al., 1996).

Structural Family Therapy

Minuchin's structural family therapy (Minuchin, 1974) is considered a contemporary model of systemic care and family therapy (Cottrell & Boston, 2002). The model was developed

at the Philadelphia Child Guidance Clinic and places emphasis on structural change within families, with the clinician as the restructuring agent (Minuchin et al., 2014).

Minuchin (1974) indicated family interactions are governed by family rules, which are invisible and set functional demands on the organization of a family. Family rules and boundaries must be redesigned in therapy to more closely fit the family's ideal. The *Structural Family Instructor's Manual*, constructed by Minuchin et al. (2014), indicates "a family is functional or dysfunctional based upon its ability to adapt to various stressors . . . which, in turn, rests upon parity and appropriateness of subsystem boundaries" (p. 8). They added that a healthy family system includes boundaries that are clear, semi-permeable, and allow for some degree of authoritative parenting. Ultimately, therapy is used to release family members from stereotyped roles and functions (e.g., problem child) by challenging rules and building new lines of interaction.

The three main techniques within structural family therapy are joining, reframing, and enactments. It is key for the therapist to first join with the family to develop a good therapeutic alliance. The clinician must allow time for the family to accept them into the system and to grasp invisible rules and map relationships between family members and subsystems. When the clinician has joined the family, the expectation is that they remain in their position throughout treatment. Minuchin (1974) labeled the clinician's therapeutic role as curious expert. As the curious expert, the clinician uses curious questions to elicit insight from the family about areas of concern and strength. In doing so, the family structure is disrupted and prepared for change.

Reframing is a technique that involves placing the presenting problem into a new perspective that is realistic and workable for treatment. By reframing, the clinician works to shift the family focus from one family member as the problem to the problem being a separate entity

maintained and contributed to by the whole family. When applying reframing in treatment for low-SES, urban youth with emotional and behavioral dysregulation, family members and loved ones are challenged to see the youth in a new light and acknowledge personal contributions to the young person's sadness, anger, or aggression (Minuchin et al., 2014). Last, enactments are used in treatment to observe the family's ability to regulate emotions and behaviors and to determine the interaction patterns that perpetuate the presenting problem. Through enactments, the clinician can disrupt unhealthy family interactions in the moment to generate insight and change.

Szapocznik et al. (1989) conducted a study to determine the efficacy of structural family therapy in comparison to individual psychodynamic therapy or no treatment. Participants included adolescents with severe behavioral issues. Results showed families who received structural family therapy experienced improvements in youth behaviors and family functioning 1 year posttreatment. Youth in individual therapy reported improvements in behaviors, but deterioration in family functioning. Study results are highlighted for two reasons. First, to recognize the long-term impact of structural family therapy on youth and family functioning. Second, to note that family functioning is not the sole moderator of youth mood and behaviors. However, good family functioning provides support and stability for youth functioning.

Structural family therapy is a systemic treatment approach focused on family interactions as contributing to youth functioning and emotional and behavioral symptoms as serving a purpose across multiple systems (Minuchin et al., 2014). This approach has been found to be more effective than individual therapy (Cottrell & Boston, 2002) by using tools such as joining, reframing, and enactments to externalize the presenting problem and reshape relationships in support of systemic change. From a structural family therapy perspective, emotional and

behavioral dysregulation among low-SES, urban youth serves a purpose within their families and communities, and therefore must be treated across systems.

Trauma-Informed Care

According to Coulter (2014), evidence-based interventions for treating psychological trauma are still in the early stages. Current research is limited to using the diagnostic criteria of PTSD to operationalize experiences of trauma and posttraumatic stress for treatment purposes. To add, there is little research on the diagnostic presentation and treatment of PTSD among adolescents aside from studies focused on sexual trauma (National Institute for Clinical Excellence, 2005; Saunders et al., 2003). Research shows one of the most significant impacts of traumatic stress on children and adolescents is the loss of the ability to regulate the intensity and duration of posttraumatic effects (Bath, 2008), leading to increased emotional and behavioral symptoms.

Bath (2008) prioritized three main trauma-informed principles as fundamental and universal for care: safety, connection, and affect and impulse management. Safety is essential for building trust with youth and families who feel unsafe as a result of trauma or adversity. The clinician is expected to create a space to represent physical and emotional safety as well as consistency, reliability, availability, and honesty. Connection with the clinician is suggested to aid in restructuring negative interpersonal expectations and foster willingness to engage in change and develop positive supportive connections with others. For youth facing chronic stress, Bath suggested forming a healthy connection with a caring adult is most necessary, yet complex because of the undermining nature of trauma. Last, affect and impulse management is an important focus for youth with symptoms of emotional and behavioral impulsivity in order to build locus of control (Alvord & Grados, 2005). The clinician is to guide the young person and

their family through effective coping mechanisms to navigate symptoms of trauma and build empowerment (Bath, 2008).

Harden et al. (2015) developed a trauma-informed, community-based project to study the importance of empowerment among low-SES, urban youth. The Truth N' Trauma project took place on the South Side of Chicago with 44 majority Black and Hispanic youth who reported symptoms of community violence and desired intervention. Truth N' Trauma was implemented for 9 months and included youth participation in one concentration topic: video production, action theatre, or action research. Each concentration used specific methods to increase youth empowerment and leadership. All youth were also provided with training on trauma-informed care and guided through explorations of culture, identity, critical thought, community support, and spirituality. Restorative justice (Zehr, 2002) was noted as a specific technique used to address the harmful impact of trauma and processes to heal.

Youth who participated in the trauma-informed intervention program were compared to youth who received no interventions. Each group was given pre- and postevaluations to measure level of empowerment through indicators of self-esteem, academic achievement, social climate, and sense of community. As well, youth were asked qualitative questions about their involvement in the community, exposures to violence, motives for participating in the project, experiences in the project, and experiences of change. Results showed youth who received Truth N' Trauma interventions experienced significant improvements in qualities of empowerment over time compared to the non-intervention group (Harden et al., 2015). At posttreatment, youth in the intervention group reported increased family problems (e.g., parent separation, loss of parent) and community concerns (e.g., attacked or victimized, discriminated against), though they also reported increased empowerment in school (e.g., engagement in school and after school

activities), the community (e.g., a voice in the community, taking initiative to make change), and within the self (e.g., increased self-improvement, practice in mutual respect; Harden et al., 2015).

Results from the study signify the power of trauma psychoeducation and practice of trauma-informed interventions among professionals as well as youth, families, and community groups (Harden et al., 2015). In addition to a focus on safety, connection, and affect and impulse management (Bath, 2008), TIC is used to build empowerment and leadership skills to overcome adversity and maintain resilience.

