Evidence-Based Practices for Juvenile Justice-involved Youth Exposed to Trauma

Elizabeth D. Joseph, M.S.

Exposure to traumatic events can have both psychological and neurological consequences long after they occur, particularly for children and adolescents who are still undergoing development. The seminal adverse childhood experiences (ACEs) study conducted by Felitti et al. (1998) demonstrated that exposure to ACEs in childhood is linked to multiple diseases and health risk behaviors in adulthood. The symptoms of trauma can present differently based on the context and frequency of the traumatic experience, or whether the trauma is acute (i.e., Type 1) or complex (Type II) (Wamser-Nanney & Vandenberg, 2013). Acute or Type I trauma refers to an adverse experience that occurs once or infrequently, whereas complex or Type II trauma refers to sustained, interpersonal trauma occurring early in life. Symptoms of acute trauma can include, but are not limited to, dissociation or hyperarousal, which can affect physiological and psychosocial functioning (Bremner, 1999). Due to its frequency and onset, complex developmental trauma can have a deleterious effect on children and adolescents' functioning and ongoing development into adulthood. As defined by Cook and colleagues (2005), children and adolescents exposed to complex developmental trauma typically display impairment in the following areas: attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept.

Understanding the intricacies of trauma and its effects on children and adolescents is critical to its treatment. However, certain symptoms of trauma can complicate its treatment, particularly in the case of complex developmental trauma. The medical model of treatment seeks to address symptoms through treatment, without necessarily understanding the underlying causes (Huda, 2019). Unfortunately, this can lead to unnecessary medication, which in turn can introduce new side effects or symptoms. From a counseling perspective, people who have experienced trauma may have difficulty describing the incidents in traditional talk therapy or cognitive-behavioral therapy (CBT). This is especially true with children and adolescents who have experienced complex developmental trauma, as they may have developmental delays (e.g., regulatory or cognitive issues) related to their trauma, or be too young to understand and vocalize how they are feeling.

To address these concerns, Bath (2015) developed a framework for treating children and adolescents who have experienced trauma entitled the "Three Pillars." The Three Pillars framework leverages parents, caregivers, teachers, and other adult figures as agents of change for children who have experienced trauma. The framework posits that due to the interpersonal nature of complex trauma, the symptoms of trauma are best treated through relationships in non-clinical settings, through "healing in the other 23 hours." This is accomplished by fostering the three pillars of safety, connection, and coping. Safety refers to an environment where one feels secure and is not concerned about their survival. The idea of "feeling safe," is critical as those who have experienced trauma may feel as though they are still in danger even when there is no threat

present due to heightened arousal. The pillar of connection refers to reciprocal, healthy relationships with caregivers and peers. The interpersonal nature of complex trauma may make it difficult for youth to trust others. However, connection can be established through healthy, consistent interactions with caregivers and other adults. The final pillar, coping, refers to one's ability to regulate and manage symptoms of trauma in everyday life. Children and adolescents with histories of trauma may develop maladaptive coping mechanisms to address the traumatic situations and its subsequent effects. Caregivers and other adults can help children improve their ability to regulate and cope with both their everyday stressors and trauma symptoms by promoting verbal skills and co-regulation.

Comprehensive interventions and treatments for children and adolescents who have experienced trauma is imperative, especially for those who are involved with the juvenile justice (JJ) system. Youth involved in the JJ system are more likely to experience trauma than their peers; specifically, JJ-involved youth are approximately three to eight times more likely to experience trauma than their non-JJ-involved peers (Abram et al., 2004). Furthermore, research has shown that every trauma experience increases a youth's risk of violent offenses, and that JJ-youth who have experienced multiple traumas are likely to need more intensive mental health and substance use services (Duron et al., 2021; Fox et al., 2015). While many JJ-involved youth have already been subjected to traumatic experiences prior to their involvement with the JJ system, exposure to the justice system itself can be traumatizing, especially for youth in residential JJ facilities. Despite the strong need for trauma-informed care within the JJ system, historical and bureaucratic barriers have impeded efforts to integrate trauma-informed practices and interventions into the JJ system (Goshe, 2019). Therefore, the development and testing of efficacious, evidence-based interventions for JJ-involved youth who have experienced trauma is greatly needed. The following sections of this paper describe three current, prominent, evidence-based interventions designed to mitigate the symptoms of trauma in a variety of settings, as well as potential implications for JJ.

