A Proposed Treatment Plan for Incarcerated Male Juveniles Who Experience Posttraumatic Stress Disorder

By Katherine Gregg

This article details a plan for treating youth offenders who suffer from posttraumatic stress disorder (PTSD). Developed through work with youth offenders at the Cook County Juvenile Temporary Detention Center in 2005 and 2006, the proposed model incorporates evidence-based practice to develop a group treatment for adolescents. The plan demonstrates that creative interventions engage youth and may enable them to address symptoms of PTSD.

Posttraumatic stress disorder (PTSD) is one possible response to a traumatic experience. After a traumatic experience, an individual may be anxious, become depressed, and feel unable to deal with daily responsibilities. Over a brief period that can range from a few weeks to a few months, most who have experienced trauma find that their ability to function improves. However, someone who continues to be affected by the experience may suffer from PTSD (Martin and Pear, 2005). Evidence suggests that incarcerated male juveniles suffer these symptoms at higher rates than those observed among other adolescent communities (De Arellano et al., 2005). A reason for this disparity is that community violence is a contributor to symptoms of PTSD. A study by David Foy and Carole Goguen (1998) reveals that living in poor, inner-city areas and being a minority increases the risk for exposure to community violence. Gang affiliation and gender are other risk factors for exposure. Males witness more community violence and are at higher risk for physical assault than are females of a similar age (Foy and Goguen, 1998). Jessica Hamblen (n.d.) reports that PTSD emerges in as much as 100 percent of children who

witness a parental homicide or sexual assault. Her review finds that PTSD symptoms are experienced by 77 percent of children exposed to a school shooting. Furthermore, Hamblen notes that 35 percent of urban youth develop PTSD as a result of exposure to community violence. These proportions are substantially higher than those found among adolescent general populations; in general, among adolescents who experience trauma, 3 to 15 percent of adolescent girls experience PTSD; the rate is only 1 to 6 percent among boys (Hamblen, n.d.).

Adolescents' experience of PTSD differs from that of adults. Hamblen's review finds, for example, that adolescents suffering from PTSD are likely to engage in traumatic reenactment; that is, they reenact aspects of the trauma in their daily lives. Also, adolescents suffering from PTSD are more likely than their adult counterparts to exhibit impulsive and aggressive behaviors (Hamblen, n.d.). It is thus important that the mental health community offer effective and client-centered interventions for juveniles, because subjects who are incarcerated and suffer from PTSD are vulnerable to further court involvement.

This article proposes a treatment plan for youth offenders who suffer from PTSD. It examines the research literature, the criteria for assessing PTSD, and the different modes of available treatment. The article thus reviews the empirical foundation for the treatment of a population of adolescent offenders suffering from PTSD. It proposes a treatment approach for youth incarcerated at the Cook County (Illinois) Juvenile Temporary Detention Center. Incarcerated youth were referred through the Cook County (Illinois) Juvenile Court Clinic. The clinic works with the Cook County probation department, juveniles, and the youths' families in order to complete forensic psychological evaluations for the court. In this context a forensic evaluation refers a mental health assessment completed by a state licensed psychologist in order to provide a judge with information about the youth's social and emotional level of functioning. The judge then uses this information to determine sentencing in relation to the youth's offense. Youth referred to Cook County Juvenile Court Clinic for psychological evaluations are disproportionately male and from a minority population. These youths are often affiliated with gangs. The population is therefore likely to have experienced trauma. It is thus an appropriate target population for short-term efforts to assess and treat PTSD.

OVERVIEW

Diagnostic Criteria and Symptom Presentation for PTSD

The definition for the criteria of PTSD gives clinicians leeway in determining whether an event qualifies as a traumatic stressor (American Psychiatric Association, 1994). The practice parameters of the American Academy of Child and Adolescent Psychiatry (AACAP) indicate that a youth's reaction must include intense fear, horror, helplessness, or disorganized or agitated behavior (AACAP, 1998).[1] Some children with PTSD symptoms regress from previously learned skills; they are unable to do things that they were able to do before the trauma (AACAP, 1998). For example, an adolescent may show lack of speech or wet the bed. Also, adolescents who have experienced trauma occasionally engage in magical thinking; a youth imagines, for example, that the trauma will not happen again if he or she behaves well, or that he or she possesses the power to see into the future. Some other symptoms of PTSD in children and adolescents include social withdrawal, separation difficulties, hoarding of possessions, and loss of fantasy or imaginary play (Hillman, 2002).

Commonly Used Treatment Approaches

Published treatment guidelines indicate that, among the methods for treating children with PTSD, cognitive-behavioral therapy (CBT) has the strongest empirical support (Cohen et al., 2000). Recommendations published in the AACAP practice parameters endorse treatment that uses exposure, stress management, relaxation, narrative retelling, and parental participation in treatment sessions.[2] This article will briefly outline main features of several approaches used for work with clients who experience PTSD.[3]

Cognitive-behavioral therapy works to change an individual's emotions, thoughts, and behaviors (Martin and Pear, 2005). Exposure, as part of CBT, uses repeated, detailed images of the trauma in a safe context that helps the survivor face and gain control of the fear that was overwhelming during the trauma. Techniques include flooding and desensitization. Each method confronts the trauma in a way that is specific for the individual. In flooding, the client is helped to confront the full memory of the traumatic event. Desensitization uses relaxation techniques to enable the client to gradually confront the trauma. Cognitive-behavioral therapy may also include developing social skills, learning skills for coping with anxiety, preparing for stress reactions, and discussing how to handle future trauma symptoms (Martin and Pear, 2005).

Another common approach is pharmacotherapy, which involves the treatment of a mental health disease through the administration of drugs by a medical provider. Pharmacotherapy can be used to reduce the anxiety, depression, and insomnia caused by the trauma memories. Medication may be useful for symptom relief while the individual engages in psychotherapy (Hillman, 2002).