Narrative Therapy

Narrative therapy was pioneered in Europe in the 1980s and later expanded across the United States (Epston & White, 1992; Shapiro & Ross, 2002). The approach is based on the premise that individuals give meaning to their lives and relationships through storytelling, and their most prominent stories influence their daily experiences and overall ability to cope with adversity.

Narrative therapy has been found to be effective for the treatment of youth and families with trauma histories (e.g., Ikonomopoulos et al., 2015; Sanborn, 2011; Seymour & Epston, 1989) and those with symptoms of posttraumatic stress, anxiety, and depression (Weber et al., 2006). In particular, research shows low-SES, urban youth often share stories of disadvantage and oppression (Coulter, 2014). Thus, narrative therapy provides understanding and safety through the validation of trauma experiences and unique perceptions of the world.

In a 2015 study conducted by Ikonomopoulos et al., eight incarcerated adolescents engaged in narrative therapy as part of a rehabilitation program. Youth were measured on symptoms including interpersonal hypersensitivity, depression, anxiety, hostility, paranoid ideation, and psychosis. Participants attended 10 sessions of individual narrative therapy.

Therapy techniques included externalizing the problem, mapping and evaluating the effects of the problem, exploring new outcomes, and reauthoring or rewriting the narrative. Results showed narrative therapy reduced global symptoms across the total sample, aside from one participant who had inconclusive results. In response to a narrative approach, youth made significant improvements in the areas of interpersonal hypersensitivity, hostility, and depression. Participants reported narrative therapy provided them with an opportunity to share their stories, explore new elements of these stories, and give meaning to them for the purposes of healing and growth.

Fraenkel et al. (2009) studied the use of narrative therapy techniques with youth and families participating in a shelter-based, multi-family intervention group called Fresh Start. Fresh Start was implemented across three New York homeless shelters, with the mission being to aid parents and families in achieving financial and household stability. In a group setting, families engaged in various methods of reauthoring their problem-focused stories and visualizing their preferred future. A key narrative technique included non-linguistic storytelling, which involved activities such as making collages to depict life's challenges and coping skills, sharing meaningful music, and developing creative performances with families. Study results showed providing youth and families with opportunities to be heard created a safe space to lower guardedness and engage in a new narrative. Youth and families reported having opportunities to share their stories and witness the telling of others' stories normalized their experience and significantly increased family cohesion.

According to Shapiro and Ross (2002), narrative therapy is particularly useful with youth and families who are guarded and hesitant to commit to treatment. These researchers conducted a historical case study of the use of narrative therapy with a noncompliant patient receiving

medical treatment for diabetic complications. Results showed the approach increased the clinician–patient alliance, patient compliance with treatment recommendations, and patient motivation. Key components of narrative therapy were indicated as contributing to these changes. First, the researchers applied a strategic, trauma-informed approach to questioning. Questions were used to gently invite the patient to share their story and be open to the addition of new perspectives. Second, the researchers guided the patient to envision their preferred or ideal outcome in life. This method was used to guide focus on hopeful events that empower change and contradict the current problem-focused narrative. Third, Shapiro and Ross renamed the problem with the patient's language to normalize their experience and de-pathologize their narrative. Fourth, narrative therapy was used to externalize the problem and build the clinician–patient alliance. In separating the problem from the person, trust in the clinicians was strengthened and the patient became open to meaning-making and problem solving. Fifth, the researchers joined with the patient to explore the impact of the problem, rather than the origin. Sixth, Shapiro and Ross searched the patient's narrative for moments of hope and exception to the problem to begin the reauthorizing process. As this research shows, identifying strengths within past narratives can be used as a tool to empower current and future narratives.

> When clients are able to notice all the actions that they chose to engage in, despite the challenge of the situation, and how congruent these actions were with their values, they are more likely to experience themselves as competent and capable individuals. (Coulter, 2014, p. 49)

The researchers remained sensitive to the patient's preference and maintained a supportive role in decision-making and personal choices. Eighth, the researchers conducted ritual exchanges (e.g., letter-writing/sharing) with the patient to maintain the clinician–patient alliance and patient

openness to new perspective. Finally, Shapiro and Ross worked with the patient to generate a healthy support system that prompted accountability, encouragement, and the witnessing of a new and healthy narrative.

Overall, research shows narrative therapy is a trauma-informed approach that best fits the needs of low-SES, urban youth and families who face chronic adversity. Narrative therapy benefits those with trauma histories, including youth engaged in criminal and delinquent behaviors (Ikonomopoulos et al., 2015) and families who face financial instability and impoverished living conditions (Fraenkel et al., 2009). In using the nine components of narrative therapy provided by Shapiro and Ross (2002), trauma-informed clinicians can assist youth and families in externalizing their problems, sharing their narratives, understanding the impact of trauma, and taking on new perspectives to reauthor their stories and establish resilience.

Strengths-Based Care

Across the past 2 decades, there has been a shift from a focus on disorder and dysfunction to a focus on well-being, resources, strengths, and positive mental health (Neipp et al., 2016; Peterson, 2006). Research highlights that therapy approaches with more focus on client problems versus strengths generally give less direct attention to positive development and empowerment of resources. Therefore, problem-centered approaches function from an incomplete picture of young people and families (Marques et al., 2011). Contrary to the notion that strengths-based care (SBC) minimizes presenting problems, this approach focuses on expanding life and adverse experiences to include strengths and solutions. Research shows strengths and presenting problems are on two separate continuums and therefore can be focused on simultaneously in treatment (Scheel et al., 2012).

SBC stems from positive psychology, which took form in the 1990s, and theories of achievement of happiness and fulfillment of inner potential. Aristotle's vocabulary for this experience was eudaimonia (Peterson, 2006). In Peterson et al.'s (2005) research on orientation to happiness and life satisfaction, results confirmed that increased pleasure, engagement with others, and meaning-making led to greater life satisfaction over time, regardless of presenting problems. In 2011, Marques et al. studied the role of hope and life satisfaction in predicting academic achievement and mental health among youth. Their longitudinal study took place over 3 years and involved 367 participants. Similar to Peterson et al.'s (2005) study, results of Marques et al.'s study showed increased levels of hope and life satisfaction led to stronger academic performance and emotional and behavioral health over time. Findings from both studies indicate maximizing positivity and social support improves life satisfaction, academic achievement, and overall mental health.

