

refocus

THE RESIDENTIAL CHILD CARE PROJECT NEWSLETTER • VOL. 17, 2012

In This Issue

- 2 Frequently Asked Questions: RCCP Conference
- 6 The Wrong Job?
- 7 The RCCP Has a New Home
- 8 RCCP Media Spotlight
- 8 Trainer Certification Vs. Staff Certification
- 10 From the Instructor's Booth
- 11 Announcing: TCIF Revision – Fourth Edition
- 12 Serious Fun and Games: Life With the Wright Family
- 14 TCI For Schools
- 16 2012 Training Calendar

Emotional Matters and Meaning Making in Residential Child Care

By John Gibson, MSW, MSSc, CQSW

The intention of this article is to focus attention on emotions and the process of interaction and meaning making in residential child care. To make meaning “means to make sense of an experience ... to make an interpretation of it” (Courtenay et al., 1998). Fundamental to the discussion that follows is an appeal for greater conceptual breadth in how we think about the meaning of events and emotions in care settings. The argument is for “mind set shift” (Kegan and Lahey, 2009, Kegan and Lahey, 2001) from predominantly “structuralist” perspective, i.e. what is in individuals that produces behaviour (including emotions) to thinking that embraces a structuralist and “interactionalist” perspectives, i.e. what happens between people to produce meaning and emotions. It seems that adopting the latter is the most difficult to do. It is easier to act on the belief that behaviours are caused from within the “other person” than to consider that “I” as one of the parties involved in a sequence of behaviours may also be a causative factor. The core processes of daily life and living in this form of social care are achieved via interaction (Anglin, 2002, Anglin, 2004) thus, conceptual tools that help us think about the form and nature of interaction are essential.

Daily life in group care settings is made up of numerous interactions in which children and adults join in mutually satisfying moments. Most of these are the simple but important stuff of life. A child and adult exchange in which one party asks the other to “pass the sauce” and the reply is “thank-you” is one example. The meaning of the moment is about more than good manners. There is acceptance, respect, person meets person and there is emotion. Staff handover meetings in which the phrase, “Last night was a good shift”, suggests a time period

Emotional Matters, continues on page 3.

ANNOUNCING: The Residential Child Care Project's Third International Conference

Myrtle Beach, South Carolina
May 9-11th, 2012
Pre-Conference CARE event
May 8th, 2012



This is an exciting time for all of us here at the Residential Child Care Project (RCCP). Bringing together keynote speakers and workshops from around the world is always an amazing experience. What has us even more excited with this third international conference is the opportunity to include not just Therapeutic Crisis Intervention (TCI), but also our newest project which is our practice model, Children and Residential Experiences: Creating Conditions for Change (CARE).

Cornell University will host the TCI/CARE conference May 9-11th, 2012 in Myrtle Beach, South Carolina at the beautiful Kingston Plantation, Embassy Suites. The theme, *In the Best Interests of the Child: Caring for Them, Caring for Us*, will give participants an opportunity to share best practice strategies and outcomes from a variety of settings and countries. Presenters and participants from Canada, the United Kingdom, Ireland, Israel, Australia, Bermuda, and the United States will come together for three days of keynotes, workshops, and panel presentations as we discuss how we can, as professionals, strive to provide care that is in the best interests of the child.

Participants will be offered a variety of workshops and panels related to both TCI and CARE. Participants are welcome to attend any of the offered workshops in either area and are encouraged to take advantage of this unique opportunity to learn more about TCI and CARE. Workshops for TCI will focus on the domains of leadership and program support, clinical participation, training and competency standards, supervision and post crisis response, as well as incident monitoring and feedback. Workshop titles include: Whose Communication Difficulty is it Anyway—Mine or the Client's? Building Staff Skills; Beyond the Basics: Additional, Prevention and De-escalation Strategies; Green Chimneys' Story about Sanctuary Certification: One Year Later; Planning and Implementing the Use of Physical Restraints in School Settings; Living in Crisis and Leaving the Crisis in the Holy Land; The Israeli TCI Model;

RCCP Third International Conference, continues on page 2.

In the Best Interests of the Child Conference Frequently Asked Questions

When does the conference start and end?

The conference officially starts on Wednesday May 9th at 11:00 am and officially ends at 12:30 on Friday May 11th. For TCI trainers applying for recertification, it continues until 3:30 on Friday May 11th. There is a pre-conference CARE event for CARE agencies on Tuesday May 8th from 1:00-5:30 pm. The CARE event is an additional \$25.00 USD to attend.



How much is the conference and what does it include?

The registration fee for this 3-day conference is \$575 USD. The conference fee will cover all programs including a reception, lunches, a dinner, conference keynotes, panel presentations, workshops, as well as morning and afternoon refreshments. Accommodations are not included in the registration fee.

Where is the conference being held and how do I make plans for accommodations?

The conference is being held at the Kingston Plantation Embassy Suites. Plans for accommodations should be made directly with the hotel by calling 1.800.876.0010 and are not included in the conference registration fee. When you are ready to book your accommodations, please provide them with our SRP code: RCC to ensure that you receive our group rate.

How do I register for the conference?

You can register by filling out a registration form that has come to you in an email or you can find it on our website www.rccp.cornell.edu. Once you have completed the form, please mail the form, along with payment, to Bronfenbrenner Center for Translational Research, Cornell University, Attn: Alissa Burns, Beebe Hall, Ithaca, New York 14853-4401. Please do not fax your registration. Please make all checks payable to Cornell University.

I am a TCI trainer, will I be able to attend the conference in lieu of an update for recertification?

Yes. You will have an opportunity to apply for recertification at the conference. Testing for recertification will be on Friday afternoon immediately following lunch. In order to be eligible for recertification, TCI trainers must indicate in advance (on their registration form) their wish to be recertified, they must attend the entire conference and complete the attendance sheet included in their conference packet, and successfully pass the written and physical testing. Notification of certification status will be mailed out after the conference. *

RCCP Conference, continued from p. 1.

Policy and Practice; Ethos and Values: Alliance not Compliance; Help Me Help Myself...and my Child: The Use of TCI in Mother-Baby Group Homes; Grief and Loss: Implications for Crisis; Speak to the Hand: Engaging the Hard to Reach Young People with the LSI; and many more.

CARE workshops will focus on issues related to integration of the CARE principles in program, implementation strategies, congruency across all levels, and sustainability of CARE. Workshop titles include: Lessening the Struggle for Congruence: A Lesson from the Business World; Learn to Play, Play to Grow; Staff Recruitment and the Implications of Modern Personality Research; Risk Assessment or Risk Aversion? Proceeding Cautiously to Improve the Quality of Life of our Clients; Implementing CARE: Meeting the Challenge of Personal and Professional Change; and many more.

Dr. Larry Brendtro, the founder of the Circle of Courage Institute and Dean of the Starr Commonwealth Institute for training, will open the conference with a keynote entitled "The Quest for the Best Interests of the Child." He will also be offering a workshop based on his most recent book, *Deep Brain Learning: Pathways to Potential with Challenging Youth*. We are honored to have such featured speakers as Sandra Bloom, Kenneth Hardy, Paul Baker, and David Allen. Dr. James Anglin, School of Child and Youth Care, University of British Columbia, Canada, will provide the endnote address.

For TCI trainers, the conference is an excellent opportunity to network with other TCI trainers and apply for recertification. The Residential Child Care Project will offer testing for recertification on Friday afternoon immediately following lunch. In order to be eligible for recertification, TCI trainers must

RCCP Conference, continued from p. 2.

indicate in advance (on their registration form) their wish to be recertified, they must attend the entire conference and complete the attendance sheet included in their conference packet, and successfully pass the written and physical testing. Notification of certification status will be mailed out after the conference.