A less-common approach to working with clients who experience PTSD is Eye Movement Desensitization and Reprocessing (EMDR). Francine Shapiro (2001) describes EMDR as an information processing therapy that combines CBT with eye movements, hand taps, and sounds that are completed by the client. The client is instructed to focus on the image, negative thought, and body sensations while simultaneously following the therapist's fingers as they move across his or her field of vision for a short period (Shapiro, 2001). The goal is to decrease the individual's negative belief or intense fear associated with the trauma memory. For example, a rape victim may hold the belief that the attack was her fault. However, EMDR focuses on changing the belief so the client may recall the memory without guilt, shame, or fear (Shapiro, 2001). There is some limited evidence that EMDR increases an individual's ability to process the memories of the trauma (Hillman, 2002).

Psychodynamic psychotherapy provides an alternative method for work with emotional conflicts caused by the traumatic event. In brief psychodynamic psychotherapy, the client and therapist examine maladaptive functions developed early in life that contribute to daily problems (AACAP, 1998). The therapist helps the individual to recount the traumatic event and to identify effective ways of coping with his or her emotions. By doing so, the client can replace maladaptive functioning with a healthy substitute. This form of treatment often requires a substantial amount of introspection and reflection from the client.

Group treatment is one setting in which CBT and the other approaches might be delivered to clients who experience PTSD. A group provides an environment where clients can share the memories of and symptoms related to the trauma with group members who may have also experienced a traumatic event. Sharing their own trauma narrative enables individuals to process the event and focus on other aspects of their lives. Whereas individual treatment provides a controlled therapeutic environment, group methods offer validation and help normalize clients' traumatic experiences (Hamblen, n.d.).

JUVENILE OFFENDERS WITH PTSD

Research identifies several useful approaches for working with juvenile offenders who suffer from PTSD. Because research suggests that both group and individual modalities are effective for children and adolescents, the current discussion focuses on the significance of the modality in treatment for juvenile offenders with PTSD symptoms.

The literature shows that treatment for an adolescent should be developmentally appropriate (Davis, 1992). Inger Davis (1992) examines studies of individual and group treatment, reviewing how the differences in therapeutic effects for adolescents differ from those of younger children.[4] The studies in the review include problem adolescents who received treatment as a result of referrals from teachers, parents, social workers, probation officers, or juvenile court judges. Davis criticizes meta-analytical techniques for "superimposing ... statistical computations across studies" (Davis, 1992, p. 49). The review synthesizes similarities in failed treatments and suggests how future interventions may improve treatment. She demonstrates that if a similar intervention is used, children 4 to 12 years have a better outcome in decreased symptoms than do adolescents between 13 and 18 years (Davis, 1992, p. 51). Of the 108 outcome studies examined, the mean age of study subjects was 10.23 years. Ages range from 4 to 18 years; 66 percent of participants were male. Her review suggests that early intervention may be helpful in working with adolescents. Davis (1992) also notes that behavioral therapy is better than nonbehavioral therapy for juvenile offenders who experience PTSD. She concludes that the outcomes of individual therapy do not differ significantly from those of group therapy. The review suggests that outcomes vary by the method of intervention. The findings are meaningful for the intervention proposed in this article, because the majority of those in samples reviewed by Davis are male and involuntary clients.

There is limited evidence that group therapy is more effective than individual treatment for children with PTSD. However, research shows that the treatment modality is not as important as a trauma-focused approach that targets the adolescent's specific symptoms (Friedrich, 1996). Group interventions often provide a timely response to a large number of adolescents.

For treatment of adolescent trauma, cognitive-behavioral interventions enjoy the most empirical support (Ahrens and Rexford, 2002, Cohen et al., 2000, Davis, 1992, Friedrich, 1996, March et al., 1998, Ovaert, Cashel, and Sewell, 2003). Typically, these interventions target the specific symptoms of PTSD by focusing on the thoughts and feelings that the client associates with the traumatic experience. The existing literature finds two cognitive-behavioral

approaches to be effective: trauma-focused cognitive-behavioral therapy (TF-CBT) and cognitive-processing therapy (CPT).

Judith Cohen and associates (2000) review the major components of TF-CBT for children and adolescents. As Cohen and colleagues observe (2000), this approach includes three basic components: educating the client about his or her posttraumatic stress reactions, cognitive therapy, and exposing the client to the memory of the traumatic event by encouraging him or her to recount the traumatic event (Cohen et al. 2000). Much of the empirical evidence that establishes the efficacy of TF-CBT is found in treatment studies with young children. Cohen and associates (2000) reveal that the approach has been adapted to treat clients who are between the ages of 3 and 18 years old and who have experienced a variety of traumas (e.g., physical abuse, sexual abuse, domestic violence, rape, natural disasters, and community violence). A limitation of the review is that it does not identify which populations of children may not benefit from CBT treatment components. Cohen and associates (2000) acknowledge that there is insufficient data to determine which CBT components are most efficacious in treating specific symptoms and specific populations of children, but they find strong empirical support for the use of TF-CBT in treatment of adolescents experiencing symptoms of PTSD. The review also shows that TF-CBT is most effective for treatment of PTSD in a time-limited context. The authors suggest that 8 to 15 sessions are effective. Time sensitive approaches are particularly applicable for work with the specific population examined in this article, because incarcerated juveniles have stays of varying length at the Juvenile Temporary Detention Center.