Seeking Safety (Najavits, 2007)

The program Seeking Safety utilizes a present-focused counseling model to aid people with truly feeling safe following the occurrence of trauma. Seeking Safety was developed in 1992 by Lisa M. Najavits, PhD, through funding by the National Institute on Drug Abuse. Based in CBT, the program is centered around the key principles of safety as the priority of treatment, integrated treatment, a focus on ideals, the four content areas of cognition, behavior, interpersonal relationships, and case management, and attention to clinical processes. Safety as the priority of treatment refers to the ultimate goal of the program, which is to provide participants with the tools to achieve safety in their relationships, thought patterns, behavior, and emotions . The concept of "Integrated Treatment" is unique to Seeking Safety, as the curriculum was designed to directly address substance use and trauma if a client presents with both. Additionally, clients' ideals play a large role in the curriculum, as Seeking Safety intends to reinstate ideals that may have been lost due to trauma and/or substance use.

As trauma can affect multiple aspects of peoples' lives, the curriculum addresses the effects of trauma and substance use in multiple areas, namely cognitive, behavioral, interpersonal, and case management. Its curriculum includes 25, independent topics that correspond to these areas, such as "Safety," "Taking Back Your Power," "Setting Boundaries in Relationships," "Coping with Triggers," and "Detaching from Emotional Pain." The final principle of Seeking Safety is attention to clinical processes, which refers to clinicians' own emotional responses that in turn can influence how a clinician responds to their own clients or participants. Unique to this program, Seeking Safety explicitly does not include exploration of past trauma or interpretative psychodynamic work, due to concerns over the use of these techniques with people who engage in substance use and the time required to appropriately implement the techniques.

While intended for use with females exhibiting concurrent trauma and addiction, Seeking Safety has been implemented across genders, age groups, cultures, and settings (e.g., women, men, adolescents, people who are incarcerated, war veterans). The program is flexible, in that it can be administered in a group setting or individually. Furthermore, no formal training or licensure is required to administer the program. Seeking Safety has been empirically studied in outpatient women, inner-city women, men, women in prison, women in substance use treatment, adolescent girls, female veterans, and women in residential treatment. However, all of the studies on Seeking Safety included a relatively small number of participants (at or under 100) and only one of the aforementioned studies was a randomized control trial (RCT). The California Evidence-Based Clearinghouse for Child Welfare (CEBC) scored Seeking Safety as having "promising research evidence" for adolescents and as "supported by research evidence" for adults. Taken together, the results from these studies indicate that Seeking Safety is efficacious, with reductions in trauma-related symptoms, substance use, and psychosocial functioning. However, further research is needed on the implementation and outcomes of the intervention for youth and adolescents, specifically for those within a JJ context.

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

(Ford & Russo, 2006)

The Trauma Affect Regulation: Guide for Education and Therapy (TARGET) intervention was created in the early 2000s by Julian Ford, PhD, with funding provided by the National Institute on Mental Health. The curriculum includes seven, self-regulatory lessons taught sequentially, known as the acronym "FREEDOM." FREEDOM stands for focus, recognize, emotions, evaluate, define, option, and make a contribution, with each word representing the learning outcome of the step. Using the FREEDOM steps, TARGET seeks to aid participants' responses to stress reactions and triggers in their everyday lives. In addition to the FREEDOM steps, participants receive lessons on the biological and behavioral factors that contribute to SUDs and PTSD and develop their own autobiographical narrative addressing their trauma.

The program is intended to be completed in 12, weekly sessions, but actual time to completion varies based on participant needs, with 10 average sessions according to the National Child Traumatic Stress Network. However, there are instructions and curriculum for a 4-session, 10-14-session, and over 26-session administration. Furthermore, the program can be administered to individuals or groups, making it feasible for use in a variety of settings. The TARGET program can be used with youth and adults, from ages 11 and up. Additionally, the program has been conducted with youth and their caregivers; specifically, with foster families, biological families, and with single parent families. The program has also been reportedly used within juvenile and adult criminal justice contexts. The program does, however, require training. To conduct TARGET sessions with individuals or groups, a minimum of three full days of in-person training are required. Further training is required for use with youth and families. These training requirements, coupled with the associated trainings fees, could restrict the accessibility of the program.

