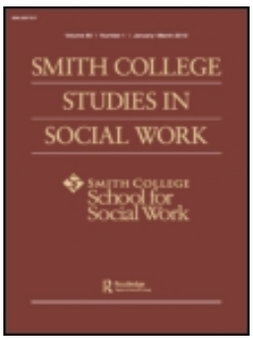

Smith College Studies in Social Work

ISSN: 0037-7317 (Print) 1553-0426 (Online) Journal homepage: http://www.tandfonline.com/loi/wscs20

Trauma Informed Clinical Social Work Practice: Case Composite with Court-Involved Adolescent

Jillian Graves & Janet Shapiro

To cite this article: Jillian Graves & Janet Shapiro (2016) Trauma Informed Clinical Social Work Practice: Case Composite with Court-Involved Adolescent, Smith College Studies in Social Work, 86:3, 204-224, DOI: 10.1080/00377317.2016.1191836

To link to this article: https://doi.org/10.1080/00377317.2016.1191836

Published online: 11 Jul 2016.

SMITH COLLEGE STUDIES IN SOCIAL WORK
2016, VOL. 86, NO. 3, 204–224
http://dx.doi.org/10.1080/00377317.2016.1191836

Routledge
Taylor & Francis Group

Trauma Informed Clinical Social Work Practice: Case Composite with Court-Involved Adolescent

Jillian Graves, MSW, LCSW and Janet Shapiro, PhD

Bryn Mawr Graduate School of Social Work and Social Research, Bryn Mawr, Pennsylvania, USA

ABSTRACT

According to the Office of Juvenile Justice and Delinquency Prevention (Puzzachera, 2013), there were approximately 1.47 million arrests of juveniles in the United States reported in 2011, including 68,150 serious violent crimes and 190,000 simple assaults. These data demonstrate that violent crimes are a significant national issue. Past studies have indicated that court-involved and delinquent adolescents frequently report a history of trauma symptoms and exposure to violence. The goal of this article is to present a framework for practice with court-involved youth that reflects the intersection of literature on adolescent development, trauma, and court-involved youth. Improving our understanding of the influence that trauma has on court-involved adolescents will support our ability to better understand the needs of this population in terms of treatment and crime prevention. This article presents a trauma-specific context for addressing the needs of court-involved youth from developmental, neurobiological, and trauma informed perspectives. One of the central components of this article is the inclusion of the TARGET model, a research-informed exemplar for the treatment of adjudicated adolescents who have histories of trauma. A review of the literature is followed by the presentation of a case composite vignette that exemplifies the need for a trauma-informed approach to working with court-involved adolescents.

ARTICLE HISTORY
Received 16 May 2016
Accepted 17 May 2016

KEYWORDS
adolescents; delinquency; trauma; violence

Introduction

According to the Office of Juvenile Justice and Delinquency Prevention (Puzzachera, 2013), there were approximately 1.47 million arrests of juveniles in the United States in 2011. Within this population of 1.47 million, 68,150 involved serious violent crimes, which include homicides, aggravated assaults, forcible rapes and robbery. An additional 190,000 arrests involved simple assaults and 12,600 other types of sex offenses. These data demonstrate that violent crimes continue to be a significant national issue, despite the declining rate. In addition, past studies have indicated that court-involved and delinquent adolescents frequently report a history of trauma symptoms and exposure to

CONTACT Jillian Graves, MSW jgraves@brynmawr.edu Bryn Mawr Graduate School of Social Work and Social Research, 300 Airdale Road, Bryn Mawr, PA 19010.

violence (Copeland, Keeler, Angold & Costello, 2007; Espinosa, Sorensen, & Lopez, 2013; Ford, et al., 2013). Improved understanding of ways that trauma has influenced court-involved adolescents will support our ability to better assess the needs of this population, in treatment and crime prevention. The goal of this article is to present a framework for practice with court-involved youth that reflects the intersection of literatures on adolescent brain development, trauma, and court-involved youth.