Julia Ahrens and Lillian Rexford (2002) examine the effect of short-term cognitive-processing therapy on incarcerated adolescents with PTSD. Cognitive-processing therapy is based on Peter Lang's (1977) observation that information is stored in fear networks. When recalled through external stimuli, these networks cause avoidance behavior. Although there may be no actual threat, a person may nonetheless alter his or her behavior because a preexisting thought (caused by the memory of the traumatic experience) is recalled. Ahrens and Rexford (2002) find that CPT is associated with statistically significant declines in clients' reports of symptoms of trauma, including anxiety, depression, intrusion, avoidance, and numbing. The examined procedure was conducted over eight 60-minute sessions. Each adolescent in the study learned about the symptoms of PTSD, participated in exercises to distinguish between thoughts and feelings, examined thoughts associated with the traumatic experience, and wrote a narrative describing the trauma. The youth were also assigned homework (e.g., journaling, worksheets) related to antecedents, beliefs, and consequences of their targeted behavior.[5]

After youth received treatment, PTSD symptoms diminished among participants in the treatment group (Ahrens and Rexford, 2002). The rates of symptom reduction were higher among those who received treatment than among those in a similar group that was not treated. In contrast to the samples in alternative studies, the sample group in this study had many comorbid disorders, such as ADHD, as well as histories of head trauma. Comorbid disorders may have complicated Ahrens and Rexford's (2002) findings, and treatment outcomes may thus be difficult to duplicate with the present study's sample.

In another study, 14 children (ages 10–16) received cognitive-behavioral therapy. Participants were assessed for PTSD before and following treatment. After 18 weeks, 57 percent of the sample did not meet criteria for PTSD; at a 6-month follow-up assessment, 85 percent did not meet the criteria (March et al., 1998). Although the study by John March and associates (1998) is limited by a small sample, it represents another CBT treatment that has been found to effectively decrease symptoms of PTSD in a group setting.

Lynda Ovaert and associates (2003) test a cognitive-behavioral group intervention that included adaptations of CPT techniques (e.g., narrative exposure). The study's sample included 43 incarcerated males between the ages of 13 and 18. Approximately 30 percent were Caucasian, 40 percent were African American, and 25 percent were Hispanic. Ten groups of juveniles completed a 12-session intervention that met twice weekly for 6 weeks. All participants were diagnosed with PTSD. The treatment approach was administered in three phases: rapport building and education about PTSD (sessions 1–5), reexperiencing (sessions 6–11), and resolution (session 12).[6] The results indicate that group participants experienced significant reductions in self-reported PTSD symptoms, as well as reductions in behavioral problems. The reductions of PTSD symptoms were greater for youth who experienced community (e.g., gang) violence than for those who experienced personal violence.

It should be noted that the Ovaert and associates' (2003) approach devotes a disproportionate amount of time to building rapport with the client; it involves a relatively short period (one session) on resolution. The study is limited by a small sample, and the size makes it difficult to project how the effects of this approach might generalize to all juvenile offenders who experience PTSD. A strength of the study is that the diagnostic measurement included an open-question interview, which was used to evaluate the type of trauma exposure that each adolescent participant experienced. Of the 43 participants, 90.3 percent experienced gang-related trauma. Ovaert and associates (2003) also observe that participants reportedly found it helpful to discuss the traumatic

experience with peers. These findings are also valuable because the group treatment was effective for youth who experienced gang and community violence. Effectiveness of a given treatment type (i.e., group or individual treatment) may vary for each adolescent.

Motivational interviewing introduces an added benefit for working with adolescents who may be ambivalent towards changing their targeted behavior. William Miller and Stephen Rollnick (2002, p. 33) explain that, "anything from cash vouchers to cattle prods" has been called motivational interviewing. The clearest definition describes motivational interviewing as a "directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence" (Rollnick and Miller, 1995, p. 326). Motivational interviewing addresses the client wherever he or she is in the change process. In the current article, and for the proposed target population, motivational interviewing will be helpful in determining whether the youth is ready to discuss the traumatic experience, associated behaviors, and their consequences in a group setting. Such information may prevent an adolescent from harming himself and may also protect other group members.

The motivational interviewing approach uses the transtheoretical model as its basis for support. James Prochaska and Carlo DiClemente (2005, p. 148) describe the transtheoretical model as a response to the dilemma that clinicians face daily in "what to do, when, with whom, in what way, with which problem." They argue that no one system of therapy addresses these questions. Motivational interviewing draws upon four dimensions of the transtheoretical approach: the processes of change, the stages of change, the benefits and liabilities of change, and the levels of change (Prochaska and DiClemente, 2005). Miller and Rollnick (2002) rely on the stages of change dimension, which presents five stages: precontemplation, contemplation, preparation, action, and maintenance (Prochaska and Prochaska, 1999). If the client is matched to the correct change process, he or she can address his or her readiness to participate in treatment.

Research indicates that motivational interviewing is effective in work with adolescents (Greenwald, 2002). Two hypotheses suggest reasons for this effectiveness. First, motivational interviewing allows youth to discuss their ambivalence with the therapist. The youth are able to elaborate from their own perspective on why they may not need to change their behaviors. Secondly, youth are often involuntary clients and are accustomed to being told what to do by authority. This, in turn, causes some youth to rebel. By providing informal feedback, educating the adolescent about other youth behavior, and asking what changes the youth is willing to make, the therapist initiates

exchanges in which the therapist and adolescent work together instead of against one another (Greenwald, 2002). This collaboration differs from previous therapeutic approaches, and obstacles identified during motivational interviewing are not failures or resistance from the client but part of the process. Motivational interviewing lends itself to working with adolescents because the method emphasizes consistent feedback and a listening style that provides the youth with a sense of safety, especially when he or she discusses sensitive material. In order to meet the specific needs of juvenile offenders in this article, the proposed treatment plan integrates motivational interviewing techniques to assess if individual or group treatment is best.

