



Evidence-Informed Interventions for Posttraumatic Stress Reactions with Youth Involved in the Juvenile Justice System

Introduction

Therapeutic treatment of the psychosocial after-effects of childhood exposure to traumatic stressors is a key component in the development of trauma-informed juvenile justice systems (Branson, Baetz, Horowitz & Hoagwood, 2017; Kerig, 2012). Although the focus of this fact sheet is on therapeutic interventions for clinically significant posttraumatic stress symptoms, delivery of these interventions is likely to be feasible and beneficial. Not only are they feasible and beneficial based on their therapeutic effectiveness, but also on the extent to which they are provided (whether within juvenile justice programs or by external referral) in a context of a juvenile justice system that has a foundation of trauma-informed practices and principles.

As summarized by Branson and colleagues (2017), trauma-informed juvenile justice systems employ practices that foster safety, privacy, dignity, predictability, restorative practice, shared responsibility, collaboration, and cultural competence (for adult staff as well as for youth). To make these practices actual rather than merely aspirational, it is necessary to establish trauma-informed systemic and organizational policies while also providing ongoing education, tangible support, and guidance for staff at all levels as they engage with youth and one another. Trauma-informed juvenile justice practices and policies are based on an affirmation of the core mission of the system – to protect public safety and prevent youth from engaging in activities and relationships that are directly or indirectly cause physical or psychological harm to others or to themselves. However, trauma-informed programming also involves a paradigm shift: a shift from viewing rehabilitation and redirection of youth as a matter of enforcing discipline with punishment, criticism, or coercion to a program of identifying and building strengths, prosocial values, reflective self-awareness, empathic concern and respect for others, and constructive long-term goals.

For many youth who become involved in juvenile justice, this includes providing educational and vocational services and supports that address disparities and disabilities that have played a role in their contact with law enforcement. Trauma informed juvenile justice systems also take into account, in supervising and providing services to youth, the effects that traumatic adversity have had, and continue to have, on youth and their families and communities as a result of racism, homophobia, misogyny, and other forms of identity- and culturally-based stigma, discrimination, disparities, and violence (see the NCTSN Essential Elements in Trauma Informed Juvenile Justice Systems <https://www.nctsn.org/resources/essential-elements-trauma-informed-juvenile-justice-system>).

This trauma-informed approach to all aspects of juvenile justice programming is essential because more than 80% of juvenile justice-involved youth report a history of exposure to at least one traumatic event at some point in their lives, and the majority of youth report multiple forms of victimization (e.g., Abram et al., 2004; Charak, Ford, Modrowski, & Kerig, 2019; Dierkhising et al., 2013; Ford, Grasso, Hawke, & Chapman, 2013; Bennett, Kerig et al., 2014; for a review, see Kerig & Becker, 2012). Longitudinal research also demonstrates that childhood traumatic stress is predictive of adolescent delinquency (Widom, 2017). Although, it is important

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to note that the vast majority of youth who have experienced traumatic adversity do not become involved in delinquency or with the juvenile justice system. If they are on a delinquent course, past or ongoing exposure to traumatic stress is associated with the severity of youth's offenses and their likelihood of recidivism (see Kerig & Becker, 2014). Moreover, many youth in the juvenile justice system have experienced multiple, chronic, and pervasive interpersonal traumas, which places them at risk for chronic emotional, behavioral, developmental, and legal problems (Charak et al., 2019; Ford, Charak, Modrowski, & Kerig, 2018; Ford et al., 2013). Unresolved posttraumatic stress can lead to serious long-term consequences across the entire lifespan, such as problems with interpersonal relationships; cognitive functioning; mental health disorders (PTSD, substance abuse, anxiety, disordered eating, depression, self-injury, risky behavior) and conduct problems (Ford, 2020a). These consequences can increase the likelihood of involvement in delinquency, crime, and the justice system (Ford, Chapman, Pearson, & Mack, 2006; Kerig, 2019; Kerig & Becker, 2010). Further, youth who are exposed to traumatic stressors while in juvenile justice supervision or detention are prone to problem behaviors that endanger other youth and adults (DeLisi et al., 2010; Ford et al., 2012; Stimmel et al., 2013). Juvenile justice detention has not been shown to reduce recidivism and may iatrogenically increase the risk as a result of exposure to negative peer models and to traumatic events (including race-related trauma) while in detention, as well as the separation from family and community.

Trauma-informed juvenile justice programming also involves identifying youth who are experiencing behavioral or psychological problems related to past or current traumatic adversities. Thus, connecting youth and their families to behavioral health professionals and programs can provide treatment that promotes recovery from traumatic stress-related problems. A separate fact sheet describes approaches to identifying trauma-affected youth (e.g., screening) that juvenile justice staff can utilize, as well as methods of clinical assessment of trauma-related symptoms that behavioral health professionals and programs can utilize to determine the best approach to providing effective therapeutic interventions for youth who are experiencing problematic traumatic stress reactions (LINK). When trauma-focused therapeutic interventions are provided on a timely basis, matched to each youth's specific needs and life circumstances, this can begin the crucial process of restoring responsible social citizenship and healthy development, as well as enhancing the safety and health of their families, communities, schools, peer-groups, and workplaces.