For CARE trainers, the conference will be your opportunity to become the first group of certified CARE trainers as the RCCP rolls out the CARE certification process. In order to be eligible for certification, CARE trainers must have previously been registered to train CARE by the RCCP, indicate in advance (on their registration form) their wish to be certified, they must attend the entire conference and complete the attendance sheet included in their conference packet, attend the workshop session entitled Building CARE Training Skills and take the written test. Notification of certification status will be mailed out after the conference.

While there will be much learning taking place over the course of this conference, in traditional TCI and CARE style, we are also planning to have lots of fun. Your conference fee will also include daily snacks, excellent lunches, a reception and a dinner. Wednesday night we are planning to have an opening reception and Thursday night we will be hosting a Carolina Beach Party that you will not want to miss!

For more information regarding the conference, please visit the RCCP website: <http://rccp.cornell.edu>. For additional information regarding registration please look for the FAQ in this refocus for some of the most frequently needed information. If you still have questions, please contact Alissa Burns at ab358@cornell.edu. We hope to see you in May! ★

Emotional Matters, continued from p. 1.

with many such moments. And each of these moments are filled with meaning for all participants. As the reader, your imagination and experience will fill in other examples. These are the moments of meaning and emotion that seldom get written up or formally recorded. Emotion is an ever present force in all human interactions and is the glue that binds people together and that generates commitment to as well as rejection of cultural practices in both micro and macro social organisations from the family to business life and a host of other everyday activities (Turner and Stets, 2005).

For several years now I have spent many moments reading reports that arise out of critical incidents in group care and education settings. It is an emotion-laden task and often disheartening. Sometimes it is as if the writers, whether front line care workers, teachers, youth workers, foster carers, or supervisors write about events as if the writers themselves were not participants in reported sequences of escalatory interaction. It is as if the young person is the only actor in the scene who has emotions and does behaviour. Here is an amalgamated example from reading critical incident reports. Staff triggered and escalated a situation with an anxious 14 year old. The youth was later told, "Your behaviour has caused a bad atmosphere here". Carers have a tendency to leave personal actions out of these moments. I have done it myself. To write as it were, from a position of superiority and produce narrative that puts the writer in better light than the young person involved (Convery, 1999). I have no idea how many written reports or verbalised descriptions put the young person centre stage as if they were acting alone instead of in an immediate interpersonal, social, and emotional context. However, there is a dynamic exchange in which all those involved in moments of interaction,

generate meaning and emotion saturated outcomes. And some of these are so personal that open discussion with colleagues can be difficult.

Organisational forms of all sorts are saturated with emotion, (Ashforth and Humphery, 1995). Residential programmes for children and young people are no exception. An essential difference between residential programmes and other forms of organisation is the intensity with which participants are thrown together. There is little opportunity for avoidance and withdrawal. As Davis (1977 p.26) notes, there can be, "sudden and frequent intense involvement from which there is no immediate refuge". Expressed and felt emotions in group care and education settings range from joy to rage, and include sadness and rejection, attraction and revulsion. And these emotions are not the sole preserve of the children and young people. The emotionality of residential care extends to parents, senior managers, and workers in parallel services like education. No one escapes. The emotionality referred to here, does not just reside within individuals; it is one product of daily life in residential child care. I have sat with groups of managers who are more than one step removed from the front line of daily life in group care and have felt emotion permeate the air as they discuss staffing, referrals, the effects of childhood trauma on the children in their care, funding, and more.

Emotions can draw people together or tear them apart. But what is emotion? Emotions have a biological origin (Damasio, 2000) and both influence and are influenced by culture and context (Turner and Stets, 2005). Another point of view is that emotions are socially constructed (Gordon, 1990 – cited in Turner and Stets, 2005). It can be helpful to think of emotions as primary and secondary (Kemper, 1987). Primary emotions are those like, fear, disgust,

Emotional Matters, continued from p. 3.

anger, and sadness. Secondary emotions are derived through culture. For example, sadness as a primary emotion in the face of bereavement is universal, but how grief is expressed is culture specific. Damasio (2000) points out that emotions occur in two types of circumstances, firstly when we as human beings process through our senses an object in the environment. The second type of circumstance in which emotions occur, is when an individual brings to mind objects and events from memory. There is of course a connection between emotion and thinking, Davis (2001 p. 439) captures this in her observation that thinking is our information processing system and that emotion accompanies our every thought. It has long been believed that some of our emotions operate below the level of consciousness. Damasio (2000) shows that there is ample evidence from brain science to show that human beings do indeed experience some emotions without knowing. Behaviour fuelled by emotions may first be expressed and, only on reflection, might the individual then recognise, name, and learn to manage in future the driving emotion. Emotional states of what ever type involve complex body based processes. Damasio (2000 p 282) states it succinctly, "... emotional states are defined by myriad changes in the body's chemical profile; by changes in the viscera; and by changes in the degree of contraction of varied muscles of the face, throat, trunk and limbs." He goes on to describe how emotional states change neural circuits in the brain itself. His discussion in this citation is with reference to non-elevated emotional states. Therefore when emotions are elevated,

Crisis Co-Regulation Skills are critically important.

Parallel with emotional content is the idea that the multiple moments that make up the day in residential care have "meaning". Earlier in this article, I used an example drawn from reading critical incident reports. In that example the young people and staff definitely arrived at different meanings. The staff concerned gave meaning to their actions by explaining that they were pointing out to the youth how his feelings and actions created a bad atmosphere. They were trying to teach him. The youth interpreted staff actions as being "mean" and "getting at him" from the previous day. The idea of "meaning" applies to all aspect of life when people interact. It applies to how participants respond to the CARE Best Practice Model. On one training event one person said, "I like this – it reinforces the way I work, I feel liberated" and another in the same group commented, "If we adopt this we'll lose control". Different meanings from the same source. A staff member arriving on shift opens the office door, reads worried facial expression of colleagues already there and immediately derives "meaning" from this split second interaction. The following paragraphs take up the theme of "meaning".

How can we understand and learn to shape these moments in ways that help children and each other change in purposeful ways? Symbolic Interactionism (SI) is a micro social theory that focusses on meaning making that arises out of interpersonal interaction (Blumer, 1969, Charon, 2001, Forte, 2004a, Forte, 2004b, Reynolds and Herman-Kinney, 2003).

Herbert Blumer (1979) explains that SI rests on three simple premises. The first is that human beings act toward things on the basis of the meaning that things have for them. In SI terms,

"things", are defined as "social objects" and according to Charon (2001p.44) "social objects" are "anything that can be indicated" and by Hewitt (2000p.76) as anything created through "the attention and action of several individuals coordinating their conduct toward it". Thus, as defined here, things or "social objects" cover a much greater range of phenomenon than physical objects. For example, moments of interaction are created, can be referred to or pointed at and according to SI are regarded as social objects. Physical objects are social in that they have social meaning for observers. A fallen tree is fire wood to one observer but is a place of rest to a tired walker who would rather not sit on the ground. The shift change-over meeting in residential programmes in SI language becomes a social object. Interestingly and importantly, SI holds that the "self" is also a social object.

Blumer's second premise is that the meaning that social objects have is derived from interaction with other human beings. The fallen tree is a business opportunity to a person who sells fire logs to neighbours and to another person it is the death of a beautiful natural object. Note how these different meanings have the power to evoke very different emotional states. Attitudes, values and perceptions depend upon how our connections and interactions with reference groups, like family, community, business enterprise, conservation groups, etc., shape us and the self that we live by. Interactions that influence development of meaning are not confined to early socialisation; they also refer to meanings that arise out of "in the moment" interactions. For example, a twelve year old boy said to staff in a care home, "All of you hate me". In that moment he sees and speaks to his "self" as a social object; he interacts with the "self" "as if" from the eyes of staff as significant others in his life. We all do this. Imagine

Emotional Matters, continues on page 5.

