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The National Child
Traumatic Stress Network



Trauma-Focused Interventions for Youth in the Juvenile Justice System

From the National Child Traumatic Stress Network
Juvenile Justice Working Group

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Trauma-Focused Interventions for Youth in the Juvenile Justice System

Introduction

Each year, over two million young people come into contact with the juvenile justice system, and hundreds of thousands of children and youth enter correctional facilities of some type. Numerous studies document that many of the youth in the juvenile justice system have been exposed to myriad traumatic events, either as victims or as witnesses. Because of this exposure, many of these youths have developed post-traumatic stress disorder (PTSD) and other stress-related disorders (Arroyo, 2001; Abram et al., 2004; Cauffman et al., 1998; Steiner, 1997; Wasserman et al., 2002; Wood et al., 2002a; Wood et al., 2002b). In addition, arrest and detention experiences themselves can be traumatic events for some children, can expose children to risks for additional trauma, and can also trigger memories and reactions to previous traumatic experiences.

A number of effective trauma-focused treatments have been either designed or adapted for adolescents. Unfortunately, few of these trauma-focused treatments are used much in juvenile justice settings, due to lack of clinical resources in these settings, underidentification of trauma symptoms, and a greater focus on behavioral management issues. Below, we review trauma-focused, family-based, and group-based interventions that show promise for use with youth in the juvenile justice system.

Pretreatment Assessment

Prior to beginning trauma treatment with a youth in the justice system, the therapist should evaluate the youth's environmental and contextual risk and safety. Trauma-focused treatments are designed to address traumatic stress with youths who are not in imminent danger due to living in unsafe environments. Trauma-focused therapy typically involves teaching skills to reduce hypervigilance, hyperarousal, and intrusive re-experiencing. However, these symptomatic reactions are often appropriate or necessary in currently dangerous environments. Teaching such skills to someone living in a dangerous environment could be harmful in that it may desensitize them to real danger, putting them at greater risk in the future. Exposure to trauma cannot be entirely eliminated in many youths' lives, but an acceptable level of safety should be established prior to trauma-focused treatment.

Family-focused interventions are widely used as an approach to treatment for youths with PTSD, but there are limitations to their effectiveness if family members are unable or unwilling to invest themselves (Glynn et al, 1999; Copping et al, 2001). Assessment of the parent's perception of the youth's traumatic experience(s) and post-traumatic symptoms gives the assessor information about potential strengths or weaknesses in the youth's family support system, and potential obstacles to parental engagement. Family members may also need to be assessed for their own distress at

having witnessed, caused or failed to prevent the victimization or traumatization of their child. Assessment of parental perceptions, primary or secondary PTSD symptoms or associated distress, and stage of readiness to change is essential to the formulation of a treatment plan.

Trauma-Focused Interventions

Research studies done with the juvenile justice population over the past 10 years show generally that the most effective programs with this population are highly structured, emphasize the development of basic skills, and provide individual counseling that directly addresses behaviors, attitudes, and perceptions (Altschuler, 1998). Cognitive behavioral approaches have been shown to be particularly effective for youth in the juvenile justice system, as well as for children with more general anger and disruptive behaviors.

The US Department of Justice recently published guidelines for the treatment of victims of physical or sexual trauma (Saunders et al, 2003). Given the limited outcome data available on adolescent trauma interventions, all the treatments considered were rated based upon their theoretical bases, clinical-anecdotal literature, acceptance among practitioners, and risk of causing harm.

The only trauma-focused therapy that received a high rating for adolescent trauma treatment was Cohen, Mannarino, and Deblinger's (2003) Cognitive Behavioral Therapy (CBT) for PTSD (Saunders et al, 2003). This therapy is designed to reduce negative emotional and behavioral responses and correct maladaptive beliefs and attributions related to traumatic experiences. To date there are no known research studies on the use of CBT for trauma with youth involved in the juvenile justice system. But this therapy has been proven effective for youth exposed to a variety of traumatic events and has received the strongest empirical support from studies with abused children (Saunders et al., 2003). This therapy can be used in individual, family, and group therapy and in office- or school-based settings.

Other widely utilized trauma treatments include Cognitive Processing Therapy and Eye-Movement Desensitization and Reprocessing (EMDR). These trauma treatments lack empirical validation with adolescents. Several other therapies that do not address PTSD directly, but do target symptoms and functional problems that are relevant to PTSD, have empirical support and are widely used to address behavioral health problems of youths in the juvenile justice system. These therapies include: Behavioral Parent Training, Multisystemic Therapy (MST), Functional Family Therapy, Treatment Foster Care, Brief Family Therapy (Borduin et al., 2000; Chamberlain and Moore, 2002; Ford et al., 2003; Kashani et al., 1999). Most of these interventions do not report data on cultural differences in technique or outcomes.