Identifying Youth Who Have Trauma-Related Emotional and Behavioral Problems

Traumatized youth may develop not only posttraumatic stress disorder (PTSD), but also a wide range of emotional and behavioral problems, particularly when trauma exposures are multiple and complex (Ford, 2011; Spinazzola & Briere, 2020). Therefore a thorough diagnostic assessment is warranted to identify the key targets for treatment (see Kerig & Ford, 2021). The diagnosis of PTSD itself was dramatically expanded in the 5th Revision of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 2013. PTSD no longer is classified as an anxiety disorder, but as a "Trauma- and Stress-Related Disorder" (American Psychiatric Association, 2013, p. 271).

The key features of PTSD in DSM-5 include symptoms of intrusions (e.g., nightmares, re-experiencing the event); avoidance (e.g., efforts to avoid thinking about or encountering trauma reminders); negative cognitions and mood (e.g., self-blame, inability to feel happiness, and arousal (e.g., irritability, being easily startled) that occurs in the aftermath of exposure to traumatic event. In addition, the newly released version of the International Classification of Diseases (ICD-11) includes a separate diagnosis of Complex PTSD (CPTSD). CPTSD notes an additional array of symptoms that follow prolonged exposure to inescapable interpersonal traumas such as child abuse, commercial sexual exploitation, or torture. In addition to the three core symptoms of PTSD according to ICD-11 (i.e., re-experiencing the event, effortful avoidance, and perceptions of being under current threat), the CPTSD diagnosis includes severe and persistent problems in affect regulation (e.g., being unable to calm down when upset); negative self-perceptions (e.g., beliefs that the self is damaged, worthless, or guilty); and difficulties in sustaining relationships or feeling close to others (Cloitre et al., 2013).

Although not currently an official diagnosis under either DSM-5 or ICD-11, it is also noteworthy that support is emerging for an additional proposed diagnosis that may serve to capture the experiences of youth in the justice system. Many of whom have undergone multiple forms of interpersonal trauma from an early age. The proposed diagnosis of Developmental Trauma Disorder (DTD) (van der Kolk et al., 2009) was developed to capture, and put under one umbrella, the wide range of negative emotional and behavioral consequences that follow from early-onset exposure to violence and disruptions in caregiving (Cook et al., 2005; D'Andrea et al., 2012; Ford & Courtois, 2020). These include difficulties with affective and physiological regulation (e.g., inability to tolerate or recover from strong emotional states, or impaired awareness of emotions; attentional and behavioral dysregulation (i.e., self-harming or difficulty with sustaining goal-directed behavior; as well as self and relational dysregulation (i.e., persistent negative sense of self, lack of empathy toward others). An emerging body of research is providing evidence that symptoms of DTD can be reliably recognized and distinguished from PTSD (e.g., Ford et al., 2018; Spinazzola et al., 2018; Stolbach et al., 2013; van der Kolk et al., 2019). Consequently, interventions for youth who present with this constellation of symptoms are being developed and tested (e.g., Briere & Lanktree, 2012; Kagan et al., 2014; see Ford & Courtois, 2013), although not specifically in the context of juvenile justice.

Setting the Stage Before Providing a Therapeutic Intervention or Making a Referral for Traumatized Youth Who are Involved in (or At Risk for) the Juvenile Justice System

An effective intervention must have a rigorously documented evidence-base for improving these difficulties with juvenile justice-involved youth while also being acceptable to the youth, their families, the courts and legal representatives, and juvenile justice staff. However, before providing a therapeutic intervention to traumatized youth in the juvenile justice system, or referring these youth for a therapeutic evaluation, several key issues must be considered (adapted from Kerig, 2013).

Questions to Consider When Providing Traumatized Youth with Therapeutic Services

Is the youth likely to be able to engage in and benefit from trauma-focused therapy?

- Motivated to deal more effectively, or be less troubled by, distressing memories, or avoidant behavior, or hypervigilance (which may take the form of anger, depression, panic attacks, flashbacks, withdrawal, reactive aggression, impulsive or addictive behaviors)?
- Capable of empathy for self/others even if overtly callous, unemotional or vengeful?
- Willing to engage in therapy and with the specific therapist, even if with reluctance due to avoidant behavior, emotional numbing, or distrust in adults and authorities/systems?
- Not self-harming, or motivated to control/prevent self-harm and reckless behavior?
- Not imminently suicidal (note: suicidal ideation without imminent risk is not a rule-out)?
- Able to safely manage dissociative symptoms without persistent identity fragmentation?
- Able to manage psychotic symptoms/severe flashbacks (with medication if indicated)?
- Able to manage substance use or other addictive behavior without imminent crises?
- In a sufficiently stable residential/interpersonal setting to provide the support and time necessary to provide an adequate dose of a trauma-specific therapeutic intervention without interruption due to residential changes or crises in the residence/setting?

What modalities and approaches to therapy best fit the youth's needs/stage of change?