The best of a book is not the thought which it contains, but the thought which it suggests; just as the charm of music dwells not in the tones but in the echoes of our hearts.

~ Oliver Wendell Holmes

Emotional Matters, continued from p.4

for a moment that you have done a nice piece of work with a child in your care and colleagues observe it. They give approving looks. Almost without words, you note a satisfying thought about that piece of work. You have just interacted positively with your “self” “as if” through the eyes of significant others, your colleagues. In other words, you, your colleagues and the child have had a moment of “meaning making” derived through interaction. SI recognizes that “human beings are in a constant state of explicit and implicit emotional arousal about self, and they are constantly evaluating self from the perspective of others and the larger community” (Turner, 2007 p. 508).

The final premise is that meanings are handled in and modified by an interpretative process used by the individual as they encounter these social objects. The idea here is that individuals are not tied to their initial interpretation or meaning of events. Meanings are open to change; essentially a change of mind that is reached through interaction with others (Layder, 2006, Houston, 1994). It is in the context of this “individual interpretative process” that interactionalist perspectives and structural perspectives join together. For example, Green and Ablon (2006) provide a treatment strategy to help children who have skills deficits. Tishelman and Geffner (2011) offer insights into the inner world of children who have experienced complex trauma. Skills deficits and the effects of trauma on children’s development affect how children perceive and interact in the world and have a profound impact on how they give meaning to moments of interaction; perceptions of events may already be skewed, (Houston, 1994).

SI states that humans are self-reflecting, thinking, experiencing beings who use gestures and symbols to convey

meaning. That statement on its own is neither revelational nor more than everyday knowledge. However, it is so much part of daily experience that it requires conscious attention to draw out the power of interaction to which emotion both attaches and energises.

George Herbert Meade (1934), the originator of SI contrasts how animals and humans communicate. Like humans, animals also communicate through gestures; hostile dogs, snarl, growl, adopt a stiff legged posture as they walk round each other. This is an elaborate “conversation of gestures”, (Meltzer, 1970). But the dogs do not respond to the others’ intention. They simply react. Humans beings are different. We do respond to the gestures of others. Gestural communication (Meltzer, 1970) takes place instantly. For example, individual A approaches a glass door at the same time as individual B. Individual B pauses, bends forward slightly from the waist, and holds the door open. Individual A in his imagination fills in the meaning of the gesture and acts like he has said to himself, “Individual B means me to proceed through he door while he holds it open”. This is a straightforward example that at face value is simple non-verbal communication. However there is more attached. For gestures and the entire act to be successful, each individual has to interpret the gesture as meaning the same thing. However, not all encounters are mutually positive and agreeable. Why? Well, as noted above in Blumer’s (1969) third premise, meaning or intention is modified as each actor involved interprets the interaction. Thus, in the door opening example, individual A may well understand B’s gesture, but might think, “How patronising – I can hold the door myself”. He rejects A’s gesture and immediately A understands B’s gestures that now communicate rejection of intention. Meaning changes and now hostility “hangs around the

door”. One person’s gestures serve as the stimulus to others, (Turner and Stets, 2005). Here is what Meltzer (1970 p. 9) says about gesture, “When a gesture has a shared, common meaning ... we can designate it as a ‘significant symbol’”. This interpretative process which Mead (1938, 1922) calls “meaning” takes place through “role taking” (Hewitt, 2000, Charon, 2001). Each individual through thinking or imagination puts himself in the place of the other to reach understanding of or a different interpretation of the other persons intention. Meaning making operates at the level of cognitions. It is thought based and, as Turner (2007) points out, the brain does “not always think in words” because cognitive processing is so rapid as to barely register as a series of words. The implication is that meaning making can happen in seconds.

So how does this apply to group care? These settings are rich in social objects and significant gestures. Recall that social objects are defined according to Charon (2001p.44) as “anything that can be indicated” and by Hewitt (2000p.76) as anything created through “the attention and action of several individuals coordinating their conduct toward it”. The daily programme, routines, the staff office, the key worker role, assessment protocols, supervision meetings, case reviews, daily recordings, point and level systems, staff meetings, young people’s meeting, home visits, parental visits, supervised access visits, discharge, admissions, a restraint episode; all of these and more besides are social objects in the sense that they are created, given shape, and have meaning for the different actors as they interact. Meaning making and emotionality are not separate processes; rather they are two sides of the same coin. Thus, social objects evoke emotions.

Residential child care is a sophisticated and skilled activity. It is a

The Wrong Job?

By Nick Pidgeon, BSc

What would be your answer to the following question: How many people have you worked with in child care over the years who were in the wrong job? In other words, how many people have you worked with who did not have the right qualities for child care work? I have begun some informal research on this and have asked many participants in training in Britain this question. Answers were recorded confidentially. The average answer so far is shocking and disappointing. Those questioned believe around 24 percent of the colleagues they have worked with over the years did not have the right qualities for this type of work.

Perhaps my sample is too small at the moment and the percentage will change. Perhaps this is just about Britain. Perhaps the figure would be about the same for all professions. Perhaps plumbers and architects and motor mechanics would make the same assessment of their colleagues. There's a Drew Carey joke that goes something like this: What's the name for people in the wrong job? Answer: Everyone and the support group meets at the bar. But my suspicion is that the percentage of child care staff that do not have the right qualities for the work might be higher than for most professions. Why? Because I think the qualities required to make a good child care worker are particularly unique, difficult to define and hard to spot during the staff recruitment process. My suspicion is also that the damage that can be done by employers making mistakes during the recruitment process is greater in our profession than most others. This raises two further questions: What are the qualities that make a good child care worker? And how can we identify those candidates with these qualities during staff recruitment?

I am coming to think that modern personality theory might help us answer the first of these questions. It won't provide the whole answer but could

HIGH SCORE

OPENNESS

Open to new experiences, curious, has original ideas, broadminded and socially tolerant, left wing politically, accepts change, likes creativity, art and music

CONSCIENTIOUSNESS

Self control and willpower, organised, trustworthy, copes with delayed gratification, makes long term goals and plans, craves achievement, can concentrate on one focused task

EXTRAVERSION

Friendly, talkative, funny, sociable, has frequent positive emotions, seeks excitement, self confident socially, prefers working with and trusting others, seeks dominance and leadership, physically active

AGREEABLENESS

Warm, kind, sympathetic, empathetic, trusts others, compliant, seeks harmony with others, adapts to other's needs, avoids conflict with others

NEUROTICISM *(Some psychologists refer to this as emotional stability. A high score in neuroticism indicates low emotional stability.)*

Neurotic, anxious, worried, self-conscious, depressed, quickly gets angry or upset, slow to rebound from setbacks

LOW SCORE

OPENNESS

Seeks simplicity and predictability, resists change, respects tradition, conservative, conventional, close-minded, authoritarian

CONSCIENTIOUSNESS

Likes spontaneity and chaos, impulsive, accepts "good enough", lower drive and ambition, shifts between tasks, disorganised, untidy, not punctual

EXTRAVERSION

A loner, socially and physically passive, low level of social status seeking, less trusting, less likely to seek leadership

AGREEABLENESS

Pursues own needs, seeks glory or notoriety, express opinions forcefully, critical of others, selfish, aggressive, takes advantage of others

NEUROTICISM *(Some psychologists refer to this as emotional stability. A high score in neuroticism indicates low emotional stability.)*

Mature, resistant to stress, optimistic, calm, quickly rebounds from setbacks, generally happy, likely to experience school, job, relationship and life satisfaction

contribute something useful.