In 2006, Peterson developed a categorization system for inner strengths called Values in Action (VIA). VIA is based on the notion that the most central qualities contributing to happiness and resilience are not zero-sum and therefore do not depend on environmental context or SES. This belief also indicates there are innate human strengths and internal resources available to low-SES, urban youth and families despite exposure to chronic adversity. Peterson's (2006) VIA system labels 24 character strengths that fall within five categories of virtues. Character strengths are defined as unique psychological mechanisms that demonstrate virtues, and virtues are defined as core, human characteristics that are universally valued and contribute to human excellence.

The first virtue, wisdom and knowledge, is defined by character strengths in creativity, curiosity, judgment (i.e., critical thinking), love of learning, and perspective-taking. The second

virtue, courage, is described by character strengths in bravery, persistence, authenticity, and vitality. The third virtue, love, is categorized by strengths in intimacy, kindness, social intelligence, justice, fairness, and leadership. The fourth virtue, temperance, includes strengths in forgiveness, humility, prudence, and self-regulation. Finally, the fifth virtue, transcendence (i.e., meaning-making and connection with the larger universe), is defined by character strengths in appreciation of beauty and excellence, gratitude, hope, humor, and spirituality (Peterson, 2006).

The VIA system is used formally and informally as a tool in treatment to identify resilience qualities, build empowerment, and combat stress. Research shows fostering character strengths in treatment leads to reduced depression and suicidal ideation among youth (Park, 2009). As well, studies indicate character strengths in leadership, kindness, altruism, diversity awareness, and delayed gratification are associated with increased academic achievement and life fulfillment among young people (Scales et al., 2000). Ultimately, a focus on inner strengths and virtues in treatment with low-SES, urban youth and families can reduce emotional and behavioral distress and increase positive life engagement.

> It is difficult to define SBC by a set of evidence-based interventions. Research shows, the positive psychology movement has created interest and energy to find ways to optimize human functioning, but the explicit identification of positive processes in therapy to access and use human strengths seems to have not kept pace with the movement. (Scheel et al., 2012, p. 4)

Thus, Scheel et al. (2012) conducted a qualitative analysis to identify the key processes strengths-based therapists use in therapy to address client problems and maximize solutions. The researchers evaluated eight therapists working within a community mental health center in a Midwest city. Therapists presented with differing theoretical orientations, clinical backgrounds,

and years of clinical experience, yet considered themselves strengths-oriented in practice. The researchers analyzed session transcripts and verbal reports from therapists to measure their use of strengths-based interventions in treatment.

Results revealed four themes of SBC intervention across therapists: amplification of strengths, contextual considerations, orientation toward strengths-based outcomes, and positive meaning-making (Scheel et al., 2012). Primary areas of focus in sessions included building the therapeutic alliance, increasing motivation, instilling hope, providing clients with positive regard and a sense of empowerment, and broadening the perspective of the presenting problem. The therapists focused on both problems and strengths in sessions. Rather than omitting problem-talk, therapists labeled exceptions to the problem and emphasized strengths to provide solutions.

In conclusion, SBC is a pivotal approach to treatment with youth and families that expands the perspective of the problem with consideration of context, resources, and ability to overcome (Coulter, 2014).

Solution-Focused Brief Therapy

Solution-focused brief therapy (SFBT) is an effective treatment approach used with youth and families (Coulter, 2014). Therapy emphasizes the resources youth and families already possess to aid in the adaptive change process. Key elements of SFBT include a focus on client goals, eliciting exceptions to the problem, and maximizing client strengths to generate solutions (Bond et al., 2013).

In 2011, the Department for Education commissioned a systemic literature review to assess the efficacy of SFBT in the treatment of youth and families and to identify which presenting problems are most receptive to SFBT. Researchers (Bond et al., 2013) reviewed 38 studies that took place between the years of 1990 and 2010. There were mixed results for the

efficacy of SFBT, with some studies showing minor effectiveness for general youth treatment (e.g., Conoley et al., 2003; Corcoran & Stephenson, 2000; T. S. Zimmerman et al., 1996). However, a majority of the studies showed significant effectiveness for the treatment of internalizing and externalizing symptoms among youth (e.g., Cepukiene & Pakrosnis, 2010; Frels et al., 2009; Georgiades, 2008; Korman, 1997; Shin, 2009; Wilmshurst, 2002). In one study (Wilmshurst, 2002), SFBT was applied to youth with severe emotional and behavioral symptoms. Results showed SFBT improved social skills and decreased anxiety, depression, and ADHD symptoms posttreatment. Thus, SFBT is suggested to be an appropriate approach to treatment for low-SES, urban youth with emotional and behavioral dysregulation.

In application, SFBT uses exception-talk (i.e., identification of times when the problem was manageable or not present) as a primary way to guide families in identifying available resources used to combat problems in the past (Corcoran, 2002). Exception-talk is elicited through therapeutic questioning and the use of meaning-making to encourage insight into resilience (Neipp et al., 2016). SFBT includes three primary methods of questioning: the miracle question, coping questions, and scaling questions (Berg, 1994; Bond et al., 2013; Corcoran, 2002; De Shazer, 1994).

The miracle question encourages youth and families to envision a future without the current problem. The clinician might ask the family, “If you woke up tomorrow and a miracle happened, causing your problem to go away, what would that look like?” With this question, the therapist conjures details of family interactions and realistic steps for new and attainable goals. Coping questions are particularly useful for families who bring youth into treatment with the belief that they are the problem that must be fixed (Corcoran, 2002). This perception is common among parents of youth with emotional and behavioral dysregulation, as they have likely

engaged in many failed efforts to regulate conflict, delinquency, or aggression. Thus, to remain sensitive to different perspectives and still challenge the family's understanding of the problem, the clinician can curiously inquire about coping skills and resources relied upon in daily interactions. The therapist might ask a parent, "How are you able to manage your emotions in that moment?" (Corcoran, 2002, p. 303). Ultimately, coping questions are used to validate resilience and identify resources to obtain desired goals.

Last, scaling questions are used as a ranking process to identify progress and motivate youth and families to take small steps toward desired outcomes. Envisioning progress in terms of a scale (e.g., 1 to 10) enables families to think of behaviors and goals on a continuum, rather than all-or-nothing (Corcoran, 2002). A scaling question might sound like, "On a scale of 1 to 10, how likely are you to meet your goal for today?" Corcoran (2002) suggested that following a scaling question, the clinician should ask additional questions to initiate task-setting, such as, "What needs to happen for you to move from a 5 to a 6 in meeting your goal for today?" In general, questions as an SFBT intervention are used to provoke new perspectives, implement strengths, and create movement toward the preferred future.