- How could motivational enhancement techniques maximize the likelihood that the youth, their family or other caregivers will be willing to engage in therapy?
- Would the youth and family benefit from traumatic stress psychoeducation?
- If the youth is in an out-of-home placement, would the people responsible for care and supervision (e.g., juvenile justice staff) benefit from traumatic stress psychoeducation?
- Would the youth benefit from developing/improving skills for emotion regulation (including related to anger, guilt/shame, sadness, and dysphoria as well as fear or anxiety)?
- Would the youth benefit from developing/improving skills for constructive problem solving, goal setting, goal attainment, decision making, and mental focusing?
- Would the youth benefit from developing/improving skills for interpersonal communication?
- Is the youth caught in a vicious cycle of intrusive re-experiencing or reenactment of specific trauma memories or general interpersonal difficulties that are thematically related to past traumas that is perpetuated/exacerbated by attempts to be hypervigilant and to avoid memories/feelings?
- Is the youth troubled by grief related to past or current traumatic losses?
- Is the youth experiencing dissociative states/reactions?
- Is the youth engaging in addictive behaviors (involving substances, gambling, sexuality, eating, or repetitive escape activities such as video gaming) to self-medicate distress?
- Does the youth react to perceived psychosocial threats/injuries defiantly or aggressively?
- Is the youth isolated or involved in a deviant peer group (consider group or milieu therapy interventions that would promote prosocial peer involvement and social skills)?
- Is the youth experiencing, or has the youth experienced racial or other identity-related (e.g., discrimination, exploitation, or violence based on gender, sexual identity, ethnicity, nationality/language, or disability) stressors or traumas?
- Does the youth have consistent involvement of prosocial adult/older peer mentors?

What is the goal of therapy in the context of the youth's juvenile justice involvement?

- What evidence of remorse, responsibility-taking, and prosocial future intentions is required by the court, attorneys, probation/parole, the school, or the community?
- What strengths (e.g., motivation, values, empathy, ethical beliefs/conduct) or developmental attainments (e.g., school graduation, involvement in a prosocial peer group) should be enhanced to demonstrate evidence of the youth's ability to safely be an independent and productive member of the community?
- What actions by the youth can be supported to support the youth in engaging in the restorative justice process?
- What adverse reactions to law enforcement, detention, probation, or court procedures should the intervention enable the youth to proactively anticipate and prevent/manage? *cont'd on pg 5*

- What cues, contexts, or trigger events/situations that could lead to recidivism should the intervention enable the youth to proactively anticipate and prevent/manage?
- How does the intervention help the youth prevent/reduce self-harm, risky/reckless behavior, and associations with delinquent peers or adults involved in criminal behavior?
- How does the intervention increase the family's ability to provide the youth with positive role modeling, emotional and academic support, and helpful guidance and supervision?
- How does the intervention engage other important adults in the youth's life (e.g., mentors, teachers, coaches, extended family members) in supporting prosocial changes?
- How does the intervention prepare the youth to anticipate and effectively handle threats, stressors, reminders of past traumas, and additional traumatic events in daily life?

What is the justice system's readiness to support therapy by providing trauma-informed services?

- Are the physical and social environments in which juvenile justice services are conducted set up to provide privacy, safety, clear/developmentally appropriate communication, helpful social support, consistent/logical routines and rules, motivational enhancement, and facilitative adult role models?
- Do the system/organization's policies and procedures mandate and explicitly support staff and officials in establishing a safe, healthy physical/social environment?
- Is there training and supervisory support to equip staff to respond sensitively and effectively to youth stress reactions and to protect staff from vicarious traumatization?
- Is there training and supervisory support to equip staff to understand, buy into, and reinforce the skills/knowledge that therapy teaches youth for handling stress reactions?
- Are juvenile justice officials (including judges, attorneys, probation, detention, and parole staff, juvenile review board members, and diversion program staff) fully informed about the nature, requirements, and potential benefits and realistic time frame of the intervention?
- Are channels and a plan for timely regular and as-needed communication to and from family, juvenile justice officials, and other key adults and systems (e.g., teacher, mentor) set up and accessible to all parties?

Who will be informed about therapy progress/outcomes and how will they utilize this information?

- The court/judge? Attorneys (Prosecution/Defense)? Probation/parole officers? Schools? Child Protection Services? Families/caregivers?
- How could progress/outcome reports be used to adversely affect the youth's legal status or sanctions, and how can this be prevented or identified and mitigated if not preventable?
- How will youth's privacy and rights to avoid self-incrimination be protected?

What resources are in place to ensure the youth's safety and benefit during and after therapy?

- How are the responsible adults in the youth's environment prepared to handle flare-ups of stress reactions, dissociation/re-enactments, and trauma disclosures by the youth?
- Are trauma-informed behavioral health services accessible by the youth and family after trauma-focused therapy ends and after the youth's juvenile justice involvement ends?

Interventions with an Evidence Base for Traumatized Youth Involved in Juvenile Justice

Five therapeutic interventions have demonstrated empirical evidence of effectiveness specifically with traumatized adolescents involved in, or at risk for or involvement in, the juvenile justice system: TARGET, TGCT-A, CPT, TF-CBT, and STAIR-A.