Ricky Greenwald (2002) argues that adolescents who experience trauma develop persistent conduct disorder. To assess the effectiveness of motivational interviewing with adolescents, he adapted motivational interviewing, self-control training, and trauma resolution in an open-trial treatment of six adolescents with school and conduct problems (Greenwald, 2002). Greenwald (2002) finds that five out of the six participants had significant reductions in PTSD symptoms, and the number of problem behaviors decreased. Greenwald also reports an unexpected outcome: the school performance of each participant improved. Weaknesses of the study include the relatively small sample size and the lack of a control group. However, Greenwald (2000) presents innovative ideas that could be used in the current therapeutic adaptation. For example, the trial suggests an imaginative way to decrease ambivalence among teens through a motivational interviewing technique called "Future Movies" (Greenwald, 2002, p. 242). This form of motivational interviewing occurs when a client is asked to "fill in the details of a movie of the next 10 years of his life" (Greenwald, 2002, p. 242). In this activity, the therapist is able to highlight personal risk and negative consequences for a client. He or she may also affirm a client's positive choices and projected accomplishments. Future Movies offer a way to address the adolescents' preoccupation with thinking of the traumatic events and instead to focus on how the juvenile visualizes his life. This article will adapt elements of Greenwald's work, including the Future Movies approach, for the proposed treatment plan (Greenwald, 2002).

Cognitive-behavioral therapy delivered in a group setting has been shown to be effective for youth who experienced such traumas as sexual abuse, and it may be used to treat whose who experienced community violence (Foy and Goguen, 1998). In addition, there is no empirical evidence that successful treatment of traumatized children always requires repeated retelling of the details of the traumatic event (Cohen et al., 2000). It is relevant that there is

no such evidence to retell the traumatic experience, because this article proposes a treatment plan that excludes a narrative retelling by the clients. The treatment plan proposed here will follow Trauma Adaptive Recovery Group Education Therapy for Adolescents (TARGET-A; Mahoney, Ford, and Cruz St. Juste, 2005) and will focus on group methods for working with incarcerated males.

The proposed approach attempts to refocus the youth's attention on gaining a sense of control and making sense of traumatic stress reactions. It is most similar to trauma-focused cognitive-behavioral therapy. A current study is following 20 youths in a juvenile justice program that includes the TARGET-A intervention, and those findings have not been published yet. Preliminary findings, however, indicate that the intervention is associated with reductions in PTSD symptoms, posttraumatic cognitions, and maladaptive coping (University of Connecticut Health Center, n.d.). These findings also indicate that TARGET-A is associated with improvements in self-efficacy and psychosocial functioning.

In contrast to exposure therapies, TARGET-A is designed for adolescents and provides a "sequence of specific behavioral skills for processing emotionally-charged somatic and cognitive information" (Mahoney et al., 2005, p. 54). The goal of TARGET-A is not to coach the individual to be desensitized to the fear or other negative thoughts that are triggered by the trauma, but instead to give attention to trauma reminders (extreme vs. normal stressors) and to guide the client to live life in the present. In this way, the plan is most similar to Lang's (1977) aforementioned information processing, yet it differentiates itself by providing a model for recovery and resilience. The plan focuses the client's awareness on external and internal stimuli that provoke a reminder of the traumatic experience. The approach is a strategy for acknowledging and moving beyond a trauma reminder or memory.

GROUP CHARACTERISTICS

In sentencing juvenile offenders, judges in Cook County, Illinois, may base their decisions on the results of forensic evaluations (i.e., in order to return the youth to a normative level of social and emotional functioning, a judge may order psychotherapy services rather than confinement for a youth who is found to exhibit a mental health disorder). These evaluations are administered by the Cook County Juvenile Court Clinic. The clinic has expanded its efforts to provide trauma-focused group therapy for incarcerated male youth. Youth are referred for this therapy by correctional facility staff and probation officers. The period of observation occurred from October 2005 through June 2006.

The population remained stable because youth remain in treatment for the duration of their incarceration. Two staff will participate in this form of treatment for each group session. This article does not use specific youth as a study sample, but rather reports characteristics in order to develop a treatment plan.

Juvenile offenders are characterized as a special subgroup of urban adolescents who are exposed to "high levels of chronic family and community violence" (Ovaert et al., 2003, pp. 294–95). Daniel Coleman (2005, p. 114) proposes that incarcerated youth are at risk of "developing serious sequelae of trauma exposure, given high rates in this population of known risk factors such as lower socioeconomic status (SES), family problems, family substance abuse, and lower [intelligence quotient]." As the literature suggests, juvenile offenders experience PTSD at a higher rate than youth not involved with the juvenile justice system (Ovaert et al., 2003). Numerous studies suggest that PTSD occurs across diverse ethnic backgrounds (Hamblen, n.d.). However, incarcerated youth are more likely than nonincarcerated youth to come from minority families and from socioeconomically deprived backgrounds (Coleman, 2005). In many of the multistressed families that are court-involved, the lack of familial support places the imprisoned adolescents at higher risk for an increase in symptoms associated with PTSD than that for adolescents who are not court-involved (Ovaert et al., 1997). This article expects the targeted group to reflect the outlined characteristics. The group that uses this intervention plan will be limited to those who identify as male and report at least one traumatic experience.

PROBLEM DEFINITION

This article attempts to propose a method for treating incarcerated male adolescents with PTSD symptoms. The presence of such symptoms is suggested by target behaviors; the tasks of accurate assessment and effective treatment are facilitated by documentation of the intensity, frequency, and duration of the target behaviors. Such target behaviors include, for example, learning difficulties (e.g., perceptual distortions; problems with sensory integration), displays of aggression, increased drug use, and risk behavior for HIV, social withdrawal, and feelings of helplessness or fear. Documentation also records the physical setting in which these behaviors occur and who is present. For example, a youth who was referred for group intervention urinated without control during the day and night. The behavior and the setting in which it occurred was recorded. The record was compared to the youth's case file, which showed that he "urinated when he felt pressured by his abuser."[7] Research indicates that this

indicates a possible regression from to a previously learned skill and a diagnosis of PTSD was made (American Psychiatric Association, 2000).

In order to treat PTSD, it is also necessary to document the effects (i.e., consequences) of target behaviors and environmental influences, like medication, medical conditions, sleep, diet, schedule, and social factors, that may affect behaviors. Location is also an environmental influence; youth from high-risk PTSD samples often reside in areas that have high incidences of community violence. Finally, it is important to document indicators of adolescents' resilience. For example, resilience may be evident in a juvenile offender's ability to engage with peers in a positive, constructive manner during a school group exercise.