Neipp et al. (2016) evaluated the differing impact of solution-focused questions versus problem-focused questions on young-adult students. The researchers tested the hypothesis that problem-focused questions search the origin and determinants of a problem and therefore perpetuate it, whereas solution-focused questions target current resources and steps for achieving goals. A total of 204 students participated in the study and were measured on affect, self-efficacy (i.e., belief in one's ability to complete tasks and solve problems), goal approach, and action steps. Participants were asked to describe a real problem they were facing and complete an online questionnaire in which they answered either problem-focused or solution-focused

questions. Following, participants listed action steps they intended to take to reach their goals or overcome their problem.

Results showed solution-focused questioning reduced negative affect, though it did not increase positive affect (Neipp et al., 2016). Problem-focused questioning did not have a significant impact on negative or positive affect. Both methods of questioning did lead to increased self-efficacy, goal-approaching, and action-planning; however, participants who were asked solution-focused questions demonstrated greater improvements in these areas (Neipp et al., 2016). Evaluation of problem-focused questioning highlighted a new understanding that problem-related talk is not innately negative and does not need to be avoided when conducting solution-focused interventions. Rather, solution-focused talk increases the chances of experiencing significant changes.

Additional techniques that are vital within SFBT and must be reiterated in this review include normalizing, reframing, emphasizing context, and externalizing (Corcoran, 2002; White & Epston, 1990). Normalizing is used to depathologize youth, families, and their problems by presenting their situation as a part of moral and life adversity. When treating youth, the clinician normalizes their stage of psychosocial development and self-exploration. Reframing, as mentioned prior (i.e., structural family therapy; Minuchin, 1974), capitalizes on positive aspects of youth and family interactions and a new perspective of adversity to include strengths and resources. Reframing is powerful in shifting a problem to be workable and the solution to be apparent. Emphasizing context is used to validate the influence of the environment on presenting problems. This tool includes eliciting details from parents and siblings about their roles in generating exceptions to the problem. Finally, externalizing, another technique mentioned previously in this chapter (i.e., structural family therapy, Minuchin, 1974; narrative therapy,

Ikonomopoulos et al., 2015; see also Shapiro & Ross, 2002), builds separation between the problem and the symptom-barer to enable recognition of strengths and empowerment (Corcoran, 2002).

In conclusion, SFBT is a strengths-based approach that shifts clinical focus from the problem to the solution. Though problem-focused talk and questions can be of no harm to youth or families and even lead to improvements, solution-focused dialogue actively decreases negative emotions and increases self-confidence and the capacity to set and obtain goals (Neipp et al., 2016). For low-SES, urban youth and their families, the purpose of using SFBT methods would be to separate the youth from their symptoms of emotional and behavioral dysregulation and determine new ways to maximize youth and family strengths, maintain healthy support systems, and move toward the desired future.

Conclusion

There are various evidence-based methods for providing treatment to youth and families. This chapter was designed to answer the second research question: What makes trauma-informed, strengths-based care optimal for the treatment of low-SES, urban youth with dysregulation? The chapter included a discussion of principles and methods for treating emotional and behavioral distress and other presenting problems common among low-SES, urban youth and families. Three approaches were explored: systemic care (e.g., Minuchin, 1974), TIC (e.g., Shapiro & Ross, 2002), and SBC (e.g., Corcoran, 2002).

Systemic and structural family therapies have been successful in treating youth with severe conduct issues and legal implications. Systemic therapies have been shown to strengthen family support and parent–youth bonds, which enable youth regulation of mood and behaviors (Sydow et al., 2013; Szapocznik et al., 1989). TIC has been shown to be beneficial with low-

SES, urban youth with symptoms of distress, as demonstrated in Harden et al.'s (2015) south Chicago study. TIC interventions focused on increasing knowledge of trauma, creative expression, and community engagement have shown the greatest influence. Narrative therapy is a TIC approach that has been effective in treating youth and families with exposures to trauma and adversity, through communal storytelling and perspective-taking (Fraenkel et al., 2009; Ikonomopoulos et al., 2015). Last, SBC and SFBT have been deemed beneficial to youth with behavioral dysregulation as well as anxiety and depression (Wilmshurst, 2002). SFBT encourages perspective-taking toward hope (Marques et al., 2011), resilience, and goal attainment (Neipp et al., 2016), and builds empowerment and achievement of goals.

Overall, this review indicates integrating principles and interventions from all approaches described within this chapter yield best practice for the treatment of low-SES, youth with emotional and behavioral dysregulation. In the next chapter, the review moves to providing integrated guidelines for conducting family therapy with low-SES, urban youth consisting of integrated trauma-informed, strengths-based interventions.

CHAPTER IV: GUIDE FOR THERAPEUTIC APPLICATION

This chapter is designed to address the third research question: What are clear guidelines for providing trauma-informed, strengths-based care to low-SES, urban youth with dysregulation? The chapter provides a guide to outpatient therapy for youth and their families from an integrated and systemic trauma-informed, strengths-based perspective.

Seven elements were generated by the reviewer based on evidence-based concepts and interventions presented across Chapter 3, including techniques from SFT and structural family therapy, narrative therapy, and SFBT. As this review consistently revealed the role of environmental context in the development of emotional and behavioral distress, guidelines are sensitive to the impact of community risk factors on the response to treatment among low-SES, urban youth and families. Furthermore, guidelines exemplify the use of character strengths, family virtues, and alternative resources to achieve empowerment and future goals.

The guide represents a flexible approach to treatment and meeting the unique needs of low, SES urban families (Bond et al., 2013). The seven elements in this chapter can be used as a stepwise and simultaneous intervention process for providing care. Clinicians are encouraged to use their clinical discretion when moving through the guidelines and to seek supervision and consultation when necessary. Novice clinicians are encouraged to seek supervision and consultation when providing treatment to any diverse populations. The elements are (a) engage in clinical preparation, (b) initiate a strong therapeutic alliance, (c) assess basic needs and community resources, (d) validate the trauma narrative, (e) empower systemic family change, (f) build strengths and reauthor the trauma narrative, and (g) establish and obtain unified goals.

Element 1: Engage in Clinical Preparation

First, in preparing to treat urban youth and families, clinicians must explore their own personal diversity awareness and cultural humility. Trauma-informed, strengths-based clinicians are expected to maintain awareness of their own cultural values and biases prior to entering treatment with all clients. Before engaging in treatment with low-SES, urban youth and their families, clinicians are to process their personal views of sensitive topics, including racial disparity and discrimination, systemic poverty, and delinquent and aggressive youth behaviors.