Trauma Affect Regulation: Guide for Education and Therapy (TARGET).

TARGET (Ford, 2017, 2020) is an educational and therapeutic intervention for trauma-impacted adolescents and adults, which may be implemented as an individual or group therapy, or as a milieu intervention (Ford & Blaustein, 2013; Ford & Hawke, 2012). TARGET teaches a seven-step sequence of self-regulation skills summarized by the acronym FREEDOM. The first two skills, Focusing and Recognizing triggers, provide a foundation for shifting from stress reactions driven by hypervigilance to proactive emotion regulation. The next four skills provide a dual-processing approach to differentiating stress-related and core value-grounded emotions, thoughts, goals, and behavioral options. The final skill teaches ways to enhance self-esteem and self-efficacy recognizing how being self-regulated contributes to the world. A randomized clinical trial with delinquent or justice-involved girls with dual diagnosis PTSD, substance use and other (e.g., oppositional-defiant, depression, panic) disorders showed that a 10-session individual TARGET intervention was superior to relational psychotherapy in reducing PTSD and depression and improving emotion regulation (Ford, Steinberg, Hawke, Levine, & Zhang, 2012). Additional evidence for TARGET's effectiveness as a group and milieu therapeutic intervention with detained or incarcerated youth was provided by three quasi-experimental studies that showed reductions in violent behavioral incidents and coercive restraints and improvement in PTSD, depression, and hope/engagement in rehabilitation following TARGET (Baetz et al., 2019; Ford & Hawke, 2012; Marrow, Knudsen, Olafson, & Bucher, 2012). TARGET was adapted as a family therapy for at-risk youth in foster and adoptive family placements in two statewide effectiveness studies. With children in foster family placements, TARGET was associated with increased contact by foster children with their biological father and other family members and significantly more youth exiting foster care to adoption than services as usual (<https://www.childwelfare.gov/pubPDFs/IllinoisPII.pdf>). With children in adoptive family placements, TARGET was associated with fewer school suspensions and episodes of truancy (16% vs. 33-35%) (https://qic-ag.org/wp-content/uploads/2019/10/6-QIC-AG_Ch6_Illinois_10.15.19.pdf). A 4-step skill set, and an abbreviated group, one-to-one, and family intervention, T4, was developed based on the field trials for JJ facility and community (e.g., probation) staff and foster and adoptive families. TARGET has been disseminated in several state juvenile justice and child protective services systems (e.g., Connecticut, Florida, Illinois, Ohio), and is being disseminated in Learning Communities in the New York City, Oakland (Alameda County), San Diego, and San Jose (Santa Clara County) juvenile justice systems by the NCTSN Center for Juvenile Justice and Trauma Recovery. TARGET has been certified as an "effective" intervention (highest level of evidence) by the Office of Juvenile Justice and Delinquency Programs Model Programs website (<http://www.ojjdp.gov/mpg/Program>) and received the highest rating for dissemination infrastructure (and a positive rating for the science evidence base) by the National Registry of Evidence-based Programs and Practices (www.nrepp.samhsa.gov).

Trauma and Grief Component Therapy for Adolescents (TGCT-A)

TGCT-A (Layne, Saltzman, Kaplow, Olafson, & Pynoos, 2018) is a four-module treatment model first developed, disseminated, and evaluated in a randomized trial for adolescent war survivors in Bosnia in the 1990's (Layne, Saltzman, et al., 2008), and since been implemented successfully for urban, gang-involved and at-risk youth in California (Saltzman, Layne, Steinberg, & Aisenberg, 2001), for at-risk youth in the Delaware schools (Grassetti, Herres, Williamson, Yarger, Layne, & Koback, 2014), and most recently successfully implemented in juvenile justice settings (Olafson et al., 2016). It has been disseminated in NCTSN Learning Collaboratives and Learning Communities in many states since 2011 with trauma-informed milieu training (Think Trauma, see www.NCTSN.org) for facility staff. TGCT-A's four modules address: (1) foundational knowledge and skills to enhance posttraumatic emotional, cognitive, and behavioral regulation and improve interpersonal skills; (2) group sharing and processing of trauma experiences; (3) group sharing and processing of grief and loss experiences; (4) resumption of adaptive developmental progression and future orientation.