The TARGET program evidence-base includes three RCTs. However, all of the RCT studies had adult participants. The findings from one RCT indicated that TARGET participants reported greater improvement of both PTSD symptoms and affect regulation than those who were waitlisted for treatment. However, the other two RCTs did not find that TARGET participant outcomes were significantly different from typical treatment and one of the two found ethnic differences between participants' results. Other relevant studies of TARGET were conducted with youth in juvenile justice facilities or juvenile justice involvement, but were not RCTs. The California Evidence-Based Clearinghouse for Child Welfare scored Seeking Safety as having "promising research evidence" for adolescents and as "supported by research evidence" for adults. These results indicate that Seeking Safety is efficacious for adults, with reductions in trauma-related symptoms, substance use, and psychosocial functioning. However, further research is needed on the intervention for JJ-involved youth.

Trust-based Relational Intervention (TBRI)

(Purvis et al., 2013)

Developed by Drs. Karyn Purvis and David Cross in 2005, the Trust-based Relational Intervention (TBRI) was designed for parents to use with young adopted children who may have experienced trauma prior to their adoption. The intervention is grounded in attachment theory, which maintains that early interactions with caregivers influence one's later self-regulation and relationships, and maps onto the aforementioned pillars of trauma-wise care. The intervention has three core principles: empowering, connecting, and correcting. Empowering refers to guaranteeing one's physical needs are met, with the empowering strategies dichotomized into physiological and ecological strategies. Physiological strategies refer to physical and internal needs, such as hydration, nutrition, and sensory needs. Ecological strategies include transitions and "rituals," or set routines that are reliable and enable connection. The connecting principles refer to meeting children's attachment needs by encouraging felt-safety through mindfulness and

engagement strategies. Mindfulness strategies refer to a caregiver's awareness of their own attachment style and how that influences the way in which they provide and receive care in their relationships. The engagement strategies encourage healthy connection through gentle touch, eye contact, voice quality, behavioral matching, and playful interaction. The final principle, correcting, can be divided into the subcategories of proactive strategies and responsive strategies. Proactive strategies seek to teach appropriate responses before problematic behavior arises, through modeling, role-play, and the use of scripts and phrases. These strategies are taught to the youth in "Nurture Groups," or small group sessions where youth and caregivers practice utilizing TBRI principles through interactive activities and games. In contrast, the responsive strategies are used in the moment when behavioral issues occur. The responsive strategies include a immediate, direct, efficient, action-based, leveled-at-the-behavior response, referred to as the "IDEAL response," and levels of response, ranging from playful engagement to protective engagement.

The intervention has been utilized in a variety of contexts: homes, group homes, residential facilities, schools, orphanages, and JJ facilities. The intervention is in the process of being adapted and tested for use with adolescents in the JJ system and their caregivers. While the other interventions mentioned in this article are typically intended for use with the person who has experienced trauma, TBRI is unique in that it is intended for use with the whole family and utilizes the caregiver as the agent of change in day-to-day interactions, as opposed to a clinician who meets with the client during specified intervals. It is important to note that the previously mentioned adaptation includes materials designed specifically for adolescents so that they are learning the same material and strategies as their caregivers. While not required to utilize TBRI, in order to access all of the intervention materials and officially be a TBRI practitioner a one-week training is required. Other resources, such as books and videos, are available online for those who cannot attend the formal training.

The Trust-based Relational Intervention has primarily been studied in the context of adoptive families, but research on TBRI has also been conducted in schools, group homes, and residential facilities. In RCTs where parents and caregivers received TBRI training, children in the treatment group demonstrated significant decreases in both problem behavior and trauma symptoms. Additional studies found that children who attended a TBRI day camp exhibited decreased thought problems, attention issues, aggression, improved attachment behaviors, and decreased salivary cortisol levels. The CEBC scored the TBRI caregiver trainings as having "promising research evidence," and ranked its relevance to child welfare as "high." Taken together, the results from these studies indicate that TBRI is efficacious; however, more rigorous research is needed on the use of TBRI with youth involved in the JJ system (see Knight et al., 2021, for ongoing research efforts).

Conclusion

While the interventions described in this paper may have promising implications for the JJ system, further research is necessary. Specifically, studies that employ RCT designs within JJ contexts are needed to confirm the efficacious of these interventions for JJ-involved youth. The interventions described in this paper share commonalities in their efforts to mitigate the symptoms of trauma, such as a focus on regulatory skills and establishing safety; however, each intervention does so through a different mechanism. Both Seeking Safety and TARGET are intended to be administered to the person who has experienced trauma, whereas TBRI is designed to be taught to the caregiver who then uses the intervention when interacting with their youth. Each of these interventions has its benefits, yet none were specifically intended for youth and adolescents involved in the JJ-system. Additionally, none of the described interventions are intended to be used with youth and their caregivers simultaneously. Adolescence is a critical time in development, wherein youth seek independence yet still rely on caregivers for guidance (Steinberg & Morris, 2001). Therefore, future interventions should grant adolescents agency in their own treatment by leveling the intervention at them, while incorporating caregivers into the programming. Learning in tandem could reinforce the intervention, and promote continuity and consistency of care in everyday life. With respect to JJ-involved youth and their caregivers, providing intervention to youth in residential JJ facilities and their caregivers has the potential to extend in-facility gains once youth are released back into their homes and communities, and perhaps lessen the youth's risk of future offending.