As low-SES, urban communities are known to be disproportionately inhabited by Black families and families of color (Copeland-Linder et al., 2011), clinicians must consider their clinical experience in working with diverse racial groups. As well, they should have insight into any stereotypical beliefs and expectations they hold toward youth and families of color. With increased cultural awareness at the start of providing care, clinicians can become available to embrace youth and family values. By embracing family values, clinicians demonstrate positive regard for the family and reinforce feelings of safety and commitment to treatment. Overall, clinicians are to prepare for acculturating themselves as well as the family to treatment (Simmons et al., 2008).

Trauma-informed, strengths-based clinicians must have a good understanding of strengths, believing all individuals, families, and communities possess strengths. Clinicians must grasp the idea that many important strengths are not zero-sum and can include character traits and virtues (Park, 2009; Peterson, 2006). As well, strengths are influenced by cultural context (Coulter, 2014; Harris et al., 2012). Thus, low-SES, urban youth and families are expected to present to treatment with character strengths and access to some community resources depending on neighborhood location and communication access.

In conclusion, trauma-informed, strengths-based clinicians must prepare to provide treatment that is supportive of strengths, considerate and appreciative of diversity factors, and free from judgment and discrimination.

Element 2: Initiate a Strong Therapeutic Alliance

Research emphasizes the notion that the therapeutic alliance is the primary agent for client change (Minuchin, 1974). Therefore, clinicians must establish trust with youth and their families at the start of treatment to allow time for their acculturation to services (Henggeler et al., 1996; Minuchin et al., 2014) and growth in feelings of safety and security. Research shows many low-SES, urban youth and families enter treatment with guardedness and poor expectations for change as a result of their chronic histories of adversity and societal barriers (Fraenkel et al., 2009). Thus, it is the trauma-informed, strengths-based clinician's duty to provide an environment of safety and meaningful connection (Bath, 2008) that strengthens the therapeutic relationship and provokes willingness to change.

Minuchin et al. (2014) indicated families who are guarded respond best in treatment to clinicians who function as a curious expert. In this role, the clinician grows the therapeutic alliance via the use of curious questioning and nonjudgmental dialogue. Dialogue is used to empower families to identify their problems, strengths, and pioneer their own change process. Examples of curious dialogue include: "I wonder what triggers your anger and frustration"; "I can't imagine how you've managed to deal with so much stress for so long"; and "Wow, you've gone through many obstacles. How has the family supported each other?" Curiosity from the clinician functions to gently build the therapeutic relationship through genuine clinician and family exchange as well as family storytelling.

When establishing the therapeutic alliance, the clinician is joining with the family (Minuchin et al., 2014). The joining process must be consistent and predictable across all family members in order for the clinician to maintain a position of integrity and equal ability to challenge system rules and boundaries (Minuchin, 1974). In joining with low-SES, urban youth and families, the clinician must maintain a balance between relationships with family members and sensitivity toward their hesitations in receiving treatment. It is important that the clinician not label nor treat the youth with emotional and behavioral dysregulation as the problem, but rather demonstrate positive regard and a genuine willingness to understand their narrative.

Ultimately, it is the trauma-informed, strengths-based clinician's role to engage the youth and their family in unconditional feelings of safety, acceptance, and willingness to change by consistent influence of the therapeutic alliance.

Element 3: Assess Basic Needs and Community Resources

When providing treatment to low-SES families, it is a priority to assess basic needs and access to community resources prior to setting higher-level treatment goals. If unmet basic needs are high at the start of treatment (e.g., transportation), it is likely that the family will have trouble committing to services. As well, it is likely families with chronic unmet needs will terminate treatment early (Fraenkel et al., 2009; Shapiro & Ross, 2002).

The trauma-informed, strengths-based clinician is expected to aid families in networking with community resources that are affordable and accessible (Simmons et al., 2008). For low-SES, urban youth and families, the clinician might need to assist in connecting them with services for housing, transportation, childcare, and food and hygiene supply. Providing support in building these networks contributes to overall well-being as well as empowers youth and their

families to initiate meeting their own basic needs and creating healthy community relationships (Bath, 2008; Fraenkel et al., 2009).

In conclusion, clinicians working with low-SES, urban youth and families must consider the impact of contextual and financial stressors on functioning and proactively support families in establishing a basic sense of stability prior to engaging in treatment (Scheel et al., 2012).

Element 4: Validate the Trauma Narrative

Within trauma-informed, strengths-based therapy, youth and their families are encouraged to share their narratives. It is important to note that though this treatment takes on a strengths-based approach, therapy first includes exploring and validating the current narrative, solely from the youth and family's perspectives. Following, the clinician can encourage a new perspective, including moments of exception to the problem and when strengths or resilience were present (Ikonomopoulos et al., 2015; Scheel et al., 2012).

As the homeless, urban families reported in the Fresh Start project, the restorative process for exposure to chronic adversity includes the telling, hearing, and witnessing of narratives (Fraenkel et al., 2009). Thus, trauma-informed, strengths-based clinicians are to normalize trauma narratives by simply listening and reflecting back the family's thoughts and emotions (Corcoran, 2002). As well, to build trust in the therapeutic alliance and depathologize the symptom-bearer, the clinician is to externalize the problem as an entity separate from and not representative of any one family member (Shapiro & Ross, 2002). Through this process, the family is challenged to consider their multiple roles in maintaining the problem (Corcoran, 2002; White & Epston, 1990).

In treatment for low-SES, urban youth and families, the clinician must take time to understand narratives that include elements of poverty, neighborhood disorganization, racial

disparity and discrimination, and community violence. While listening to trauma narratives from each family member, the clinician is to normalize and externalize the youth's emotional and behavioral dysregulation. As well, the clinician should provide psychoeducation on how dysregulation serves as a symptom of adversity and is contributed to and maintained by patterns of family engagement.

Overall, trauma-informed, strengths-based clinicians must allow time and space for low-SES, urban youth and families to share their trauma narratives. In doing so, the clinician has opportunities to explore and validate their stories, externalize trauma symptoms, and create insight into family member contribution to symptoms.

Element 5: Empower Systemic Family Change

In order for youth to generate long-lasting change, research indicates the immediate family should be involved in treatment (Minuchin et al., 2014). This is not to suggest that involving the family is the ultimate solution for change; however, as the family generally represents the young person's main support system (Minuchin, 1974), restructuring this system can have a significant impact on symptoms of stress.