For the last thirty or so years most psychologists have come to a consensus on the best framework for understanding human personality. This is called the five factor or big five model. The psychologist Daniel Nettle writes, "The five-factor model has emerged from a welter of research over the last few decades and looks to be the most comprehensive, reliable and useful framework for discussing human personality that we have ever had", (Nettle, 2007). The psychologist Geoffrey Miller writes, "The Big Five theory is distinctive because it

Table 1. Five Factor Model Scores

emerged gradually, over the course of decades, through cumulative empirical research and consensus-building literature reviews," (Miller, 2009).

The model describes personality traits under five headings. The acronyms CANOE or OCEAN are used to help us remember the five factors:

- O**penness to experience
- C**onscientiousness
- E**xtraversion
- A**greeableness
- N**euroticism

The Wrong Job?, continues on page 7.

The Wrong Job?, continued from p. 6.

For each of the five factors there is a continuum of scores from high to low depending on the personality of the person tested. One of the best ways to begin to understand each factor is to consider the meaning of high and low scores as show in *Table 1. Five Factor Model Scores* on the opposite page.

These five factors can be measured reliably and tend not to change throughout a lifetime. Variation is evenly distributed on a bell curve, is significantly genetic and, according to twenty plus years of behaviour genetics, what causes the non-genetic variation is still a mystery. Variation in these five traits helps explain our interests, how we engage with life and with other people. They also predict our suitability for different jobs. For example advertising agencies would want to employ people high in openness, accountancy firms those high in conscientiousness, and shops would want to employ sales staff high in extroversion. What about child care?

I'm going to end this short piece with some predictions. Fifty years from now we will have a much better idea of the personality traits suitable for most professions. The pattern for child care will look something like this:

- Openness is not particularly relevant, although some employers would want to rule out very low scorers, those with authoritarian, close minded personalities.
- All employers want staff that are Conscientious and would avoid low scorers.
- Probably the most important of the five factors to child care is Agreeableness. Child Care is a job for high scorers: warm, kind, sympathetic, empathetic people who put the needs of others before their own.
- Extroversion is also important. Employers would want to avoid low scoring introverted loners.

The Wrong Job?, continues on page 15

The Residential Child Care Project Has A New Home

By Michael Nunno, DSW

On July 1, 2011, after nearly two years of discussion and planning, the Family Life Development Center and the Bronfenbrenner Life Course Center merged to create the Bronfenbrenner Center for Translational Research (BCTR) in the College of Human Ecology. This newly-formed Center, led by John Eckenrode, PhD, will allow the College to capitalize on one of the most dynamic and exciting recent developments in the scientific community: The new emphasis on translational research (TR) as a means to link the College's long-standing twin missions of linking research and outreach to address complex human problems in communities. Translational research, as defined by the College and the new Center, is the systematic movement of research findings into the development of innovative interventions, practices and policies that may ultimately improve health and well-being, and also the use of knowledge derived from interventions, practices, and policies to inform research. This merger will bring together the vast expertise, the resources and the programs of the Bronfenbrenner Life Course Center and the Family Life Development Center, as well as maximize connections to the Weill Cornell Medical College in New York City, the Weill Clinical and Translational Science Center, Cornell Cooperative Extension and multiple Ithaca-based departments, centers, and research initiatives.

We at the Residential Child Care Project welcome this emphasis on problem-focused research that has the potential to have a significant and positive impact on our audience – the organizations and agencies that serve the best interests of high-risk children and their families. Anticipating our College's movement to a translational research model, the

faculty and staff of the Residential Child Care Center have been examining our Therapeutic Crisis Intervention (TCI) and our Children and Residential Experiences (CARE) projects to integrate translational research perspectives into their ongoing development and evaluation. We have supported and encouraged innovative research designs with practical applications for practitioners that have the potential to improve child safety and well-being while serving the child's best interests. We have also integrated practitioner perspectives that enhance effective translation of knowledge, improve practice, and create learning organizations that can sustain innovation. To be congruent with our new Center's principles, we understand that our research-informed programs have to contain more rigorous evaluation and research methodologies and standards to test their effectiveness and their impact. Two of our current efforts that are congruent with our Center's translational research principles are the Fidelity Study on the implementation of TCI in selected agencies supported by the New York State Office of Children and Family Services and our CARE program model field study in the Carolinas supported by The Duke Endowment. Both of these research studies employ multiple methodologies that examine the process of program implementation; its impact on the organizational culture, climate and congruence; and seek to measure child safety and well-being improvements. Over the next five to ten years, we hope to seamlessly integrate these research and evaluation methodologies into our programs so that the child welfare organizations that use them will have access to more precise and useful evaluation tools to measure their impact on families and children.

Michael Nunno and David Allen will be facilitating a panel on Restraint Reduction Practices at the TCI/CARE Conference in May. ★

RCCP Media Spotlight

Problem Child: We Need To Talk About Kevin

A film by Director Lynne Ramsay

Reviewed by Raymond Taylor, MSc

There are many resources, books and films, whose themes can be used to promote discussion and the engagement of participants during TCI training: *The Breakfast Club* directed by John Hughes might prompt discussion on group dynamics and tolerance, *Holes* by Louis Sachar might be used to consider children's perceptions of justice, *Lord of the Flies* by William Golding highlights concerns about the use and misuse of power. All of these, if referred to at the right moment and in the correct context, can be used to aid reflection and emphasise and clarify key learning points in a rich and memorable way.

I am not aware, however, of many resources that illustrate proactive and planned aggression more chillingly than *We need to talk about Kevin* (2003). The North American author, Lionel Shriver wrote the novel when she was anticipating having her own child. The film directed by the Glasgow born Scottish director, Lynne Ramsay focuses on the exclusion and animosity that Kevin's mother encounters as a result of having a murderer for a son.

Kevin is difficult to fathom and harder to reach. Throughout the film as he matures from infancy to late adolescence, his behaviour whilst rarely overtly aggressive and challenging, disturbs and unsettles the adults who are trying to care for him. All of efforts to settle Kevin the crying baby, the distressed toddler or isolated adolescent appear to fail.

The director avoids graphic Hollywood style visuals and opts instead to use symbols, everyday items such as tomatoes or red paint, to create startling crimson images that suggest, rather than graphically depict, the brutal and horrific consequences of Kevin's actions.

Even when called to account in the juvenile court or when we see Kevin serving out his time in prison, he appears remorseless, cold and calculating. Deriving, it would appear, a secret satisfaction from his mother's anguish and distress. All of this is conveyed to the audience by Tilda Swinton who plays Kevin's mother and Ezra Miller, the teenage Kevin, through eye contact and body language which is stiff and always somehow "held back". The audience is never left in any doubt about the absence of meaningful communication between the adult and the child. The question of nature or nurture is touched on but never fully addressed. The reasons behind Kevin's behaviour and the psychology of mother/son relationship are never fully explained, nor do they need to be. The key message of this bleak, and yet very beautiful film, is contained in the final redemptive images. ★

Trainer Certification Versus Staff Certification, To Teach Versus To Do

By Rich Heresniak, TCI Instructor

Over the course of the last several decades, the TCI program has continued to grow and evolve in terms of both its content as well as its scope. There are thousands of certified TCI trainers and countless direct trainings, TCI Updates, and Train the Trainer weeks that are occurring around the world on a regular basis. Given the relative depth and scope of the TCI program, misunderstandings, misinterpretations, and various other complexities are bound to arise – concerning a myriad of issues related to TCI and how it translates into practice within agencies. And occasionally, some clarification is needed.

TCI is a best practice model for crisis prevention and management and in addition to the core curriculum, offers guidelines, implementation criteria, and suggestions for best practice around issues of crisis prevention and management within organizations that care for children and young people. The TCI system does not make policy or establish specific protocols within organizations, but rather serves as a guide for best practice.

The fact that TCI is a best practice model and not directly involved in policy making, occasionally leads to some confusion as agencies and trainers work to implement TCI. One such issue deals with the topic of "certification" and the differences between being certified as a TCI trainer, and the certification process that is used within agencies to certify their staff – specifically connected to TCI physical skills.