ASSESSMENT

An intake interview is the initial point of contact in the proposed treatment. During the intake interview, the clinician will assess whether the adolescent should participate in the group intervention or be referred to a community-based agency for individual treatment. The clinician will be encouraged to use motivational interviewing techniques to order to assess the youth's readiness for the intervention process. If the youth is able to discuss the traumatic experience, the clinician may inquire whether he or she would prefer to attend sessions with a group of peers or to receive one-on-one treatment. This discussion will allow the youth to experience the intake interview as part of the intervention process.

The assessment for PTSD in adolescents remains challenging and characteristically requires a comprehensive approach. In the proposed model, assessment will take place in direct clinical interviews and may also include the youth's parents. Because one or both of the parents may be perpetrators of the traumatic experience, it is important that the interview occur with the nonoffending parent. Although the AACAP encourages parental involvement (AACAP, 1998), the organization also notes that youth must feel safe to report information without fearing that it will get back to their guardians. To encourage adolescents to express their opinions and feelings, data will be gathered from information self-reported by the youth, as well as from clinical interviews. Measures that gather self-reported data also enable researchers to efficiently screen large groups and to determine who may need further assessment. Greenwald (2002) cites one study of delinquent adolescents that used the 43-item Los Angeles Symptom checklist. This measure gathers self-reported

data and was tested effectively to measure the presence of child and adolescent PTSD. This checklist will be used to determine appropriate referrals for treatment.

To further determine participant involvement in the proposed treatment, the clinician will examine the client's symptoms and the location of the client's residence. Specific questions on the traumatic experience inquire about the following four symptoms: (1) reexperiencing, or the existence of a mental replay of the trauma and the strong emotional reactions attached to it; these reminders may occur when the adolescent is awake or during sleep (e.g., nightmares); (2) avoidance, exhibited through the youth's effort to escape activities, places, or people that may remind him or her of the trauma; (3) numbing, which involves the loss of emotions, especially positive feelings; and (4) arousal, which involves a heightened sense of awareness and is often experienced as difficulty in sleeping or concentration. The clinician will also document the length and severity of the symptoms. It is equally important that the clinician consider the environmental factors affecting each individual. Some adolescents currently in the Juvenile Temporary Detention Center may experience a heightened sense of anxiety due to their environment. For others who reside in communities with high crime rates and violence, the community environment may affect the targeted behavior.

Youth with PTSD may also suffer from other mental health disorders. The clinical interview, self-report measures, and motivational interviewing allow adequate opportunity for self-disclosure (Greenwald, 2002). Adolescents with a wide range of traumatic experiences may be effectively treated with these cognitive-behavioral techniques, however, individual treatment may be more effective than group therapy for an adolescent with multiple clinical issues (Davis, 1992).

TREATMENT PLAN

The proposed group intervention is consistent with AACAP recommendations for treatment for adolescents diagnosed with PTSD (AACAP, 1998). The proposed treatment method employs a group therapy format. Research supports this modality as an effective method for treatment of incarcerated males whose traumatic experiences are due largely to community violence (March et al., 1998; Ovaert et al., 2003). The choice to participate in group treatment will be discussed for each adolescent during his or her initial assessment with a psychologist. In that meeting, the clinician may discuss the traumatic experience with the adolescent and, with the youth's input, determine whether group or individual treatment is the more promising approach.

The primary treatment model to be discussed in this study, Trauma Adaptive Recovery Group Education and Therapy for Adolescents (TARGET-A), is currently

being used and adapted for specific populations (Ford, 2006). The TARGET-A approach is a strengths-based approach for trauma survivors. The method teaches pyschoeducation, coping skills, and lasting recovery through a seven-step practical approach that can be summarized by the acronym FREEDOM (Ford, 2006). The acronym FREEDOM stands for focus, recognition, emotion, evaluate, define, options and make a contribution (Ford, 2006). The steps center on empowering youth and teaching them to self-regulate, process current traumatic stress reactions, manage emotions, and set goals. In between sessions, adolescents complete worksheets. Through the FREEDOM approach, youth learn strategies to "use their minds to teach their bodies and emotions to be less reactive, and to create new memories that increase their self-esteem and personal control" (Mahoney et al., 2005, p. 12).

This article adapts the TARGET-A treatment plan (Mahoney et al., 2005) for use in a 10-session plan for group therapy with male juvenile offenders. Sessions will be held twice a week and will be 90 minutes long. Because most incarcerated youth are court-involved or currently placed at the detention center (located within the court complex), it is likely that they will be available to attend sessions held at the court complex. The proposed treatment plan is comprised of three elements: psychoeducation, coping skills, and lasting recovery. Sessions are delineated for each element discussed. The seven-step FREEDOM approach will also be integrated into the proposed treatment plan. To reinforce and build on what the adolescents learned previously, each successive session will review the material and handouts from the previous session. At the end of each session, each youth will be asked to assess his level of personal stress, personal control, and extreme stress reaction. Youth will be asked to rate each concern on a scale of 1 (low) to 10 (high).

Psychoeducation

Psychoeducation refers to educating an individual about the problem they experience, about how to treat it, and about how to prevent relapse. Although psychoeducation will occur to some extent in each session, it will be the main focus of the first session. The goal of this session is to provide youth with information about normal stress and to contrast normal stress with extreme stress. This first session will also set ground rules (e.g., attendance, participation, and safety guidelines) for the group's meetings (which will be held twice a week). Members will be asked to attend each session and to notify the facilitator if they cannot attend. Because this is a trauma group, aggressive behavior (i.e., causing physical harm to others) will not be tolerated. Members must feel safe if they are expected to participate in the sessions.