The trauma-informed, strengths-based clinician works with the family to understand their contribution to and maintenance of youth symptomology. The clinician might provoke insight by exploring family rules, including the impact of subsystem relationships (e.g., mother–father, mother–son), alliances, and dominance hierarchies on system relationships (Minuchin et al., 2014). Family rules and interactions can be observed and disrupted by the clinician through enactments (Minuchin, 1974; Minuchin et al., 2014). In this regard, the clinician uses moments in session to observe family interactions and interrupt problematic exchanges so they can be restructured (Cottrell & Boston, 2002). Cottrell and Boston (2002) suggested family treatment

should include restructuring to increase regulation of affect (i.e., warmth, acceptance, affection, aggression), conflict (i.e., cooperation, accommodation, hostility, argumentativeness, interruptiveness), and dominance (i.e., relative power and influence, fulfillment of personal choice).

To add, an impactful component of strengths-based family care is the teaching and practice of authoritative parenting (Forehand & Jones, 2002). Trauma-informed, strengths-based clinicians are expected to incorporate psychoeducation on authoritative parenting so parents can learn skills for establishing clear and consistent family rules, as well as developing an environment of warmth and acceptance for their youth. Authoritative parenting includes skills in parent-monitoring and appropriate boundaries around youth independence. Through improved authoritative parenting and healthy parent–youth communication, youth are expected to demonstrate long-term improvements (Darling & Steinberg, 1993; Forehand & Jones, 2002).

In treatment with low-SES, urban youth and their families, it is important to understand how emotional and behavioral dysregulation is viewed within the home. The clinician must use family enactments to disrupt and restructure interactions that lead to anger and frustration, argumentativeness or disagreement, and dominance struggles. The clinician should also label and validate healthy interactions that lead to acceptance, cooperation, and personal fulfillment. Over time, youth are expected to demonstrate an increased ability to regulate emotions and behaviors (i.e., symptoms of adversity) as a result of improved family boundaries and support (Forehand & Jones, 2002; Sydow et al., 2013), including increased parent-monitoring and communication, which are known to be protective factors for this population (Ceballo et al., 2003; Griffin et al., 2000).

To conclude, trauma-informed, strengths-based clinicians must work to restructure the family system in treatment for low-SES, urban youth to change problematic patterns that enable dysregulation, strengthen positive interactions and authoritative parenting skills that increase regulation, and develop a greater sense of family cohesion and support toward change.

Element 6: Build Strengths and Reauthor the Trauma Narrative

A foundational element of trauma-informed, strengths-based care is the belief that all humans have innate strengths and internal resources, regardless of external forces (Peterson, 2006). This belief aligns with research that shows there is a profound impact of a focus on strengths, positive circumstances, and happiness on overall life satisfaction (Peterson et al., 2005). For low-SES, urban youth and families, labeling character strengths and virtues is essential to combating chronic community stressors.

In treatment, the clinician is to use the VIA categorization system (Peterson, 2006) as a reference to assess youth character strengths, as well as strengths or virtues within the family. Character strengths that could be valuable to accentuate with a low-SES, urban young person include love of learning, social intelligence, justice, leadership, forgiveness, self-regulation, gratitude, and hope. These strengths can be used as protective factors against emotional and behavioral distress (Park, 2009). To add, the identification of family values and virtues (e.g., knowledge and wisdom, courage, love, temperance, and transcendence) can aid in restructuring the family system by placing emphasis on the system's protective qualities and positive interactions. Overall, emphasis on youth strengths and family virtues provides low-SES, urban youth with positive regard and the systemic support they need to overcome adversity.

From a trauma-informed, strengths-based perspective, building strengths is a method of fine-tuning effective coping and empowerment skills and minimizing symptoms of stress (Bath,

2008). In therapy, the clinician is to highlight various resources for coping through an exploration of culture, individual identity, critical thinking skills, community support networks, and spirituality (Harden et al., 2015). The development of strengths in these areas releases low-SES, urban youth from the role of being emotionally and behaviorally dysregulated and enables a new perspective by considering unique identities and empowerment through coping abilities to combat neighborhood stress, violence, and discrimination.

Following the sharing of trauma narratives at the start of treatment (Element 4), youth and families are now encouraged to search their stories for meaning, hope, and strength. The clinician must work with the family to shift focus from moments of stress to moments of exception to stress (Shapiro & Ross, 2002). As a result, the reauthoring process takes place (Shapiro & Ross, 2002; White & Epston, 1990). Reauthoring includes incorporating all actions that took place within a narrative; in particular, actions that were congruent with core values and not evident in the initial trauma narrative (Coulter, 2014; Park, 2009). At this point, storytelling is used to identify the problem and stressors as well as solutions, coping skills, and strengths. The new narrative should eventually carry additional themes of empowerment and resilience in response to trauma. For low-SES, urban youth with emotional and behavioral dysregulation, the clinician must not only challenge the family to understand youth symptoms as a post-trauma stress response, but to consider other identities of the youth and their positive attributes that contribute to resilience (e.g., love of learning, leadership, gratitude).

Finally, storytelling and reauthoring should occur through linguistic and non-linguistic means. Fraenkel et al. (2009) suggested non-linguistic reauthoring can often be more captivating for guarded youth through less-intrusive avenues of meaning-making. Thus, non-linguistic methods for the telling and retelling of stories are most beneficial for low-SES, urban youth and

families who enter treatment with reservations. Useful non-linguistic techniques have included creating challenges and strengths collages, sharing meaningful music, and engaging in creative family role-plays or performances (Fraenkel et al., 2009).

Overall, trauma-informed, strengths-based clinicians must believe in the strengths of low-SES, urban youth and families and collaborate with them to incorporate these strengths into their trauma narratives. For youth with dysregulation, identifying strengths and ability to overcome lends to their ability to self-regulate and engage in a new perspective of the self. For families, reauthoring trauma narratives with their youth changes their perspective of the problem, encourages a new appreciation for their young person, and prompts family cohesion and support toward improvement.

Element 7: Establish and Obtain Unified Goals

Overall, it is the clinician's role to support youth and families in determining their own goals for treatment as well as the future. The clinician must remember to remain behind the family in making goal-oriented decisions to empower the use of their voices and pursuit of realistic and attainable solutions (Corcoran, 2002).

For youth presenting to treatment with their families, initial goals may look different based on unique perspectives of the problem and its solutions. For low-SES, urban youth with emotional and behavioral dysregulation, family goals might include increased youth compliance with household rules and reduced problematic behaviors, whereas youth goals might include greater understanding from others and social independence. Thus, the clinician must be diligent in helping the family navigate differing goals in relation to one another. Perspective-taking around goals and solutions is best engaged through the telling and retelling of family narratives (Minuchin et al., 2014; Shapiro & Ross, 2002). When it comes time to set goals, the clinician

must guide the family in using a unified perspective to create the same goals by highlighting common themes across narratives. In the formulation and application of joint goals, the clinician must then encourage the family to rely on strengths for newfound coping and resilience.