For apparently quite some time, there has been a false assumption about TCI trainer certification as related to the real time use of physical interventions on the job. That assumption is essentially this:

Trainer Certification, continues on p. 9.

Trainer Certification, continued from p. 8.

If someone successfully completes a TCI “Train the Trainer” week and becomes a certified TCI trainer, then that fact automatically qualifies or certifies them to use physical interventions with children and young people in care. It is important to be clear that this is not at all the case. When someone is certified as a trainer in TCI, they are only being certified to teach the physical intervention skills, not necessarily to use them. And there is a significant difference between teaching and doing.

A good analogy is the world of professional sports. There are hundreds of great coaches who teach athletes a myriad of different physical skills – and do so quite effectively. When it comes to the actual use of these athletic skills in “real life” competition, however, only the athletes are truly qualified to employ the skills. Imagine what the outcome might be if the coaches – those who teach – actually tried to do in a “real life” American football game or a European soccer match. In most cases, the coach, though possibly a great teacher, simply does not have the required level of fitness, strength, dexterity, speed, or coordination to participate in the “real life” event safely.

As we’ve tried to raise this issue in various train the trainer weeks and updates, the reactions of participants have been varied. Some people acknowledge that “trainer certification” is quite different from certification required to use the techniques on the job in their agency and have been operating as such. Many others, however, seem to struggle with this notion. For example, I recall a recent update where the “trainer certification” issue was mentioned. One participant asked something to the effect of, “Wait a minute...when I become certified as a trainer, you are saying that I’m good enough to teach these techniques to others, but not necessarily “good enough”

to actually use them?” The answer is yes.

Now, let’s take a look at why. The most obvious reason is that the TCI Train the Trainer Course is exactly what it says it is – a “train the trainer” course! The course has been designed to focus primarily on helping people develop their capacity to train TCI effectively to others. It is not designed to be an “advanced” version of TCI (another often held misconception) – nor is the train the trainer week designed to be a remedial training for unskilled staff members who “just don’t get it”. The reality is that relatively little time is actually spent on “teaching” TCI content and skills. In fact, one of the guidelines for someone applying to attend a Train the Trainer week is that they have already successfully completed a TCI direct training within their agency.

Due to the nature and intended purpose of the TCI Train the Trainer program, the overall evaluation process is also significantly different than the process that should be used during direct training in agencies – and is designed to accurately assess and evaluate the participant’s ability to effectively train many facets of TCI. During physical skills testing, for example, participants are asked to demonstrate the techniques slowly, showing all of the steps in the correct sequence and without committing any safety violations – as if the participant were demonstrating techniques to an observer watching the skill for the first time. The evaluation of the Life Space Interview is conducted in the same manner – as a training demonstration. Additionally, there is evaluation of each participant’s training skills that occurs throughout the week as they present various activities in their training teams. When it comes to certifying, qualifying, or otherwise credentialing someone to use TCI skills on the job, however, the

assessment and evaluation process is markedly different. The physical skills assessment should involve participants executing the techniques “at speed” – as the trainer evaluates such factors as technical correctness, fluidity of motion, agility, and other such characteristics that are required to safely employ the techniques in a “real life” situation. As part of the overall consideration for “certification”, the trainer would also take into account attitudinal issues, as well as the participant’s performance during resistance practice.

There are other important reasons why Trainer Certification is simply “not enough” if someone is required to use TCI with children and young people as part of their job duties. Chief among these are issues like frequency of refreshers and recertification, both in terms of best practice and various licensing regulations. TCI Trainer Certification is required at a frequency of either one or two years, depending on your location. This is the basic standard for someone who wishes to maintain their certification to train TCI to others.

However, being certified to use TCI skills on the job requires an even higher standard due to the many risks associated with managing crises and the fact that skill drop off begins at the moment one leaves the training room. TCI best practice guidelines call for refreshers and re-evaluation of physical skills every six months at a minimum for those being directly certified in agencies, and we know that a greater frequency of refreshers is even more effective in terms of skill maintenance. Many states and licensing organizations have similar minimal requirements in terms of frequency of refreshers and re-evaluation. Therefore, relying solely on one’s Trainer Certification to use TCI on the job would put the individual out of compliance with

Trainer Certification, continued from p. 9.

not only best practice standards, but likely licensing regulations as well.

So, what does all this mean for certified TCI trainers? Essentially, it means that if a certified TCI trainer is required to use TCI skills with children and young people in their agency, then they must participate in and meet the same certification standards as other non-trainers do – and at the same required frequency. In my own agency, we have trainers evaluate each other – and have found the process to be a great opportunity to do some additional work around inter-rater reliability and issues of trainer drift. This occurs every six months, per our agency policies. This process is fairly easily accomplished in agencies that have two or more trainers. In cases involving agencies with only one trainer, we might suggest the same strategy we mention around the issue of co-training, which would involve working with TCI trainers from other local agencies and accomplishing the direct certification process that way.

The logistics of directly certifying or qualifying trainers to employ TCI physical skills in real situations with children and young people will certainly vary from agency to agency, but more important than the logistics behind the process, is that the process occurs. The risks of assuming that “Trainer Certification” is “good enough” are far too great, not only to ourselves in terms of liability, but also to the population we serve.

Rich Heresniak is a Crisis Prevention and Management Specialist at Astor Home in New York and a TCI instructor. ★

From the Instructor’s Booth

Professional Certification Announcement

Congratulations to the newest TCI trainer to have achieved professional level certification:

Donna J. Crawshaw, MA, Rehabilitation Counseling.

Ms. Crawshaw is employed as a Clinician, Child and Family Intensive Outreach Department and as an Emergency Services Clinician at Gateway Healthcare Inc., Pawtucket, RI. Her professional experience at Gateway Healthcare includes: TCI Instructor, Therapeutic Activities Coordinator for Children's Residential, Case Manager for the Rhode Island System of Care, supporting adults with severe and persistent mental illness and Community Support Coach, Developmental Disabilities Program, assisting individuals with vocational, educational and community supports.

Prior to working at Gateway Healthcare, she worked for 11 years as a Residential Counselor and Activities Coordinator in Children's Residential and as an elementary and middle school teacher. Additionally, she worked as a consultant to schools and children's residential agencies locally and nationally. She has presented workshops on the effectiveness of therapeutic games and programming that she designed, copyrighted, and produced.



RCCP Full Time Faculty Announcement

The RCCP is pleased to welcome Frank Kuhn and Catherine Norton-Barker as our newest full time faculty members.

Frank Kuhn, Ph.D., Frank is a licensed clinical psychologist living in Charlotte, North Carolina. He received his bachelor's degree with honors in psychology at Wake Forest University, and both his Masters of Science degree and his Doctor of Philosophy degree in clinical psychology from Auburn University. Frank's residency in clinical psychology was at the University of Texas Health Sciences Center in San Antonio, Texas. Following his residency, Frank became a member of the faculty of the University of Texas Health Sciences Center as an Assistant Clinical Professor in Pediatrics. Frank was employed by Lutheran Family Services in the Carolinas in various clinical, programmatic, and administrative positions supporting a range of child and family services. He served as Executive Director of the Family Service Institute, offering consultation and training to child and family



service organizations across the country and as President of Thompson Child and Family Focus, an organization providing foster care, residential treatment, education, early childhood development and community services. Frank is a peer reviewer with the Council On Accreditation for Services to Families and Children, and was trained as a Peer Mentor for boards of social ministry organizations with the ELCA's Division for Church in Society. Through his private practice Frank provided consultation, technical assistance and training to hundreds of human service organizations. Typical topics included clinical services and supervision, board development, strategic planning, systems for implementation, accreditation and quality assurance, and specific program planning and evaluation. Frank has served as a part-time consultant and instructor with the Family Life Development Center (now the Bronfenbrenner Center for Translational Research) of Cornell University for more than twenty-five years. Some current interests include the CARE model, change in organizational systems of care, and congruence in clinical and caregiving systems.