The manual is designed to be used not only by trained, Masters-level clinicians but also by teachers, facility staff, and coaches. Each session contains step-by-step instructions for implementation, including suggested scripts for the exact language to use while conducting groups. Groups of 8-10 youth are generally led by two group leaders. Although single gender groups are recommended, some facilities report successful implementation with mixed gender groups. TGCT-A's unique contributions for justice-involved youth are twofold: it includes group processing of trauma experiences (most often community violence exposure), which harnesses adolescent peer influence to promote greater self-regulation; and it has a full component for group processing of grief and loss. Because TGCT-A is a modularized intervention, facilities that retain youth for briefer periods can implement only Modules I and IV, rather than implementing the full four-module version of 24 sessions, and the Bosnian research showed effectiveness for the briefer version (Layne, et al, 2008). When implemented in a secure juvenile justice setting in tandem with a staff training in Think Trauma, TGCT-A was associated with reduced PTSD and negative behavior among the youth and dramatically reduced usage of harsh measures such as seclusion and restraints among staff (Olafson et al., 2016). In a pilot field trial study with youth in a secure facility for serious offenses who participated in groups using the Traumatic Grief and Future Orientation modules of TGCT-A reported reductions in separation distress and reactive distress on the Persistent Complex Bereavement Disorder (PCBD) Checklist—including the large sub-group (>80%) of youth who met criteria for complex bereavement disorder. In a separate study (Clow et al., 2023), the TGCT-A Traumatic Grief module was implemented as a group intervention by mental health and juvenile justice staff co-leaders in a secure correctional facility with boys, and grief scores decreased significantly for separation distress and circumstance-related distress after the group. Additionally, in a 5- to 15-week follow-up after the group (versus the 5- to 15-week period before the group) there was a 50% reduction in the number of behavioral incident reports involving TGCT-A group participants compared to no change in incidents for 63 matched boys who did not receive TGCT-A.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is a (12 to 24 90-minute session), components-based intervention for children from 3 to 18 years old and their caregiver(s) using a combination of cognitive-behavioral skill building and gradual exposure to feared trauma memories and reminders. The published manual (Cohen, Mannarino, & Deblinger, 2017) describes the phase-based approach that includes psychoeducation, relaxation, emotional identification and expression, and cognitive coping skills, developing and sharing oral or written trauma narratives, and therapeutic closure; an additional text provides detailed descriptions of applications of TF-CBT to a variety of specific populations, racial and ethnic groups, and types of trauma (Cohen, Mannarino, & Deblinger, 2012). Several randomized clinical trials have demonstrated TF-CBT's superiority to supportive therapy with children (including approximately 33% adolescents) with PTSD following abuse, violence, and single-incident (e.g., severe accidents) traumatic stressors (see a review in Cohen et al., 2017). Outcomes for depression and behavioral problems have been mixed, with moderate effective sizes in some studies (de Arellano, et al., 2014). TF-CBT also has been adapted for use with youth with Complex PTSD presentations (Cohen et al., 2012; Kliethermes & Wamser, 2012). Regarding justice-involved youth specifically, TF-CBT also has been implemented in a randomized controlled trial with adjudicated youth in residential treatment facilities, with results confirming clinically significant improvements in PTSD and depression

(Cohen et al., 2016). TF-CBT also has been effectively integrated into more omnibus evidence-based treatments for delinquency (e.g., Multidimensional Treatment Foster Care) in order to meet the needs of that subset of youth who have experienced trauma (Leve, Chamberlain, & Smith, 2012; Smith, Chamberlain, & Deblinger, 2012). TF-CBT also has been shown to be safe, tolerable, and potentially effective in reducing symptoms of depression, anxiety, and PTSD with older adolescents and young adults (Peters et al., 2021) and refugee youth seeking asylum (Unterhitzberger et al., 2019)..

Cognitive Processing Therapy (CPT)

CPT (Resick, Monson, & Chard, 2016) teaches cognitive restructuring skills to address unhelpful beliefs that are keeping the youth “stuck” in the traumatic experience. Two versions of CPT are available; the original manual, which includes the creation of a detailed trauma narrative and the CPT-Cognitive Only (CPT-C) manual which involves the creation only of an “impact statement” regarding the aftermath of the trauma without requiring a detailed narrative account. Research suggests that the two versions are equally effective, and that CPT-C manual may confer the advantages of demonstrating more rapid treatment gains with fewer clients terminating prematurely (Resick et al., 2008; Walter et al., 2014). Although the manual developed for adult survivors of childhood sexual abuse has been used with success in samples of traumatized youth (Chard, 2005) revised versions of the CPT manual have been developed specifically for adolescents with abuse-related PTSD, with evidence of effectiveness (Matulis et al. 2014; Rosner et al., 2019). Regarding justice-involved youth, one study showed that a brief group version of CPT with incarcerated boys was superior to wait-list control in reducing PTSD and depression symptoms (Ahrens & Rexford, 2002).

Skills Training for Affect and Interpersonal Regulation (STAIR-A)

STAIR-A (Cloitre et. al., 2020) is an individual therapy originally developed for the treatment of PTSD following from childhood abuse among adults whose effectiveness has been supported in two randomized controlled trials (Cloitre, Koenen, Cohen, & Han, 2002; Cloitre et al., 2010). Recently, an adaptation called STAIR-A has been developed as a brief group therapy for adolescents (Gudiño et al., 2017). A psychoeducation module addressing psychological trauma and emotion identification is followed by modules on emotion regulation and interpersonal communication skills, with deep breathing and safety planning integrated into all sessions. Psychiatric inpatient adolescents (N = 38) reported decreases in PTSD and depression symptoms and increased coping self-efficacy after participating in between three and 36 group STAIR-A sessions (Gudiño et al., 2014). In two secure detention facilities, staff were trained on trauma-informed services with the Think Trauma curriculum, and STAIR was then implemented as a group intervention co-facilitated by a mental health clinician and a juvenile staff member (N=331). There was a reduction in violent incidents occurring in the facility in which 16% of the youth attended the group, but not in a second facility in which fewer (9%) of the youth attended the group (Baetz et al., 2021).