From a trauma-informed, strengths-based perspective, the use of questions can aid in determining goals; however, questions must remain thoughtful and curious to foster therapeutic rapport and effectively empower the family (Minuchin et al., 2014). Questions can include the miracle question, coping questions, and scaling questions (Corcoran, 2002). The miracle question aids the family in envisioning the future they desire and identifying steps toward obtaining that future (Shapiro & Ross, 2002). With low-SES, urban families, the clinician must remain mindful when using the miracle question, as resources are strained and achieving miracles will include unique obstacles. It is important that the clinician supports the family in developing hope toward a future that is realistic and attainable. Based on responses to questions, a low-SES, urban young person and their family might agree to work toward goals such as family cohesion, practice of coping skills, open communication, and establishment of a family member reward system.

To end, the setting and meeting of unified goals within a family is important to the change process for youth. In order for low-SES, urban youth with emotional and behavioral dysregulation to decrease poor behaviors and follow household rules, they must feel supported and be joined by their primary support system to combat stress. Thus, family members must be engaged in solutions through perspective-taking, shared responsibility, and goal collaboration. As well, goals should be reliant on individual and family strengths, as well as tangible hopes for the future.

Conclusion

Working with youth and families in therapy is an intricate process. In particular, providing care to low-SES, urban youth and families comes with various considerations and areas of focus. This chapter was used to answer the third research question: What are clear guidelines for providing trauma-informed, strengths-based care to low-SES, urban youth with dysregulation?

The chapter contained seven original guidelines for trauma-informed, strengths-based care. Element 1: Engage in Clinical Preparation focuses on strengthening the clinician's cultural humility and diversity awareness and maintaining an open perspective of strengths for working with low-SES, urban youth and families. Element 2: Initiate a Strong Therapeutic Alliance targets aspects of the therapeutic relationship that are necessary in working with guarded youth and families. These aspects include connection and safety (Bath, 2008). Element 3: Assess Basic Needs and Community Resources emphasizes the importance of meeting basic family needs and establishing a basic sense of household stability prior to alternative treatment goals. Element 4: Validate the Trauma Narrative focuses on actively listening to the stories of low-SES, urban youth and their families as well as externalizing symptoms of emotional and behavioral dysregulation from the youth and encouraging new perspectives of systemic contributions to symptomology. Element 5: Empower Systemic Family Change includes disrupting the family system to empower new and positive interactions and applying authoritative parenting to increase family cohesion and efforts toward change. Element 6: Build Strengths and Reauthor the Trauma Narrative capitalizes on the application of character strengths (Peterson, 2006), virtues, and alternative resources (e.g., community networks, spirituality) to reauthor the stories of youth and families with focus on empowerment and resilience. Finally, Element 7: Establish

and Obtain Unified Goals focuses on youth and family perspective-taking and collaboration around creating solutions and meeting goals. This element indicates youth and families must pioneer their change and engage in common efforts to diminish symptoms and increase coping and resilience.

This chapter integrated elements of systemic, trauma-informed, and strengths-based care for effective use in the treatment of low-SES, urban youth with emotional and behavioral dysregulation. The seven guidelines for care emphasize the importance of validating the youth and family's experience and understanding emotional and behavioral dysregulation within the context of trauma as serving a systemic purpose. As well, the guidelines focus on altering the youth's narrative to create space for strengths and to engage the family in taking responsibility for symptoms and united efforts toward change. Trauma-informed, strengths-based guidelines highlight the need for collaboration among the clinician, youth, and their family to create open perspectives toward differing trauma narratives and common ground for meeting new goals. Ultimately, the family must be willing to work together to improve coping skills, network with community resources, and maintain household stability to combat stress.

CHAPTER V: CONCLUSION

This review covered the many layers of treatment for low-SES, urban youth. Specifically, the focus was on understanding the trauma experience of low-SES, urban youth as well as their families. The reviewer developed guidelines of care for youth with emotional and behavioral dysregulation resulting from exposures to chronic community stress that are based on an integrated trauma-informed, strengths-based approach and include youth and family participation in psychotherapy.

Chapter 1 was used to address the first research question: How can emotional and behavioral dysregulation be symptoms of trauma among low-SES, urban youth? The chapter included discussions of aspects of adversity and chronic stress that low-SES, urban youth and their families face, including community distress (Finkelhor et al., 2009; Youngstrom et al., 2003) and family distress (Dil & Vuijk, 2012; Stolbach et al., 2013). Emotional and behavioral dysregulation was thus described as a posttraumatic stress response to routine adversity (Copeland-Linder et al., 2011). Emotional dysregulation was defined as a disruption to affect regulation within the prefrontal cortex and amygdala as a result of chronic stress (Evans & Kim, 2013; Morawetz et al., 2017). Emotional dysregulation was characterized by neurological hyperarousal toward potential threat (McCoy et al., 2016), with an influence on emotions including fear, anger, and sadness (Cole et al., 1994). Behavioral dysregulation was defined as a context-specific response to emotional dysregulation, which include aggression, violence, and delinquent or criminal behaviors (Sullivan et al., 2010; Zeman et al., 2002). The presentation of emotional and behavioral dysregulation among low-SES, urban youth was noted as a unique response to daily exposures to low-income living conditions, as well as community violence and criminal activity (Sullivan et al., 2010). Finally, Chapter 1 introduced relevant psychotherapy

approaches for the treatment of trauma-related emotional and behavioral dysregulation. Approaches that were highlighted included systemic care (Minuchin, 1974; Simmons et al., 2008), TIC (Felitti et al., 1998; Lucio & Nelson, 2016), and SBC (Coulter, 2014; Drolet et al., 2007).

Chapter 2 also was used to address the first research question: How can emotional and behavioral dysregulation be symptoms of trauma among low-SES, urban youth? The chapter first provided information on resilience theory (Kelly, 1968; Khanlou & Wray, 2014). The section highlighted resilience as it occurs across multiple systems (Bronfenbrenner, 1979; Shaw et al., 2016) and relies on individual strengths as well as adaptability, the establishment of new resources, and coping with stress over time (Grych et al., 2015). As well, resilience was noted to include posttraumatic growth, a concept that indicates positive change can occur as a result of trauma (Jirek & Saunders, 2018, Rutter, 2012). Risk factors associated with urban living and youth dysregulation discussed in this chapter included racial and ethnic disparity (Andrews et al., 2015; Schuck, 2005), racial and ethnic discrimination (Copeland-Linder et al., 2011; Jirek & Saunders, 2018; Tobler et al., 2013), poverty and neighborhood disorganization (Roche et al., 2003; Vogel & Van Ham, 2018), and community violence (Burnside & Gaylord-Harden, 2019; Richards et al., 2015). Protective factors associated with urban youth resilience were explored and included racial and ethnic identity (Tummala-Narra et al., 2014; Williams et al., 2014), parent-monitoring and communication (Ceballo et al., 2003; Forehand & Jones, 2002; Griffin et al., 2000), and school and academic interest (Ludwig & Warren, 2009; Morales, 2010).