In order to gain an understanding of the difference between the biopyschosocial effects of normal stress and those of extreme stress, youth will be asked to review handouts (Ford, 2006; pp. 4–7). The handout uses a metaphor to show youth that their brains possess something like an alarm system. The same system that wakes them up in the morning also warns them if they are in danger. The activity is designed to illustrate the protective signals that the brain sends each individual. Yet, traumatic events may damage this alarm system. This handout illustrates how the conditions in which the brain signals emotions that may help create options for decision-making or coping are distinct from other situations (e.g., trauma or extreme stress) that may trigger emotions of "survival alarm mode" (Mahoney et al., 2005, p. 4).

The metaphor may be further illustrated by showing youth an alarm clock, letting them know when the alarm is set to sound, and then continuing to speak as the alarm goes off during the session. The observable distraction demonstrates how youth may feel when they cannot concentrate because their brain's alarm continues to signal after a trauma. The metaphor of a nonstop alarm is accessible to the adolescents because they can relate it to feelings of being out of control. Once the point has been made, the facilitator can turn down the alarm to show that this treatment may help the youth to turn down their own stress alarms. The adapted treatment approach described here returns to the alarm metaphor throughout group treatment. A consistent thematic intervention applies a focal (FREEDOM) skill set to cope with and reduce PTSD symptoms. To remind participants of the significance of the alarm metaphor, they are assigned weekly homework in which they must keep track of any time that they feel they are in the alarm mode. The handout and depiction of emotions are designed to help adolescents to conceptualize how their PTSD symptoms are likely to have developed. As a result, youth may be likely to accept treatment for help with this fear response (De Arellano et al., 2005).

Psychoeducation prepares the adolescents for the second session, in which youth are coached to develop coping skills for dealing with extreme stress. The first session concludes with an overview of the FREEDOM steps that will be covered over the next seven sessions. Here, the handout "TARGET Teaches Positive Coping" (Ford, 2006, p. 11) is helpful because it shows that many different actions are possible when the alarm is triggered as a result of extreme stress. Another acronym is used to illustrate a strategy available for coping with such stress: TRAPPED (terror, rage, abandoned, pressured, pain, emptiness, and defeated). The strategy may be discussed through a dialogue in which adolescents describe how they deal with stressful situations and with reactions to their own traumatic experience. Adolescents are not asked to "get in touch and get over"

the trauma, but rather to focus on current posttraumatic reactions and to learn how to "turn down the alarm" (Mahoney et al., 2005, p. 1).

Coping Skills

Because this approach is both strengths-based and present centered, most of the treatment plan involves teaching coping skills through the FREEDOM guidelines. During the second session, the group is taught about the first of the seven FREEDOM steps. This first set encourages a three-part strategy (slow down, orient, and self-check, or SOS) to develop focus as a skill for coping with extreme stress reactions. In response to extreme stress, the youth first slows down by taking a moment during a reaction to a traumatic event and by paying attention to breathing.

In the second phase of the SOS strategy, the youth orients. That is, the youth attempts to see the current time and place, who is around, and what activity is occurring. Orienting thus focuses the youth on being present and recognizing the surroundings. Self-check is the final phase in the SOS strategy. In this phase, the youth is instructed to consider how he feels at that moment. Although some youth may find focusing difficult, the use of diaphragmatic breathing may nonetheless provide the adolescents with a means of relaxing amid stress. Research has shown that controlling breathing reduces arousal in the nervous system, lowers heart rate, and slows the individual's rate of breathing (Friedrich, 1996; Greenwald, 2002; Hillman, 2002). The breathing technique is also useful because the youth can do it on his own. To learn how to control breathing, the individual is instructed to sit on a chair, to plant both feet firmly on the ground, and to close his eyes. The youth then is asked to take a deep breath, to count to six, and then to exhale. If an individual finds this difficult at first, he is encouraged to leave his eyes open and to place an object on his belly. The object rises as he inhales and falls as he exhales. This visual component helps to train the individual to use breathing as a way to focus. The method can also be used to reduce anxiety produced as a result of talking or thinking about the trauma.

Michael de Arellano and colleagues (2005) argue that coping skills are highly effective because they provide youth with ways to address dysfunctional thoughts, label emotions, and confront those emotions. Use of these skills, in turn, increases social functioning and builds problem-solving skills that the teenagers may use in the future.

The third of the 10 group sessions examines the second element in the FREEDOM model: recognition of stress triggers. The goal of this element is to teach the group members what triggers stress and how a trigger can lead to an

extreme stress reaction. To encourage youth to think about triggers, the facilitator might ask, "What are one or two specific triggers that can set off the alarm in your brain?" and, "What can you do to increase your control and happiness when you have a trigger?" These questions encourage youth to recognize triggers and to participate in problem-solving with other group members (Mahoney et al., 2005).

The fourth and fifth group sessions address youths' emotion awareness and encourage them to evaluate central thoughts. These sessions transition from teaching initial coping skills to instruction about the early warning signs that enable adolescents to foresee and avoid extreme stressors. In the discussion of emotion awareness, youth are instructed to differentiate between reactive feelings and a main emotion. For example, the main emotion may be excitement but the adolescent may be feeling impatience. Other main emotions, such as worry, may trigger numerous reactive feelings, like irritation or anger. By considering the different reactive emotions, the youth is encouraged to continue behavioral conceptualization, and he is able to make a connection between feelings and consequent behaviors. In this fourth session, the handouts review the "EED steps," which Julian Ford (2006, p. 16) defines as "Emotion, self-check, evaluate thoughts, define goals." The purpose of this review is to transition the youth from reaction to self-regulation of targeted behavior.