Exposure to violence and subsequent traumatic reactions among adolescents can create a variety of neurobiological and emotional responses (Cloitre et al., 2009; D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012), which can result in impulsive decision-making and violence. Complicating matters is the particular vulnerability of adolescents as their brain development is normatively asynchronous. Specifically, adolescence is a time of heightened sensation seeking and low impulse control (Steinberg, Albert, Cauffman, Banich, Graham, & Woolard, J. 2008). These normative aspects of brain development can potentiate the vulnerability of adolescents who experience trauma. Adolescents are normally more likely to externalize their issues and have a less-nuanced and more-reactive response to interpersonal challenges. A history of chronic repetitive trauma amplifies these responses, setting the stage for a diagnosis of complex trauma during adolescence. Understanding the intersection of trauma with psychological and social development would lead to a much more nuanced understanding of the challenges that traumatized adolescents may face, which, in turn, may help to guide interventions. There is evidence that dysregulation, hyperarousal, and the subsequent interpersonal problems are related to participating in violent and otherwise delinquent behavior expressed by traumatized youth (Ford, 2002; Kerig, Ward, Vanderzee, & Moeddel, 2009; Silvern & Griese, 2012). Traumatized adolescents may amplify the danger by responding immediately to various conflicts using a rigid repertoire of coping techniques, which can result in the greater likelihood of violence.

In this article, we present a trauma-specific context for addressing the needs of court-involved youth from developmental and trauma-informed perspectives. A review of the literature, with an emphasis on the explication of the TARGET model (Ford, Chapman, Mack, & Pearson, 2006), is followed by the presentation of a vignette based on a case composite that exemplifies how elements of the TARGET mode, and trauma-informed approaches more generally, support a trauma-informed approach to working with court-involved adolescents.

Literature review

The high representation of traumatized youth among the juvenile justice population is well established. In fact, adolescents who have witnessed or

experienced violence and/or been abused and neglected are at high risk of developing aggressive and antisocial behavior (Ardino, 2012; Barr et al., 2012). However, pinpointing the exact mechanisms that link trauma and violence is a much more complicated proposition.

Examining developmental and functional issues is an important first step in trying to link trauma and violence among adolescent, specifically assessing how trauma affects adolescents' abilities to self-regulate, the quality of their relationships, and their worldview. This assessment guides the development of a framework to understand why traumatic exposure may increase the risk for committing interpersonal violence. Given the complexity of the problem and the lack of a prevailing philosophy, this comprehensive framework allows for an exploration of ways that adolescents who have experienced trauma cope with these traumatic events. Three sets of literature provide this framework, allowing for a clearer examination of the pathway from trauma to interpersonal violence. I will examine literature on (a) adolescent brain development, (b) court-involved youth, and then, finally, on (c) the trauma coping model, which integrates findings between the two previous sets of literature

Adolescence, brain development, and trauma

Many of the studies focus on the ways that normative changes in adolescence and traumatic events experienced in childhood influence neurobiological and emotional development and how these responses overlap with several factors that seem to lead to violent and/or delinquent behavior. These studies often view dysregulation, shame, rage, intense interpersonal needs, and emotional numbing as possible links to violent behavior (Baer & Maschi, 2003; Ford, Courtois, Steele, Hart, & Nijenhuis, 2005; Kerig & Becker, 2010). Examining the differences between these explanations of the same phenomenon may deepen our understanding of the complex ways that trauma has influenced development, including exploring the reasons for differences among court-involved adolescents with trauma histories.

Song, Singer, Anglin, and Lunghofer (1995) proposed that biological changes during adolescence influence many other aspects of development, such as identity and worldview. For example, adolescents who have been exposed to trauma may be more likely to misread the threat of impending violence from others, which results in a greater likelihood of "striking first." Adverse environments may result in a heightened state of vigilance becoming more trait-like.

Because traumatized adolescents are likely to be more vigilant than the average person, they may "overperceive" aggression from others (Baer & Maschi, 2003, p. 87). These adolescents develop in an environment where a heightened state of arousal is adaptive. Children who grow up in a household

where there is abuse or in a community with significant violence benefit from maintaining alertness because danger is ever-present and often unpredictable (Christopher, 2004). Other people are often seen as untrustworthy, dangerous, or unreliable, and so a child is left by him/herself to fend off any potential threats (Briere & Rickards, 2007). This coping style is less adaptive in safer environments, where there is an assumption that other people are trustworthy and the environment is less fraught with danger. Striking out in these safer environments is a violation of social rules and is often seen as transgressive rather than self-protective.