Chapter 3 was used to address the second research question: What makes trauma-informed, strengths-based care optimal for the treatment of low-SES, urban youth with dysregulation? The chapter began with an overview of systemic care, which involves the family

and elements of community and culture in treatment (Sydow et al., 2013). Specifically, the chapter covered systemic family therapy (SFT; Cottrell & Boston, 2002; Henggeler et al., 1996) and structural family therapy (Minuchin, 1974; Minuchin et al., 2014; Szapocznik et al., 1989) as psychotherapeutic applications of systemic care that include the youth's immediate support systems in the change process. Next, the chapter moved to a review of TIC with an emphasis on remaining sensitive to the impact of adverse experiences and the healing process (Bath, 2008; Harden et al., 2015). In particular, narrative therapy was explored as a way to create healing and empowerment through the sharing and reauthoring of trauma narratives (Fraenkel et al., 2009; Ikonomopoulos et al., 2015; Shapiro & Ross, 2002). Finally, SBC was explored (Peterson, 2006; Scheel et al., 2012). Particular emphasis was placed on SFBT as an approach that accentuates strengths and centers treatment on unifying family solutions and goals (Bond et al., 2013; Corcoran, 2002; Neipp et al., 2016). Overall, each treatment approach and intervention was noted as beneficial to youth and family relationships and for youth and families who have experienced trauma, youth with trauma-related emotional and behavioral distress, and youth and families who present to treatment with guardedness or hesitation.

Finally, Chapter 4 was used to address the third research question: What are clear guidelines for providing trauma-informed, strengths-based care to low-SES, urban youth with dysregulation? The chapter included seven elements of care generated by the reviewer that focused on the many aspects of providing effective treatment to low-SES, urban youth with dysregulation. Element 1: Engage in Clinical Preparation focused on the clinician's ability to face personal biases in working within the urban context, which involves youth and families who are low-SES and racially and ethnically diverse. As well, Element 1 encouraged clinician development of a new perspective toward strengths and resilience among low-SES, urban youth

and families. Next, Element 2: Initiate a Strong Therapeutic Alliance emphasized the clinician's power to create safety and an open environment for change. Element 2 also focused on maintaining a thoughtful position within the family system to maximize clinical integrity and the therapeutic alliance. Element 3: Assess Basic Needs and Community Resources targeted the importance of creating basic human stability within the family prior to meeting more complex treatment goals. Element 4: Validate the Trauma Narrative recognized the need for sharing, hearing, and witnessing youth and family trauma narratives to build trust in the psychotherapy process and willingness to change. Next, Element 5: Empower Systemic Family Change included methods for externalizing youth symptoms and restructuring family interactions to establish equal responsibility for the problem as well as equal efforts toward a solution. Element 6: Build Strengths and Reauthor the Trauma Narrative focused on identifying internal strengths, family virtues, and alternative resources to incorporate into youth and family narratives and to build empowerment, resilience, and ability to cope with difficult emotions and behaviors. Last, Element 7: Establish and Obtain Unified Goals highlighted the clinician's role in validating differing youth and family goals and building collaboration and consistent efforts toward unified change.

Overall, the review revealed trauma-informed, strengths-based care to be an optimal treatment approach for low-SES, urban youth with emotional and behavioral dysregulation. Dysregulation must be understood within the context of culture as well as regular exposures to violence, discrimination, depravity, and more. As well, resilience and the ability to cope with trauma exposures must be understood within a cultural context in light of youth and family strengths. The review indicates low-SES, urban youth must have their families included in treatment to change their role as symptom-bearer and to create unified support and efforts toward

change. Youth and their families are to be engaged in storytelling and retelling across their time in psychotherapy in order to process traumas, identify strengths, and reauthor narratives with a sense of empowerment. Youth and families in trauma-informed, strengths-based treatment are expected to find healing from symptoms by expressing themselves and learning in new and creative ways. When youth and families work together to meet treatment goals, they reinforce a balanced sense of identity, empowered ability to cope, feelings of support, and realistic hope for the future.

Study Limitations

As the current body of work reflects a critical literature review, guidelines and suggestions are limited to alternative evidence-based research and study findings. As there is little published on treatment with low-SES, urban youth with dysregulation, this review included research and assessment results focused on treatment with a variety of populations, including low-SES, urban youth (e.g., Harden et al., 2015); youth and families (e.g., Minuchin et al., 2014; Sydow et al., 2013); youth and families with trauma experiences (e.g., Fraenkel et al., 2009; Henggeler et al., 1996); guarded youth (e.g., Ikonomopoulos et al., 2015); and youth with anxiety, depression, aggression, and other risky behaviors (e.g., Bond et al., 2013). Treatment guidelines in Chapter 4 were developed based on reviewer integration and interpretation of systemic, trauma-informed, and strengths-based care interventions. Overall, the reviewer incorporated necessary information from a number of available scholarly resources to develop a thorough and informative review. The inclusion of varying studies provided a wide context for treatment benefits and alternative hypotheses.

Implications for the Future

It is vital that as treatment modalities expand, researchers continue to explore the impact of low-SES, urban living on youth and families. Low-SES, urban youth who are judged as angry, violent, and criminal or delinquent should be understood and treated with sensitivity to the impact of community stressors as well as qualities of resilience. To add, clinicians and therapists must believe low-SES, urban youth and their families have strengths. Thus, greater research on strengths among low-SES, urban populations would benefit the clinical understanding as well as youth and family treatment progress.

The field of psychology would benefit from additional research on culturally-sensitive and context-specific methods for reducing the symptoms associated with low-SES, urban living. Based on research noted within this review (e.g., Fraenkel et al., 2009), it would be most beneficial to publish treatment interventions that are creative, use various therapy formats (e.g., youth, group, family, multi-family), and apply non-linguistic forms of expression and storytelling. It is the hope of this reviewer that low-SES, urban youth with emotional and behavioral dysregulation and their families will be seen and understood within the context of culture and their unique community experience. Urban youth with dysregulation should be given proper psychological and psychiatric services as well as medical services, social services, and school services based on research that provides insight into their exposures to trauma, strengths and resources, and need for systemic support to change.

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