Catherine Norton-Barker. A native of Cherry Hill, NJ, Catherine Norton-Barker received a bachelors degree with honors in Psychology, summa cum laude, from Alfred University in 1999. She is a former doctoral student in Clinical Psychology who has worked in residential programs serving diverse populations from developmentally disabled adults, to combat veterans, hospital psychiatric patients and at-risk adolescents. Her roles included direct care, group therapist and cottage program director. Before joining the Residential Child Care Project, Catherine managed an educational program that engages and motivates middle school students through the medium of computer virtual worlds. She worked extensively with children and teachers in the classroom, conducted program evaluations and spoke at conferences. Catherine has published research in academic journals and has written a book chapter on the benefits of using computers in education. She is a member of three national honor societies and an active board member of the Phi Kappa Phi Chapter at Cornell University. Catherine is passionate about improving the lives of adolescents and excited to be the newest member of the RCCP team working on the CARE project. *



ANNOUNCING: TCIF Revision – Fourth Edition

In the spring of 2012, the Residential Child Care Project will release the 4th edition of the Therapeutic Crisis Intervention for Families curriculum. Since the curriculum's inception there have been three major revisions. The revision process has generally included (1) examining the evaluation results and research conducted by the RCCP, (2) reviewing related literature and research, (3) conducting surveys of organizations using the TCIF, (4) talking to other crisis management training providers, and (5) convening a group of experts for consultation and review.

Many children placed in foster care, kinship care, adoptive care and many families that are receiving in-home supportive services or day treatment have been exposed to abuse, neglect, poverty, racism, family violence, and/o community violence. Some children have special needs that can overwhelm families. These children and families are at risk for the development of one or more behavioral or emotional disorders. One of the most critical skills for these families is to teach children to manage their feelings of frustration, anger and loss in more socially and developmentally appropriate ways. Therapeutic Crisis Intervention for Families (TCIF) stresses crisis prevention and crisis de-escalation in ways that help children learn to avoid losing control. The five-day train-the-trainer program gives agency trainers the tools to teach crisis prevention strategies and crisis intervention techniques to families that care for children in their homes. Trainers are prepared to coach learners during skill practice sessions, and to use role playing and to facilitate small group discussions.

A two-day update will be offered so that current TCI and TCIF trainers can learn the content and revisions to the Therapeutic Crisis Intervention for Families (TCIF) curriculum, Edition 4. TCIF is based on TCI6 but revised for families who are caring for challenging children in their own homes. Topics that will be discussed include the effects of trauma on children; preventing crisis by creating a safe and secure environment; emotional competence; negotiating rules and expectations; using consequences; assessing what the child feels, needs, and wants; and developing individual crisis management plans. In addition to reviewing minor revisions in the TCIF curriculum, new techniques and skills to help prevent and de-escalate crises will be demonstrated and followed with practice sessions. See the RCCP website, <http://rccp.cornell.edu> for more information and schedules. *

Serious Fun and Games: Life With the Wright Family by Jack C. Holden

Materials: A small object for each participant (coin, pen, tightly wadded up paper)

Procedure: The group forms a circle. This activity can be done sitting or standing. Tell the group you are going to read them a story and every time they hear the words right or left, they are to pass the object to the person on their right or left depending on what they hear. The purpose of this activity is “just plain fun” and can be enhanced by speeding up the reading just a bit at the end.

Read Out Loud the Following:

One day the Wright family decided to take a vacation. The first thing they had to decide was who would be left at home since there was not enough room in the Wright family car for all of them. Mr. Wright decided that Aunt Linda Wright would be the one left home. Of course, this made Aunt Linda Wright so mad that she left the house immediately yelling, “It will be a right cold day before I return.”

The Wright family now bundled up the children, Tommy Wright, Susan Wright, Timmy Wright, and Shelley Wright and got in the car and left. Unfortunately, as they turned out of the driveway, someone had left a trashcan in the street so they had to turn right around and stop the car. They told Tommy Wright to get out of the car and move the trash can so they could get going. Tommy took so long that they almost left him in the street. Once the Wright family got on the road, Mother Wright wondered if she had left the stove on. Father Wright told her not to worry; he had checked the stove and she had not left it on. As they turned at the corner, everyone started to think about other things that they might have left undone at the Wright house.

No need to worry now, they were off on a right fine vacation. When they arrived at the gas station, Father Wright put gas in the car and then discovered that he had left his wallet at home. So, Timmy Wright ran home to get the money that was left behind. After Timmy had left, Susan Wright started to feel sick. She left the car saying that she had to throw up. This of course got Mother Wright’s attention, and she left the car in a hurry. Shelley Wright wanted to watch Susan get sick, so she left the car too. Father Wright was left with Tommy Wright who was playing a game in the backseat.

With all of this going on, Father Wright decided that this was not the right time to take a vacation, so he gathered up all of the family and left the gas station as quickly as he could. When he arrived home, he turned left into the driveway and said “I wish the Wright family had never left the house today!”

Author unknown, From, Furnis, Mary, Independent Living Resources, State of Nebraska. Lincoln: 1988

Jack Holden is a TCI Instructor from Ithaca, NY and has a PhD in Education, specializing in Adult Learning. ✱

Emotional Matters, continued from p.5

challenge. It requires that all who work directly in and/or provide leadership are competent in making, developing, and sustaining relationships together in the best interests of children. The challenge is in awareness; awareness of emotions in self and others and awareness of meaning making. Or, expressed differently, that all the actors involved are constantly working to make sense out of events; that they do so as they rub shoulders with each other and that each person makes sense or interprets events from within their own meaning making system (Houston, 1994). A system that helps to develop shared meanings is important.

The beginning of this article mentioned the need for a shift of mind-set from a predominantly structural perspective to one that also embraces interactionist ideas. Unless wisely applied, structural perspectives may label or even blame the child for behaviour (Greene and Ablon, 2006). When combined with an interactionist perspective the lens has a chance of changing to include the child and environment, essentially, but not exclusively, other people, as they encounter each other.

One focus in social work and social care practice founded on symbolic interactionist principles is to change meaning by improving and changing the quality of interactions. As Houston points out (1994 p. 70), “to change interaction is to change the person, his social world, reference groups and perspectives ... fundamentally, changed interaction enables a reconceptualisation of self”. The CARE best practice model can be understood as an intervention that changes interaction and provides for new meanings that are based on knowledge that is tested against what children need as opposed to “best guesses”. Implementation of the CARE best practice model changes what

Emotional Matters, continues on page 13.

Emotional Matters, continued from p.12.

staff think and feel about their job, it changes how children think – make sense of – and feel about daily life. Family member that feel the care of a residential agency as its staff at all levels work to make a child's home visits successful, may be quietly challenged through interaction and reflection upon their internal meaning making system to change their view of others and of self. The CARE model fulfills leadership's responsibility to "create and maintain a system of shared meanings to provide a basis for coordinated behaviour ... through action and interaction they, (leaders) help organisational members focus on common interpretations" (Ashforth and Humphery, 1995) in the daily struggle to achieve "congruence in the best interests of the child" (Holden, 2009).

Anglin, J. P. (2002). *Pain, normality, and the struggle for congruence: Reinterpreting residential care for children and youth*. New York, London, Oxford: The Haworth Press, Inc.

Anglin, J. P. (2004). Discovering what makes a "well-enough" functioning residential group care setting for children and youth: Constructing a theoretical framework and responding to critiques of grounded theory method. In: Eriksson, H. G. & Tjellflaat, T. (eds.) *Residential Care: Horizons for the New Century*. Aldershot, UK: Ashgate Publishing.

