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

**National Child Traumatic Stress Network  
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Evidence-Informed Interventions for Posttraumatic Stress Problems  
with Youth Involved in the Juvenile Justice System

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## Evidence-Informed Interventions for Posttraumatic Stress Problems 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 (Kerig, 2012). More than 80% of juvenile justice-involved youth report a history 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; Dierkhising et al., 2013; Ford, Hartmann, Hawke, & Chapman, 2008; Ford, Grasso, Hawke, & Chapman, 2013; Kerig et al., 2011, 2012). Longitudinal research also demonstrates that childhood traumatic stress is predictive of adolescent delinquency (Ford, Elhai, Connor, & Frueh, 2010) and that, once youth are on a delinquent course, traumatic stress is associated with the severity of youths' offenses and their likelihood of recidivism (see Kerig & Becker, 2014 for a review). 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 (Ford, Grasso, Hawke et al., 2013; Kerig et al., 2012). 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, including PTSD, substance abuse, anxiety, disordered eating, depression, self-injury, and conduct problems (Ford, 2010)—all of which can increase the likelihood of involvement in delinquency, crime, and the justice system (Ford, Chapman, Pearson, & Mack, 2006; Kerig & Becker, 2014). Further, youth who are exposed to traumatic stressors while in juvenile justice supervision or detention are prone to problem behaviors that endanger other youths and adults (DeLisi et al., 2010). Therefore, effective therapeutic interventions provided on a timely basis and matched to the specific needs and life circumstances of each traumatized youth can begin the crucial process of restoring responsible social citizenship and healthy development for troubled youths, as well as potentially enhancing the safety and health of their families, communities, schools, peer-groups, and workplaces.

### Intervening to Address Traumatized Youths' Emotional and Behavioral Problems

Traumatized youth may develop not only posttraumatic stress disorder (PTSD) but also a wide range of emotional and behavioral problems. PTSD itself was dramatically expanded in the 2013 5<sup>th</sup> Revision of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*. PTSD no longer is classified as an anxiety disorder, but as a "Trauma- and Stress-Related Disorder" (American Psychiatric Association, 2013, p. 271). In addition to anxiety, hundreds of clinical and scientific studies have demonstrated that the full range of post-traumatic stress emotional and behavioral problems following exposure to psychological trauma in childhood include numerous types of emotional distress (e.g., anger, guilt, dysthymia, grief), dissociation, somatization, impulsivity, self-harm, suicidality, aggression, substance abuse, social isolation, relational conflict, school and work avoidance or failure, sexual dysfunction, insomnia, and eating disorders (D'Andrea et al., 2012; Ford, Grasso, Greene et al., 2013). No therapeutic intervention can address all of these forms of post-traumatic dysregulation, but an effective intervention must have a rigorously documented evidence-base for improving these difficulties with juvenile justice-involved youth, as well as being acceptable to the youths, their families, the courts and legal representatives, and juvenile justice staff.

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

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 & Ford, 2014, *Trauma Assessment with Youth in the Juvenile Justice System*).

Questions to Consider When Providing Traumatized Youths with Therapeutic Services
<p>Is the youth likely to be able to engage in and benefit from trauma-focused therapy?</p> <ul style="list-style-type: none"> <li>• 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)?</li> <li>• Capable of empathy for self/others even if overtly callous/unemotional or vengeful?</li> <li>• Not self-harming, <b>or</b> motivated to control/prevent self-harm and reckless behavior?</li> <li>• Not imminently suicidal (<b>note:</b> suicidal ideation without imminent risk is <b>not</b> a rule-out)?</li> <li>• Able to safely manage dissociative symptoms without persistent identity fragmentation?</li> <li>• Able to manage psychotic symptoms/severe flashbacks (with medication if indicated)?</li> <li>• 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?</li> </ul>
<p>What modalities and approaches to therapy best fit the youth's needs/stage of change?</p> <ul style="list-style-type: none"> <li>• How could motivational enhancement techniques maximize the likelihood that the youth and family or other caregivers will be willing to engage in therapy?</li> <li>• Would the youth and family benefit from traumatic stress psychoeducation?</li> <li>• Would the youth benefit from developing/improving skills for emotion regulation?</li> <li>• Is the youth caught in a vicious cycle of intrusive re-experiencing of specific trauma memories that is perpetuated/exacerbated by attempt to avoid memories/feelings?</li> <li>• Is the youth troubled by traumatic grief?</li> <li>• Is the youth experiencing dissociative states/reactions?</li> <li>• Is the youth engaging in addictive behaviors (involving substances, gambling, sexuality, eating, or repetitive escape activities such as video gaming) to self-medicate distress?</li> <li>• Does the youth react to perceived psychosocial threats/injuries defiantly or aggressively?</li> <li>• 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)?</li> <li>• Does the youth need the consistent involvement of prosocial adult/older peer mentors?</li> </ul>
<p>What is the goal of therapy in the context of the youth's juvenile justice involvement?</p> <ul style="list-style-type: none"> <li>• What evidence of remorse, responsibility-taking, and prosocial future intentions is required by the court, attorneys, probation/parole, the school, or the community?</li> <li>• 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 in order to demonstrate evidence of restorative justice?</li> <li>• What adverse reactions to law enforcement, detention, probation, or court procedures should the intervention enable the youth to proactively anticipate and prevent/manage?</li> <li>• 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?</li> <li>• 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?</li> </ul>
<p>What is the justice system's readiness to support therapy by providing trauma-informed services?</p> <ul style="list-style-type: none"> <li>• Are the physical and social environments in which juvenile justice services are conducted set up to provide privacy, safety, clear/developmentally-appropriate communication,</li> </ul>

helpful social support, consistent/logical routines/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 youths for handling stress reactions?