Other Interventions with an Evidence Base for Traumatized Adolescents

Other interventions have an evidence base to support their effectiveness with traumatized adolescents but have not yet been empirically tested specifically with juvenile justice-involved adolescents.

Prolonged Exposure Therapy (PE)

PE (Foa, Chrestman, & Gilboa Schechtman, 2008) guides the youth through a series of repeated recountings of one or more specific traumatic events that are audiotaped in the therapy sessions and then listened to as homework between sessions. PE also assists the youth in overcoming avoidance of reminders (cues) of traumatic events in their daily life experiences. The published manual provides detailed instructions for carrying out each PE phase (preparation, imaginal exposure, in vivo exposure, closure. Two randomized clinical trial (RCT) studies with girls who had experienced sexual abuse (Foa et al., 2013) and adolescents who had experienced single-incident traumatic stressors (e.g., severe accidents; Gilboa-Schechtman et al., 2010) provided evidence of lasting therapeutic benefit (i.e., reduced PTSD and depression, improved psychosocial functioning) that was greater for 14-session PE than for supportive or psychodynamic therapies. An RCT study with adolescent girls with sexual

abuse-related PTSD in a community mental health clinic showed that PE was equivalent to client-centered therapy in reducing internalizing problems but superior to CCT in reducing externalizing problems such as rule-breaking, aggression, and conduct problems (Zandberg et al., 2016). Subsequently, an intensive version of PE provided to adolescents in mental health treatment, with five 90-minute sessions on consecutive days followed by three weekly booster sessions, was found to be associated with reductions in PTSD symptoms that persisted for 6 months (Hendriks et al., (2017).

Trauma Systems Therapy (TST)

TST (Navalta, Brown, Nisewaner, Ellis, & Saxe, 2013) helps the youth move through five phases of recovery from post-traumatic stress: “Surviving, Stabilizing, Enduring, Understanding, and Transcending.” Within each phase an array of psychotherapy modalities (e.g., cognitive processing, emotional regulation skills training, psychopharmacology), and home and community-based case management and advocacy are provided. Ellis and colleagues (2013) reported positive results in a sample of 124 children and adolescents exposed to potentially traumatic events. Over the course of a 15-month follow-up, youth who received the TST intervention showed improvements in emotion regulation, general functioning, and social-environmental stability and were less likely to be hospitalized than children in routine mental health care. When TST was implemented with youth in residential placements, reductions were reported in the use of physical restraints in behavioral incidents and in disruptions in subsequent foster care placements (Brown et al., 2013).

Other Promising Evidence-Informed Therapeutic Interventions for Traumatized Adolescents

Several other widely disseminated therapeutic interventions are available that have been applied clinically with youth involved in the juvenile justice system – in some cases on a large scale in organizations or systems serving entire communities, regions, or states – but have not yet been empirically tested with randomized clinical trial or field trial studies.

Attachment, Self-Regulation, and Competency (ARC)

ARC (Blaustein & Kinniburgh, 2019) provides therapeutic activities to achieve goals within three domains: attachment (building and supporting safe and responsive care by primary caregivers, providers, and milieu); self-regulation (supporting youth capacity to identify, modulate, and express emotional and physiological experience); and competency (building self-reflective capacities, problem-solving skills, and a coherent and positive understanding of self). The published manual describes experiential activities to address each goal in psychotherapy and in modifications to the youth’s milieu through staff training and family education.

Sanctuary

Sanctuary (Bloom, 2013) is an organizational change model rather than an individual or group therapy. Its aim is to establish a trauma-informed culture that supports youth in recovery from the impacts of traumatic stress, while simultaneously providing safety for clients, families, staff, and administrators. Seven features of the environment are addressed to build a culture of: Nonviolence, Emotional Intelligence, Inquiry & Social Learning, Shared Governance, Open Communication, Social Responsibility, and Growth and Change.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

SPARCS (DeRosa & Pelcovitz, 2008) is a group therapy that integrates key concepts from three evidence-based treatment models: Dialectical Behavior Therapy (DBT; Rathus & Miller, 2014), Trauma Affect Regulation: Guide for Education and Therapy (see above); and Trauma and Grief Components Therapy for Adolescents (see above). SPARCS is designed to enhance self-regulation, relationships, self-perception, and future goals.

Caveats and Potential Pitfalls in Providing Treatment and Prevention for Traumatized Youth in the Juvenile Justice System: Informed Consent, Privacy, Mandated Reporting and Self-Incrimination

At the outset, all parties should have a clear understanding of the extent to which youth and caregivers have the choice to provide or withhold informed consent (or assent, in the case of youth who are not legally adults) versus whether participating in therapy is compulsory (e.g., court-ordered). Youth and/or caregivers also should be informed whether any information the youth shares during therapy will be kept confidential, versus whether this will be shared with caregivers, facility staff, attorneys, judges, probation officers, child protection workers, school personnel, or others.