Ashforth, B. E. & Humphery, R. H. (1995). Emotion in the workplace: A reappraisal *Human Relations*, 48, 97-125.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Berkley: University of California Press.

Blumer, H. (1979). Symbolic interactionism. In: Budd, R. W. & Ruben, B. D. (eds.) *Interdisciplinary Approaches to Human Communication*. Rochelle Park: Hayden.

Charon, J. M. (2001). *Symbolic interactionism an introduction, an interpretation, an integration*. Upper Saddle River, New Jersey: Prentice Hall.

Convery, A. (1999). Listening to teachers' stories: Are we sitting too comfortably? *Qualitative Studies in Education*, 12, 131-146.

Courtenay, B. C., Merriam, S. B. & Reeves, P. M. (1998). The centrality of meaning-making in transformational learning: How HIV-Positive adults makes sense of their lives. *Adult Education Quarterly*, 48, p. 65-84.

Damasio, A. (2000). *The feeling of what happens; Body, emotion and the making of consciousness*. London, Vintage Books.

Davis, B. (2001). The restorative power of emotions in child protective services. *Child and Adolescent Social Work Journal*, 18, 437 - 454.

Davis, L. F. (1977). Feelings and emotions in residential settings: The individual experience. *British Journal of Social Work*, 7, 25 - 39.

Forte, J. A. (2004a). Symbolic interactionism and social work: A forgotten legacy, Part 1. *Families in Society: The Journal of Contemporary Social Services*, 85, 391-400.

Forte, J. A. (2004b). Symbolic interactionism and social work: A forgotten legacy, Part 2. *Families in society: The Journal of Contemporary Social Services*, 85, 521-530.

Gordon, S. L. (1990). Social structural effects on emotions In: Kemper, T. D. (ed.) *Research agendas in the sociology of emotions*. Albany, NY: State University of New York.

Greene, R. W. & Ablon, J. S. (2006). *Treating explosive kids*. New York: Guilford Publications Inc.

Hewitt, J. P. (2000). *Self and society: A symbolic interactionist social psychology*. Boston, London, Toronto, Sydney, Tokyo, Singapore: Allyn and Bacon.

Holden, M. (2009). *Children and residential experiences: Creating conditions for change*. Arlington, VA.

Houston, S. (1994). Working with troubled and troublesome adolescents: An interactionist perspective. *Child Care in Practice*.

Kegan, R. & Lahey, L., L. (2001). The real reason people don't change. *Harvard Business Review*.

Kegan, R. & Lahey, L., L. (2009). *Immunity to change*. Boston: Harvard Business Press.

Kemper, T. D. (1987). How many emotions are there? Wedding the social and autonomic components. *American Journal of Sociology*, 93, p 263-289.

Layder, D. (2006). *Understanding social theory*. London, Thousand Oaks, New Delhi: SAGE Publications

Mead, G. H. (1922). A behavioristic account of the significant symbol. *The Journal of Philosophy*, 19, 157-63.

Mead, G. H. (1934). *Mind, self, and society from the standpoint of a social behaviourist*. Chicago: University of Chicago Press.

Mead, G. H. (1938). *The philosophy of the act*. Chicago: University of Chicago Press.

Meltzer, B. N. (1970). Mead's Social Psychology. In: Manis, J. G. & Meltzer, B. N. (eds.) *Symbolic interaction: A reader in social psychology*. Boston: Allyn and Bacon.

Reynolds, A. J. & Herman-Kinney, N. J. (2003). *Handbook of symbolic interactionism*. Lanham, Boulder, New York: AltaMara Press.

Tishelman, A. C. & Geffner, R. (2011). Child and adolescent trauma across the spectrum of experience: Research and clinical interventions. *Journal of Child & Adolescent Trauma*, 4, pp. 1-7.

Turner, H. F. (2007). Self, emotions and extreme violence: Extending symbolic interactionism theorizing. *Symbolic Interaction*, 30, pp 501 - 531.

Turner, J. H. & Stets, J. E. (2005). *The sociology of the emotions*. Cambridge, New York, Melbourne: Cambridge University Press.

John Gibson and Mena Wilson will be presenting "Implementing CARE: Meeting the challenge of personal and professional change" at the TCII/CARE Conference in May. ★

TCI For Schools

By Marty Mineroff, MS

The implementation of TCI in schools presents unique challenges to both school personnel and TCI trainers working with schools. Having experienced the process from the perspective of a principal and now a TCI instructor working with both urban and rural school districts, some commonalities have emerged.

A school’s mission is to provide a viable education for its student population and to accomplish this task schools are provided with what may appear to be a considerable budget. The reality, however, is very little of their budget is discretionary; the majority of their funding being allocated to staff, facilities and supplies. With whatever discretionary funding remains, schools must decide how to best support initiatives in a variety of areas including instruction, attendance, use of technology, behavior supports, etc. Some of these initiatives may be mandated or recommended from the district level, while others are developed at the school level to meet the school’s specific needs. All, however, compete for finite resources (funding, staff, time) and are subject to state and local regulations as well as collective bargaining agreements.

In this era of accountability and high stakes testing educators, even though they may understand and agree with the importance of teaching social skills, arts, etc., are also under considerable pressure to target limited resources at areas that impact directly on areas of high

accountability such as math, reading and attendance. At the school level it is the principal who is ultimately responsible for making decisions about the allocation of resources as well as setting clear goals and expectations. What impact does this have for schools and TCI implementation?

The obvious answer is that in many cases individual schools may not have the financial resources necessary to send staff to become TCI trainers. As a result, what sometimes happens, and indeed what I experienced as a principal, is that schools are trained as part of a district initiative or as a group of several schools that have received a grant for the training. While this provides these schools with a unique opportunity it may also, inadvertently, create roadblocks to successful implementation. Principals may find their schools participating in TCI training without a clear understanding of what it is or what effective implementation entails.

We know that leadership and program support is one of the five domains for effective TCI implementation and “When leadership is fully informed about the TCI crisis prevention and management system and understands its foundation, leaders can support the necessary components that are integral to its implementation and maintenance. “. Moreover, it is unrealistic to expect leadership to make informed decisions without adequate knowledge. Even the task of choosing staff to attend a TxT can go astray if there is not a clear understanding that people identified as potential trainers should not only have the requisite skills to be effective trainers;

but the time, understanding and desire to be involved in a long term project that they believe will have a positive impact on their school.

We can assist schools in the effective implementation of TCI by helping leaders make informed decisions. As principal I (as well as my school’s leadership team) would have benefited from an orientation session, one that would have included:

- The concept of TCI as a crisis management system, one that could improve both safety and instruction (by reducing crisis behavior) through the appropriate use of de-escalation techniques.
- The five components of effective TCI implementation, and what implementing these components would look like at the school level.
- The TxT model and the qualities that make someone a good candidate to become a trainer.
- What training staff at the school level entails and how important practice and refreshers are since many of the strategies are counter-intuitive and require practice and self-competency on the part of the staff.
- The stress model as the conceptual foundation.
- The importance of the LSI (Life Space Interview) and enabling staff to conduct the LSI.

This information prior to our involvement would have given us adequate time to plan how TCI would be supported at the school in everything from setting up and prioritizing a

TCI Schools, continues on p. 15.

TCI Schools, continued from p. 14.

training schedule, to the setting of clear expectations and the supervision of staff.

As TCI instructors working with schools and districts we have found that while some schools and districts have been receptive to this type of pre-planning in many cases, for a variety of reasons, it has been difficult to coordinate when several schools or districts are involved. We have had some success in getting district and school leaders to participate in the action planning activity during the TxT week and we have had a few principals participate in the training that occurs back at the school.

Since many of these schools that have participated in training also receive technical assistance, we have had the opportunity to visit and follow-up with many of them. Those schools making the most progress in successful implementation are invariably the ones where school and/or district leaders have participated in some type of training and are actively involved in planning and implementation. This is not surprising given what we know about the importance of leadership and program support.