The current model adapts the provisions of the FREEDOM method to incorporate motivational interviewing into the session. This adaptation also presents an opportunity to incorporate a technique that Greenwald (2002) employs in his work with juvenile offenders. The proposed treatment will integrate Greenwald's therapeutic Future Movies technique (Greenwald, 2002). The activity will be introduced at the end of the fifth session, after the group has been instructed on how to recognize triggers, received training on emotion awareness, and learned to evaluate main thoughts. Then, each individual will depict his future movie as homework any in any medium (e.g., music, poetry, narrative, audio recording) he chooses. When the group returns for the sixth session, the adolescents will review the coping skills they learned in the preceding sessions, and each will present his future movie. Although incarcerated youth may have limited resources, the facilitator can provide the youth with access to the juvenile detention center's library so that they can complete the projects prior to the next session. The addition of future movies to the FREEDOM model promotes creativity among the group members and allows each individual to showcase his talent. It is also noteworthy that this treatment adaptation avoids focusing on the youth's retelling of the traumatic event. Rather, the method is consistent with the solution-focused, strengths-based approach.

Lasting Recovery

The seventh, eighth, and ninth sessions emphasize lasting recovery; in these sessions, the youth will begin to terminate involvement in the group treatment and to implement learned skills in daily living. Lasting recovery alludes to the expectation that PTSD symptoms have diminished as a result of participation in treatment. The Future Movies activity prepares group members to project their ideals for the future. In the seventh session, youth begin to address their plans through the fourth element of FREEDOM: defining main personal goals. For adolescents who experience PTSD symptoms, the focus on the future is essential; when individuals are overwhelmed or stressed, they often are not able to think clearly or to decide what they want out of a situation. Youth may describe this as feeling frozen or unable to control what occurs in their life. The youth's task during the seventh session is to define what he needs and then to identify main goals that will enable him to meet those needs. This process again reinforces the process of prioritization and the coping skill that enables a youth to turn down the alarm.

As the youth address their main personal goals, they consider how they might achieve these goals. For example, the goal might be to decrease aggressive behavior in the classroom at the juvenile detention center. Group members provide feedback on tried approaches that succeeded and those that failed. The feedback allows members to problem solve around failed approaches and improve goal setting skills. This record is reviewed during the eighth session, which is devoted to FREEDOM's options. The session identifies good options and has an options exercise that follows up on the records kept by youth between the sessions. It is important to reinforce the successes reported by youth. The options exercise (Ford, 2006; pp. 22–23) presents a stressful situation (typically, a common occurrence) that a youth is likely to experience. The group uses the situation to brainstorm about possible options on how to respond in a situation. This session identifies how a youth may solve problems and reduce behaviors that often occur as a result of symptoms from posttraumatic stress disorder.

The ninth session emphasizes the final element in the FREEDOM approach: making a contribution. This step is included in the treatment plan because individuals who experience stressful situations may have negative feelings about themselves (Mahoney et al., 2005). By recognizing a youth's positive contributions, the facilitator helps him to build upon small successes. Such successes may alter the individual's negative feelings about himself and may help him to react to future stresses in a controlled manner. For example, juveniles often do not give credit to themselves for being role models to younger siblings or protecting

family members. The primary function of this session is to recognize achievements that youths have already made, not to force adolescents to try harder to be a good person. The attention to the youth's small successes is crucial for juvenile offenders who may feel that they have already failed (Coleman, 2005). Session nine concludes with a review of the seven practice elements of FREEDOM: focus, recognition, emotion, evaluate, define, options and making a contribution (Ford, 2006).

The tenth and final session takes the format of a graduation ceremony in which group members review what the group has learned. In addition, the facilitator may inquire about whether the youth would like significant others, such as family members or probation officers, to attend the ceremony. The ceremony acknowledges the youth's acquisition of a new skill set for dealing with stressful situations. This acknowledgement validates the youth's work towards recovery from PTSD symptoms. Also, parental involvement may reduce the risk of future court involvement (Friedrich, 1996). Each individual is encouraged to share how he has begun to make positive changes as a result of the group. The facilitator may ask members what they particularly appreciate and value about the other group members. Members may also be encouraged to identify what they value about their own contribution to the group. The graduation ceremony is a good point to reintroduce the Future Movies activity. As the youth review their creations, they will be able to see how the expressed goals align with plans to make future contributions. Revisiting the activity also integrates the seven elements of FREEDOM into the final session. In this session, adolescents focus on current reconstruction, not on reviving memories of extreme stress experience.

CONCLUSION

Because PTSD in adolescents may manifest itself through deviant behaviors, the criminal acts of those youth may reflect the externalization of traumatic experiences. In these contexts, it is important to identify symptoms early, because reduction of the symptoms may in turn diminish deviant behaviors that cause recidivism. Because juvenile offenders are exposed to community violence at high rates, trauma-focused treatment, provided during probation or detention, may help to end patterns of violence that can persist as offenders return to their community. Most compelling for youth correctional facilities is the fact that treatment is associated with a reduction of behavioral problems (Coleman, 2005). However, juveniles who have not discussed traumatic events prior to assessment may not be prepared for group intervention. One suggestion for these adolescents is that they receive individual therapy prior to participation.

Future research should consider the form of group intervention adapted here, examining its effects on recidivism rates among juveniles with PTSD. Research should also consider the approach's effects on behavioral functioning at school and with the family.

The strength of TARGET-A is that it is flexible. An individual may use the intervention for a 4-session short-term group that addresses only the steps two through five of FREEDOM or for ongoing groups, such as those for anger management. The inclusion of motivational interviewing for the assessment and treatment intervention addresses ambivalence that many youths may feel towards their traumatic experience. The adapted treatment plan presented in this article is beneficial because it is present-centered. Among adolescents who have experienced trauma, it can also improve attachment concerns, emotion regulation, and information processing.

REFERENCES

Ahrens, Julia, and Lillian Rexford (2002). Cognitive Processing Therapy for Incarcerated Adolescents with PTSD. *Journal of Aggression, Maltreatment and Trauma*, 6 (1): 201–16.

American Academy of Child and Adolescent Psychiatry (1998, October). Practice Parameters for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, no.10 (Supplement): 4–26.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders: Text Revision: DSM-IV-TR* (4th ed.). Washington, DC: American Psychiatric Association.