Most of the trauma-focused treatments share an emphasis on teaching several key skills including

1. emotion identification, processing, and regulation;
2. anxiety management;
3. identification and alteration of maladaptive cognitions; and
4. interpersonal communication and social problem solving.

Some interventions also seek to enhance parent-child relationships by promoting positive interactions, reducing negative interactions, and using effective behavior management skills.

Treatment of Co-occurring Disorders

About one-half of juvenile detainees have at least two mental health disorders, and about one in 10 have both a major mental disorder and a substance use disorder. (Abrams et al., 2004). A number of studies indicate that PTSD is commonly comorbid with major depression and to a lesser extent with substance abuse or dependency. (Kilpatrick et al., 2003). In fact, there is some evidence to suggest that some forms of interpersonal violence may heighten the risk for diagnostic comorbidity. Clinicians evaluating youth in the juvenile justice system for mental disorders should also screen for alcohol and drug use and for history of trauma exposure and experience. Integrated substance abuse and mental health treatment should be used for youth who have comorbid disorders.

Family-Based Interventions

Evidence suggests it is important to involve family members in the treatment and rehabilitation of their traumatized children for reasons related both to child and family functioning and to delinquency (Sherman et al., 1998). However, a variety of barriers may exist when involving the families of youth in the juvenile justice system (Ko et al., 2004).

Some juvenile facilities are located far from the home communities of children they detain, making family participation impossible; many families need transportation or other assistance in order to participate in treatment. Families may feel angry, ashamed, or burdened by their child's delinquent behavior and the additional hardship it has brought to the family.

If the parent was a perpetrator (e.g., domestic violence, sexual or physical assault) and the child is still living with or in regular contact with that parent, the parent may not yet have accepted responsibility for the traumatic event(s). Nonoffending parents may experience loyalty conflicts between the victim and the perpetrator. They also may feel significant distress and helplessness due to not having been able to prevent the victimization. Parents who witness their children's exposure to trauma may experience significant post-traumatic stress, and this has been shown to be associated with traumatized children's levels of PTSD (Winston et al., 2002). Finally, caregivers themselves may be victimized or abused, or suffer from depression, anxiety, or traumatic stress. They may feel unable to help their children.

There is growing evidence from studies of children exposed to different types of trauma that less parental distress and more familial support mitigates the negative impact of trauma on children. For example, several studies have directly examined the impact of including a parent component in trauma-focused cognitive behavioral therapy sessions. These studies have demonstrated that interventions that help the parent resolve emotional distress about the child's trauma, and which optimize the parent's ability to be supportive of the child, are likely to improve the child's outcome (Cohen, Mannarino, and Deblinger, 2003).

There are different approaches to conducting clinical intervention with families. These approaches include shared family sessions in conjunction with individual or group treatment for the child, group or individual treatment with adjunctive family/parent sessions, family therapy, and family group therapy.

Therapists need to be especially alert to family members who were together during a traumatic experience. Not only do family members have very different psychological needs and different courses of recovery, but family members can actually serve as traumatic reminders to each other. One goal of therapy is to help family members anticipate, identify, and manage trauma and loss reminders. The family also needs to be aware of and be respectful of the differences in psychological

needs and course of recovery. Another goal of therapy should be to improve understanding, timely support and tolerance among family members, and to repair trauma-related estrangement.

Beyond post-traumatic stress responses, it is critical for families to develop a plan to address the secondary adversities, including demands on parents and children, changes brought about by the trauma or loss, continued medical care, and skills needed to cope with what happened.

Group-Based Interventions

Two controlled studies indicate that grouping delinquent or high-risk youth may inadvertently reinforce problem behaviors (Dishion, 1999). This research finding is most relevant to adolescents ages 11 to 14. It is important to note that not all interventions with peer groups have shown adverse effects. Some strategies to guard against these potential adverse effects include involving parents in treatment, mixing antisocial and prosocial youth in groups, limiting group size, and using cofacilitators in groups so that inappropriate behaviors can be addressed immediately prior to peers' reinforcement of the negative behavior.

Summary

Juvenile justice facilities have an opportunity to raise the standard of care for youth by providing effective trauma-focused treatments and family-based interventions. Additionally, since some youth express trauma symptoms behaviorally, treatments that address trauma symptoms can also be expected to assist juvenile justice staff with issues related to behavioral management.

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