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?
- How will youths' 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

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

*Trauma Affect Regulation: Guide for Education and Therapy (TARGET)*. TARGET (Ford et al., 2013) 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 makes a contribution 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 boys and girls was provided by two 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 (Ford & Hawke, 2012; Marrow, Knudsen, Olafson, & Bucher, 2012). A 4-step skill set, T4, was developed based on the field trials for JJ facility and community (e.g., probation) staff. 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), 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](http://www.nrepp.samhsa.gov)).

*Trauma and Grief Components Therapy for Adolescents (TGCT-A;* Layne, Saltzman, Pynoos, & Steinberg, 2002). Trauma and Grief Component Therapy for Adolescents 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). It has since been implemented successfully for urban, gang-involved and at-risk youth in California (Saltzman, Layne, Steinberg, & Aisenberg, 2001), and for at-risk youth in the Delaware schools (Grassetti, Herres, Williamson, Yarger, Layne, & Koback, 2014). 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](http://www.NCTSN.org)) for facility staff. TGCTA'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. In both the randomized Bosnian trial and open trials with gang-involved US youth, TGCTA was associated with reduced PTSD, depression, and maladaptive grief reactions and improved school behavior (Layne, et al, 2008; Saltzman, et al., 2001). 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. TGCTA'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 TGCTA 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).

*Cognitive Processing Therapy (CPT).* CPT 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-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 manuals developed for adults have been used with success in samples of traumatized youth (e.g., Chard, 2005) recently a revised version of the CPT manual has been developed specifically for adolescents (Matulis et al. 2014). Research to date shows 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). In addition, the longer (31 session) developmentally-adapted individual manual (which includes emotion regulation and interpersonal effectiveness skills) showed evidence of reduced PTSD and depression with 10 female and 2 male adolescents with abuse-related PTSD (Matulis et al., 2014).

#### Interventions with an Evidence Base for Traumatized Adolescents

Other interventions have an evidence base for traumatized adolescents but have not yet been empirically tested specifically with juvenile justice-involved adolescents. Two interventions have been tested with adolescents in randomized clinical trial research studies.

*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. Two published manuals (Cohen, Mannarino. & Deblinger, 2006, 2012) describe 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. 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 (Cohen et al., 2011; de Arellano, et al., 2014). Outcomes for depression and behavioral problems have been mixed, with moderate effective sizes in some studies (de Arellano, et al.). Recently, TF-CBT 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 youth who have experienced trauma (Leve, Chamberlain, & Smith, 2012; Smith, Chamberlain, & Deblinger, 2012). Although TF-CBT is currently being implemented for justice-involved youth, research outcomes have not yet been reported for this setting.

*Prolonged Exposure Therapy (PE)*. PE 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. A published manual provides detailed instructions for carrying out each PE phase (preparation, imaginal exposure, *in vivo* exposure, closure; Foa, Chrestman, & Gilboa-Schechtman, 2008). Two randomized clinical trial studies with girls who had experienced sexual abuse (Foa et al., 2013) and adolescent girls and boys 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.

Two interventions have shown preliminary evidence of positive outcomes in field trial studies.

*Skills Training in Affect and Interpersonal Regulation for Adolescents (STAIR-A)*. STAIR 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 (Gudino et al., 2014). 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 (Gudino et al., 2014).

*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. Recently, 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.

#### 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 provides therapeutic activities to achieve goals within three domains: *attachment* (building and supporting safe and responsive care by primary caregivers, providers, and milieus); *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). A 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 (Kinniburgh & Blaustein, 2010).

*Sanctuary.* Sanctuary is an organizational change model rather than an individual or group therapy (Bloom, 2013). 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 in order 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, & DeRosa, 2013), 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 understand the extent to which youth and caregivers have the choice to provide or withhold informed consent 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 the course of therapy will be kept confidential versus whether (and when) 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 discloses 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 (Feierman & Ford, 2015). 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 the course of 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 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 process at the initiation of treatment.

#### Additional Clinical Considerations

##### *Safety*

Safety is paramount not just for the youth but also for his/her caregiver(s) and significant others (e.g., siblings). Any therapeutic intervention with a youth in the juvenile justice system must begin with and

continuously monitor the youth's 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.

Youths in secure juvenile justice facilities (e.g., detention, inpatient units) in particular 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 youths' perceptions of their environment and be ready to work with the appropriate officials and advocates when concerns related to safety arise.

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).

#### *Ethnocultural 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 (Stevens & Morash, 2014). Therefore, the optimal wording and examples used in psychoeducation and therapeutic interventions must be calibrated based on youths' ethnicities 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 youths' 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 ethnoracially-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.

Youths 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 neurohormonally (e.g., developing secondary sexual characteristics and libido as early as age nine or ten), and correspondingly 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.

#### *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 ([www.NCTSNet.org](http://www.NCTSNet.org)) 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](http://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 youths involved in the juvenile justice system and their families and caregivers. Adaptations of these interventions are needed, additionally, to assist youths 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 youths to recover from emotional and behavioral problems caused by post-traumatic stress, are essential not only for youths 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 youths and their families, adults who are responsible for public safety, and the entire community – can become safer and healthier.

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