Cohen, Judith A., Anthony P. Mannarino, Lucy Berliner, and Esther Deblinger (2000). Trauma-Focused Cognitive Behavioral Therapy for Children and Adolescents: An Empirical Update. *Journal of Interpersonal Violence*, 15 (11): 1202–23.

Coleman, Daniel (2005). Trauma and Incarcerated Youth. In Lisa A. Rapp-Paglicci (Ed.), *Juvenile Offenders and Mental Illness: I Know Why the Caged Bird Cries* (113–24). New York: Haworth Social Work Practice Press.

Davis, Inger P. (1992). Individual and Group Treatment of Problem Adolescents: A Selective Review." In Roger Bullock (Ed.), *Problem Adolescents: An International View* (47–54). Concord, MA: Paul & Company Publishers Consortium.

De Arellano, Michael A., Angela A. Waldrop, Esther Deblinger, Judith A. Cohen, Carla Kmett Danielson, and Anthony R. Mannarino (2005). Community Outreach Program for Child Victims of Traumatic Events: A Community-Based Project for Underserved Populations. *Behavioral Modification*, 5 (1): 130–55.

Ford, Julian D. (2006). Trauma Affect Regulation: Guide for Education and Therapy. Retrieved on May 15, 2007 from http://www.ptsdfreedom.org/assets/pdfs/PresentationModified6.pdf.

Foy, David W., and Carole A. Goguen (1998). Community Violence-Related PTSD in Children and Adolescents. *PTSD Research Quarterly*, 9 (4): 1–6.

Friedrich, William N. (1996). Clinical Considerations of Empirical Treatment Studies of Abused Children. *Child Maltreatment*, 1 (4): 343–47.

Greenwald, Ricky (2002). Motivation-Adaptive Skills-Trauma Resolution (MASTR) Therapy for Adolescents with Conduct Problems: An Open Trial. In Ricky Greenwald (Ed.), *Trauma and Juvenile Delinquency: Theory, Research, and Interventions* (237–61). Binghamton, NY: Haworth.

Hamblen, Jessica (n.d.) PTSD in Children and Adolescents (fact sheet). Washington, DC: U.S., Department of Veterans Affairs, National Center for Posttraumatic Stress Disorder. Retrieved on May 19, 2006 from http://www.ncptsd.va.gov./ncmain/ncdocs/fact_shts/fs_children.html.

Hillman, Jennifer L. (2002). *Crisis Intervention and Trauma: New Approaches to Evidence-Based Practice*. New York: Kluwer Academic/Plenum Publishers.

Lang, Peter J. (1977). Imagery in Therapy: An Information Processing Analysis of Fear. *Behavior Therapy*, 8 (5): 862–86.

Mahoney, Karen, Julian D. Ford, and Marisol Cruz St. Juste (2005). *TARGET-A: Trauma Adaptive Recovery Group Education and Therapy: 10+ Session Adolescent Version: TARGET-A Facilitator Guide*. Farmington: University of Connecticut Health Center.

March, John S., Lisa Amaya-Jackson, Mary Cathryn Murray, and Ann Schulte (1998). Cognitive-Behavioral Psychotherapy for Children and Adolescents with Posttraumatic Stress Disorder after a Single-Incident Stressor. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37 (6): 585–93.

Martin, Garry, and Joseph Pear (2005). *Behavior Modification: What It Is and How to Do It* (8th ed.). Upper Saddle River, NJ: Pearson/Prentice Hall.

Miller, William R., and Stephen Rollnick (2002). What Is Motivational Interviewing? In Rollnick and Miller (Eds.), *Motivational Interviewing: Preparing People for Change* (33–42). New York: Guilford.

Ovaert, Lynda B., Mary Louise Cashel, and Kenneth W. Sewell (2003). Structured Group Therapy for Posttraumatic Stress Disorder in Incarcerated Male Juveniles. *American Journal of Orthopsychiatry*, 73 (3): 294–301.

Prochaska, James O., and Carlo C. DiClemente (2005). The Transtheoretical Approach. In John C. Norcoss and Marvin Goldfried (Eds.), *Handbook of Psychotherapy Integration* (2nd ed.) (pp. 147–71) New York: Oxford University Press.

Prochaska, James O., and Janice M. Prochaska (1999). Why Don't Continents Move? Why Don't People Change? *Journal of Psychotherapy Integration*, 9 (1):83–102.

Rollnick, Stephen, and William R. Miller (1995). What Is Motivational Interviewing? *Behavioural and Cognitive Psychotherapy*, 23 (4): 325–34.

Shapiro, Francine (2001). *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures* (2nd ed.). New York: Guilford Press.

University of Connecticut Health Center (n.d.). TARGET: Trauma Affect Regulation: Guide for Education and Therapy: Research Studies (Fact Sheet). Farmington: University of Connecticut Health Center. Retrieved on May 21, 2007 from http://www.ptsdfreedom.org/research_studies.html.

NOTES

[1] The academy does not differentiate intense fear from horror; rather, the parameters suggest that symptoms vary according to developmental age of the child and fit within three broad categories: reexperiencing, avoidance and numbing, and increased arousal (AACAP, 1998).

[2] Narrative retelling refers to when the client revisits the trauma by relating the events in a narrative, oral or written, form.

[3] Many of the reviewed treatment approaches in this article do not regard the age of the targeted client suggesting that treatment among adolescents who experience PTSD is not as well documented as it is for adults.

[4] Davis (1992) reviews research published in the United States and identified through computer searches.

[5] Here, the goal is to encourage the youth to examine how they have stored memory of the traumatic event. The antecedents and beliefs allow a youth to recognize which external stimuli cause avoidance behavior.

[6] Resolution comprised the final session, in which participants concluded their experience within the group and integrated the learned skills in relation to trauma memories.

[7] In order to protect the confidentiality of the subjects in this study, the article omits the names and other identifying characteristics of subjects.

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