As in any psychotherapy, youth may choose to make disclosures in the course of trauma treatment that bring mandated reporting laws into play (e.g., if youth disclose having been sexually or physically abused). It is essential that clinicians are knowledgeable about and prepared to comply with the mandated reporting laws in their locality (Ford, Kerig, Desai, & Feerman & 2016). However, justice-involved youth also may disclose information during therapy that does not rise to the level of mandated reporting but is relevant to legal charges or probation status (e.g., when traumatic events occurred during delinquent activities or probation violations). Although most jurisdictions enforce a therapist-client privilege protecting against the compulsory sharing of information except when reporting is mandated, in a court-ordered treatment there may be parties that would expect or demand to be informed of these kinds of behaviors. Therefore, particularly when therapy is court-ordered and therapists are required to provide progress reports or summaries of the treatment to judges, probation officers, or others, it is essential to have a shared understanding at the outset amongst all parties regarding what specific information will be shared from the therapy sessions. Moreover, even when treatment is not court-ordered, it is caregivers rather than minors who are able to provide consent and are the holders of privilege, and therefore clinicians are advised to discuss the issue of confidentiality and its limits thoroughly with youth and caregivers together as part of the informed consent/assent process at the initiation of treatment.

Additional Clinical Considerations

Safety

Safety is paramount not just for youth but also for their caregiver(s) and significant others (e.g., siblings). Any therapeutic intervention with youth in the juvenile justice system must begin with and continuously monitor their exposure to ongoing or new sources of danger or harm (e.g., family, peer, or community violence; emotional, verbal, or sexual abuse; insufficient care or protection from accidental or interpersonal victimization). Although therapists have a role that is distinct from that of an advocate, they must be prepared to communicate in a timely and helpful manner with caregivers, authorities, and advocates when a youth's safety is unsure or in jeopardy.

Youth in secure juvenile justice facilities (e.g., detention, inpatient units) may be exposed to verbal or physical aggression from peers or staff which may activate traumatic stress reactions, including hypervigilance, hyperarousal, or intrusions of traumatic images (Ford & Blaustein, 2012).

Therapists must be cognizant of the youth's perceptions of their environment and be ready to work with the appropriate officials and advocates when concerns related to safety are voiced by a youth or are unspoken but likely based upon a youth's behavior (e.g., withdrawal, reactive aggression) or history.

The therapist's ability to provide a genuinely safe setting while dealing with emotionally painful and difficult experiences or symptoms depends upon knowledge of and sensitivity to the different ways that youth may experience a lack of safety in the juvenile justice context. Juvenile processing includes a variety of settings (e.g., police contacts, detention or prison, diversion and community-based rehabilitation programs, probation

offices, courts), legal issues (e.g., mandated reporting, court or probation directives), and privacy concerns (e.g., the sense of shame expressed by boys, and often girls as well, who have been sexually abused; Feiring, Miller-Johnson, & Cleland, 2007; Friedrich, 1997) that may influence the youth or caregiver's willingness and ability to disclose information about traumatic experiences or posttraumatic symptoms. As noted above, in juvenile justice settings, safety also involves explaining clearly to the youth and family, and reliably maintaining, definite boundaries and limits concerning confidentiality and sharing of clinical information (e.g., mandated reports or requests for information by courts, correctional staff, child welfare workers, or probation officers).

Racial, Ethnic, and Cultural Background

Race and ethnicity also influence the probability of arrest and the severity of consequences faced by youth at every stage of the juvenile court process (Marchbanks et al., 2018; Padgaonkar et al., 2021; Puzzanchera & Hockenberry, 2015). Therefore, the optimal wording and examples used in psychoeducation and therapeutic interventions must be calibrated based on youth's racial and ethnic identities and cultural backgrounds. What constitutes a problem (versus expected age-appropriate behaviors) and an appropriate method of resolution (versus culturally unacceptable intrusions on autonomy, relational expectations, and spiritual beliefs) often differs substantially depending on ethnocultural background, as well as between members of sub-groups within larger ethnocultural populations (e.g., different Native American tribal communities; Central American, Mexican, or Puerto Rican Hispanic/Latino persons from different post-immigration generations). When youth's ethnic or racial background leads them to either be potentially targeted by perpetrators (e.g., gang violence; racial discrimination) or law enforcement (e.g., disproportionate minority contact; Iguchi, Bell, Ramchand, & Fain, 2005), or to be influenced by historical trauma (e.g., youth of African American, Native American, Middle Eastern, or South American backgrounds whose ancestral predecessors were subject to genocide or racially- based political violence; Pole, Garn, & Kulkarni, 2008), therapy must be attuned to help the youth recognize, understand, and develop ways of managing the emergence of trauma-related scenarios and dilemmas based on these ethnoracial-based experiences of current or historical traumatic victimization.