References

Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., & Dulcan, M. K. (2004). Posttraumatic Stress Disorder and Trauma in Youth in Juvenile Detention. *Archives of General Psychiatry*, *61*(4), 403–410. https://doi.org/10.1001/archpsyc.61.4.403

Bath, H. (2015). The Three Pillars of TraumaWise Care: *Reclaiming Children and Youth*, *23*(4).

Cook, A., Spinazzola, J., Ford, J., Lanketree, C., Blaustein, M., Cloitre, M., & Van der Kolk, B. (2005). Complex trauma. *Psychiatric Annals*, *35*(5), 390–398.

Duron, J. F., Williams-Butler, A., Liu, F.-Y. Y., Nesi, D., Fay, K. P., & Kim, B.-K. E. (2021). The Influence of Adverse Childhood Experiences (ACEs) on the Functional Impairment of Justice-Involved Adolescents: A Comparison of Baseline to Follow-Up Reports of Adversity. *Youth Violence and Juvenile Justice*, *19*(4), 384–401. https://doi.org/10.1177/15412040211016035

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Ford, J. D., & Russo, E. (2006). Trauma-Focused, Present-Centered, Emotional Self-Regulation Approach to Integrated Treatment for Posttraumatic Stress and Addiction: Trauma Adaptive Recovery Group Education and Therapy (TARGET). *American Journal of Psychotherapy*, *60*(4), 335–355. https://doi.org/10.1176/appi.psychotherapy.2006.60.4.335

Fox, B. H., Perez, N., Cass, E., Baglivio, M. T., & Epps, N. (2015). Trauma changes everything: Examining the relationship between adverse childhood experiences and serious, violent and chronic juvenile offenders. *Child Abuse & Neglect*, *46*, 163–173. https://doi.org/10.1016/j.chiabu.2015.01.011

Goshe, S. (2019). How Contemporary Rehabilitation Fails Youth and Sabotages the American Juvenile Justice System: A Critique and Call for Change. *Critical Criminology*, *27*(4), 559–573. https://doi.org/10.1007/s10612-019-09473-5

Huda, A. S. (2019). *The Medical Model in Mental Health: An Explanation and Evaluation*. Oxford University Press. https://doi.org/10.1093/med/9780198807254.001.0001

J. Douglas Bremner, M.D. (1999). Acute and Chronic Responses to Psychological Trauma: Where Do We Go From Here? *The American Journal of Psychiatry*, *156*(3), 349–351. https://doi.org/10.1176/ajp.156.3.349

Knight, D. K., Yang, Y., Joseph, E. D., Tinius, E., Young, S., Shelley, L. T., Cross, D. R., & Knight, K. (2021). Preventing opioid use among justice-involved youth as they transition to adulthood: Leveraging safe adults (LeSA). *BMC Public Health*, *21*(1), 2133. https://doi.org/10.1186/s12889-021-12127-3

Najavits, L. M. (2007). 7—Seeking Safety: An Evidence-Based Model for Substance Abuse and Trauma/PTSD. In K. A. Witkiewitz & G. A. Marlatt (Eds.), *Therapist's Guide to Evidence-Based Relapse Prevention* (pp. 141–167). Academic Press. https://doi.org/10.1016/B978-012369429-4/50037-9

Purvis, K. B., Cross, D. R., Dansereau, D. F., & Parris, S. R. (2013). Trust-Based Relational Intervention (TBRI): A Systemic Approach to Complex Developmental Trauma. *Child & Youth Services*, *34*(4), 360–386. https://doi.org/10.1080/0145935X.2013.859906

Steinberg, L., & Morris, A. S. (2001). Adolescent Development. *Journal of Cognitive Education and Psychology*, *1*, 55–87. https://doi.org/10.1891/194589501787383444

Wamser-Nanney R., & Vandenberg B. R. (2013). Empirical Support for the Definition of a Complex Trauma Event in Children and Adolescents. *Journal of Traumatic Stress*, *26*(6), 671–678. https://doi.org/10.1002/jts.21857