While many of these schools, including my own, were receiving training in the de-escalation techniques only, there has been an increasing interest by schools in the use of physical restraints. Whether this interest is the result of their perceived needs or due to legislation (and potential legislation) by relevant governmental regulatory bodies the inclusion of high risk interventions makes the need for an informed and supportive leadership

critical. District and school leaders are ultimately the ones responsible for developing clear policies and guidelines (that should be in place before training staff in the use of physical interventions) as well as ensuring compliance with these policies and guidelines.

As a former principal I understand the demands it makes on a person's time and energy and how difficult it can be to make decisions on where to expend a school's resources. However, I also know that if new initiatives are to be successful, it is necessary to understand, support and nurture them. As TCI instructors working with schools it is incumbent upon us to encourage the active participation of school leadership so they get the information that will allow them to make informed decisions and provide the necessary support for successful implementation.

Marty Mineroff worked for the NYC Department of Education for 29 years including 14 years as a principal and is currently a TCI instructor. He and Jack Holden will be presenting, "Planning and Implementing the Use of Physical Restraints in School Settings" at the TCI/CARE Conference in May. ★

With consultation from school personnel and experts in the field, TCI is being revised specifically for implementation in schools. In June 2012, TCI for Schools (TCIS) will be available as an onsite Training of Trainers to Schools. Information will be available on the RCCP web site in February, <http://rccp.cornell.edu>

Wrong Job?, continued from p. 7.

- Low Neuroticism is also important to child care. Employers want staff that are calm and resistant to stress.
- Another prediction is that we will have developed ways for assessing these traits during the staff selection process. What we won't do is give people personality questionnaires. The obvious reason is that people lie: they are likely to answer personality assessment questions so they look like the sort of person they think an employer wants. What we will probably do is develop a number of exercises and activities so that candidates can reveal the qualities we need. For example Nettle and his collaborator Liddle have developed a story based exercise that assesses Agreeableness. (Nettle and Liddle, 2007)
- And my final prediction is that fifty years from now child care employers will look back at the recruitment process used today and think, well, it was improving but it still involved an unscientific, hit or miss, subjective way to make very important decisions.

Further Reading

Good introductions to the five factors:
 Nettle, D. (2007). *Personality: What makes you the way you are*. Oxford: Oxford University Press.
 Miller, G. F., (2009). *Spent: Sex, evolution, and consumer behavior*. New York: Viking Adult.
 McCrae, R. and Costa, P. (2005). *Personality in Adulthood: a five-factor theory, perspective*. New York: Guilford Press.
Nick Pidgeon will be presenting, "Staff Recruitment and the Implications of Modern Personality Research" at the TCI/CARE Conference in May. ★



TCI USA 2012 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Feb. 27 - Mar. 2/12	Mesa, AZ
Mar. 5-9/12	Denver, CO
Mar. 19-23/12	Ithaca, NY
Mar. 26-30/12	Peoria, IL
Apr. 16-20/12	Cincinnati, OH
May 14-18/12	Warwick, RI
Jun. 11-15/12	Atlantic Beach, NC
Jul. 16-20/12	Pittsburgh, PA
Jul. 30-Aug. 3/12	Baltimore, MD
Aug. 27-31/12	Ithaca, NY
Sep. 24-28/12	Peoria, IL
Oct. 15-19/12	Mesa, AZ
Nov. 12-16/12	Warwick, RI
Dec. 10-14/12	Ithaca, NY

TCI UPDATES

Developing Professional Level TCI Training Skills

Aug. 9-10/12	Ithaca, NY
Oct. 11-12/12	Mesa, AZ

TCI For Developmental Disabilities

Jul. 12-13/12	Pittsburgh, PA
Aug. 6-7/12	Ithaca, NY
Nov. 8-9/12	Warwick, RI

Designing Refresher Training

Jan. 23-24/12	Ithaca, NY
Mar. 1-2/12	Denver, CO
May 22-23/12	Warwick, RI
Jul. 26-27/12	Baltimore, MD
Sep. 20-21/12	Peoria, IL
Dec. 6-7/12	Ithaca, NY

Post Crisis Response

Mar. 22-23/12	Peoria, IL
Apr. 12-13/12	Cincinnati, OH
Jun. 7-8/12	Atlantic Beach, NC

TCI for Families

June 27-28/11	Ithaca, NY
---------------	------------

ONE DAY UPDATES*

1-Day: Life Space Interview for Proactive Aggression

May 21/12	Warwick, RI
-----------	-------------

1-Day: Conflict Resolution

Sep. 19/12	Peoria, IL
------------	------------

1-Day: Legal Concepts Involved in Use of Physical Restraint

Aug. 8/12	Ithaca, NY
-----------	------------

1-Day: Testing, Evaluation, and the Transfer of Learning

Apr. 11/12	Cincinnati, OH
Nov. 7/12	Warwick, RI

1-Day: TCI Trainer Support

Mar. 21/12	Peoria, IL
------------	------------

TCI CANADA 2012 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Feb. 6-10/12	Toronto, Canada
--------------	-----------------

TCI UPDATES

Designing Refresher Training

Mar. 5-6/12	To be announced
-------------	-----------------

TCI EUROPE 2012 COURSE OFFERINGS

TCI: TRAINING OF TRAINERS (TXT)

Apr. 23-27/12	Glasgow, Scotland
Jul. 2-6/12	Dublin, Ireland
Sep. 24-28/12	Doncaster, UK
Dec. 3-7/12	Dublin, Ireland

TCIF: TRAINING OF TRAINERS (TCIF TXT)

Mar. 5-9/12	Doncaster, UK
Oct. 22-26/12	Dublin, Ireland

TCI UPDATES

Developing Professional Level Training Skills

Oct. 15-16/12	Doncaster, UK
---------------	---------------

TCI for Developmental Disabilities

Mar. 12-13/12	Dublin, Ireland
---------------	-----------------

TCI for Families

Feb. 23-24/12	Dublin, Ireland
Mar. 21-22/12	Doncaster, UK
Jun. 18-19/12	Dublin, Ireland
Nov. 22-23/12	Dublin, Ireland

Designing Refresher Training

May 30-31/12	Glasgow, Scotland
Jun. 20-21/12	Dublin, Ireland
Oct. 17-18/12	Doncaster, UK
Nov. 26-27/12	Dublin, Ireland

Post Crisis Response

Apr. 17-18/12	Doncaster, UK
Jun. 13-14/12	Glasgow, Scotland
Sep. 20-21/12	Dublin, Ireland

ONE DAY UPDATES*

1-Day: Life Space Interview for Proactive Aggression

Jun. 12/12	Glasgow, Scotland
Oct. 19/12	Doncaster, UK
Nov. 29/12	Dublin, Ireland

1-Day: Conflict Resolution

Apr. 16/12	Doncaster, UK
------------	---------------

1-Day: Testing, Evaluation, and the Transfer of Learning

Apr. 19/12	Doncaster, UK
Sep. 19/12	Dublin, Ireland

1-Day: TCI Trainer Support

Mar. 14/11	Dublin, Ireland
May 29/12	Glasgow, Scotland
Sep. 17/12	Stevenage, UK
Nov. 14/12	Belfast, N. Ireland
Nov. 30/12	Belfast, N. Ireland

1-Day: TCI For Schools

Nov. 12/12	Doncaster, UK
Nov. 28/12	Dublin, Ireland

**Note: ONE-day updates are ONLY available to TCI trainers who have successfully completed TWO, two-day updates, preferably Designing Refresher Training and Post Crisis Response.*

PLEASE CONSULT THE RCCP WEBSITE FOR UPDATES TO THIS SCHEDULE: rccp.cornell.edu