Translation and back-translation of therapeutic materials or manuals into different languages must be done by qualified (technically and ethnoculturally) individuals, but even with formally translated protocols therapists must be alert to differences in regional and group-specific differences in dialect and colloquial meanings (which also may vary depending upon the client's identified peer group and extent of acculturation versus adherence to traditional cultural practices and norms).

Developmental Level

Youth in the juvenile justice system range in age from middle childhood (e.g., as young as nine or ten years old) to adolescence and early adulthood (e.g., early 20s in some jurisdictions). Apart from normative developmental differences based on objective chronological age, developmental delays should also be considered. Youth in the justice system average two years behind expected grade level (Wasserman et al., 2002) and therefore many of these have reading skills below grade level and/or have learning disabilities or developmental disabilities that may make the use of written materials or assignments in therapy stressful, embarrassing, or simply not informative for them.

Youth in the juvenile justice system also may be physically or psychosocially mature beyond their objective chronological age, in ways that may increase their risk of victimization or adverse legal sanctions. Physically abused or neglected youth are likely to have developed precocious abilities to detect potential threats (i.e., hypervigilance) which may lead them to be acutely aware of, and to react intensely (e.g., hyperarousal) or appear indifferent (e.g., emotional numbing, dissociation) to, subtle cues associated with potential threats (e.g., reactive aggression or oppositional defiance in reaction to what appear to be minor frustrations or social challenges) (Ford et al., 2006). Sexually abused girls have been found to experience an accelerated onset of puberty (e.g., developing secondary sexual characteristics and libido as early as age nine or ten), and correspondingly are at risk for further sexual victimization in adolescence (Noll, Trickett, & Putnam, 2003; 2011). Adaptations to therapeutic interventions

are vital to help these youth to understand how their differences from same-age peers are understandable and adaptive adjustments that their bodies have made to protect them and enable them to cope with psychological (and often physical) threats to their survival that occurred in traumatic experiences – and to develop ways to make intentional adaptations that reflect their personal goals and preferences now that they have the knowledge, support, and appropriate control over their lives and safety which they lacked when they were experiencing traumatic victimization.

Sexual Minority Youth

LGBTQ+ youth are estimated to be 5-7% of adolescents in the United States, but they represent more than double that proportion (13-17%) of youth in the juvenile justice system (Wilson et al., 2017). In secure juvenile justice facilities, 3% of boys and 39% of girls identify as LGB, and those sexual minority youth were more likely than detained heterosexual youth to have experienced sexual victimization both before and during detention, as well as 2-3 times more likely to be detained for a year or more (Wilson et al., 2017). LGBTQ youth face many identity related stressors that place them at risk (Johns et al., 2018) for traumatic victimization (Levine & Button, 2021; Williams et al., 2021), substance use problems (Nguyen et al., 2020), body dysmorphia (Calzo et al., 2015), and mental health problems including suicidality (Williams et al., 2021). A survey of LGBTQ young adults found that a person-centered collaborative approach to therapy in which the youth's sexual identity, and the stressors and traumatic experiences that are associated with being a sexual minority, are acknowledged and integrated into therapeutic work on all aspects of the individual's self and life was consistently identified as crucial to engagement and positive outcomes (Quinones et al., 2017). A trans-theoretical approach to culturally sensitive psychotherapy for LGBTQ individuals thus can serve as the foundation for trauma-focused therapy with justice involved youth (Tomicic & Rodriguez, 2020).

Sources for Further Information

Descriptions of evidence-informed therapeutic interventions for traumatized children and youth may be found on the National Center for Child Traumatic Stress website and in the 2013 book, *Treating Complex Traumatic Stress Disorders in Children and Adolescents*. Reviews of the scientific evidence base, clinical features, and dissemination programs of models of therapeutic intervention for children and adolescents with behavioral health problems can be found on the National Registry of Evidence-based Programs and Practices website (www.nrepp.samhsa.gov). Reviews of evidence-based therapeutic and rehabilitative interventions for adolescents involved in delinquency or the juvenile justice system may be found on the Office of Juvenile Justice and Delinquency Programs Model Programs website (<http://www.ojjdp.gov/mpg/Program>).

Summary and Conclusion

A growing array of evidence-based and evidence-informed, gender sensitive, developmentally appropriate, and ethnoculturally-acceptable therapeutic interventions can be accessed for the treatment and rehabilitation of traumatized youth involved in the juvenile justice system and their families and caregivers. Adaptations of these interventions are needed, additionally, to assist youth who are traumatized as a direct result of juvenile justice involvement or on an ongoing basis in their lives during and after juvenile justice involvement.

Restoring healthy development and functioning as well as personal safety are key goals for trauma-informed juvenile justice systems. Therapeutic interventions that help to establish a safe milieu and prevent potentially traumatizing (or traumatic stress reactivating) sanctions (e.g., physical restraints, seclusion), as well as enabling youth to recover from emotional and behavioral problems caused by post-traumatic stress, are essential not only for youth but also the staff and clinicians who work them. When post-traumatic emotional and behavioral problems are effectively addressed in all services and programs within the juvenile justice system, everyone – troubled youth and their families, adults who are responsible for public safety, and the entire community — can become safer and healthier.

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