Kerig and Becker (2010) examined another aspect of the effects of trauma, namely the difficulty of self-regulation. They describe posttraumatic stress disorder symptoms as a mediator that increases the likelihood of delinquent behavior, where reexperiencing may appear as dysregulation and hyperarousal may manifest itself as irritability. The overlap in symptoms consistent with the effects of trauma and oppositional defiant disorder, for example, may indicate the role that trauma plays in the development of violent or otherwise delinquent behavior. Self-regulatory development is a normal part of adolescence, while younger adolescents tend to be much less well developed at regulating in social situations than are nonsocial ones, though their abilities generally improve during development (Silvers et al., 2012). With traumatized adolescents, the capacity to "regulate affect, cope with intense emotions, and control impulses" (Singer, Anglin, Song, & Lunghofer, 1995, p. 478) is not as well developed. These adolescents whose regulatory capacities are already undeveloped are even more vulnerable to environmental influences. As a result of their difficulties with affect regulation, they may cope by using delinquent behavior, such as being aggressive or self-destructive.

Combining dysregulation with a tendency toward "hostile attribution biases" (Kerig & Becker, 2010) puts many traumatized adolescents at further risk. A tendency toward hostile attributions may mean that adolescents are likely to attribute otherwise neutral situations as threatening. In these potentially threatening situations, they may be more likely to become dysregulated and their judgment may be compromised, resulting in a higher likelihood of interpersonal violence. Conversely, nontraumatized adolescents, who do not have significant hostile attribution biases, are likely to experience a higher level of self-efficacy and a feeling of mastery over their environment. In turn, they are then more inclined to feel in control of their lives and, therefore, more likely to engage positively with others (Benight & Bandura, 2004). They will more often tend to seek positive, prosocial relationships, which will act as a buffer against violent activity.

Stuewig and McCloskey (2005) examined the development of shame, which is likely to be related to violent or otherwise delinquent behavior. Shame often develops in an environment where there are punitive styles of parenting combined with rejection and harsh criticism or if there is abuse,

especially sexual abuse (Feiring, Taska, & Lewis, 2002). The "rationale for the relationship between shame and subsequent aggression is that a feeling of powerlessness may lead to a 'shame-fury' episode, defined as a person striking out in anger to get back some control over their life" (p. 326). Shame needs to be differentiated from guilt. Feelings of guilt are often connected to efforts to make amends and the development of empathy and connectedness. With shame, a person can feel that his/her transgressions represent global assessments on his/her personhood, whereas guilt is more about a judgment of his/her actions. Shame provokes fury because the person is protecting the self, rather than his/her actions (Becker & Kerig, 2011; O'Connor, Berry, & Weiss, 1999). Because of hyperarousal, irritability, and hostile attribution bias, traumatized adolescents may lash out at others in violent and/or illegal ways and, therefore, research on, and practice experience with, court-involved youth may provide some clues about this population.

Court-involved youth

Given the prevalence of trauma among court-involved youth (Coleman, 2005) and the juvenile justice mission to produce positive outcomes, recent interventions have become more structured and responsive to the mental health needs of youth. The justice system has to balance the mental health needs while also holding adolescents accountable for their action and protecting the public, which requires demonstrable positive outcomes (McMackin, Leisen, Sattler, Krinsley, & Riggs, 2002), Interventions have to be evidenced based and efficacious across many treatment settings and with many interrelated systems with differing mission statements and individuals who need to collaborate regularly to attend to the complexities in the lives of these adolescents (Shelton, 2005). The risks are high for not effectively treating these youths. While they are not a homogeneous group, there is a heightened risk that these adolescents may offend and enter the adult criminal justice system, a risk that may be mitigated by mental health treatment (Davis, Banks, Fisher, & Grudzinskas, 2004)

Residential treatment has been demonstrated to have significant drawbacks, in terms of removing an adolescent from their environment and primary attachment figure (Zelechoski et al., 2013). However, it is important to remember that juvenile detention includes in its mission the goal of protecting the public and therefore placing an adolescent out of the home and into a restricted milieu is often unavoidable. This is particularly the case since judges, rather than the mental health system, make these determinations. As a result, focusing on the benefits and limitations of treatment in a milieu setting is critical when considering what treatment protocols are most effective.

Given these complexities and pressures, there is a need to have a coherent explanation of the pathway from trauma to interpersonal violence and delinquency and the link to effective evidence-based practices. The trauma coping model proposed by Ford et al. (2006) provides a better understanding of the link between trauma and interpersonal violence and is useful as a lens when considering what treatment is effective for traumatized, court-involved youth.

Trauma coping model

Ford et al. (2006) developed the trauma coping model. A primary assumption of the trauma coping model is that the antisocial behavior often seen in traumatized adolescents can be understood as the adolescents' efforts to defend themselves against perceived threats by any means necessary. This approach incorporates many of the ideas around self-regulation, hostile attribution biases, and interpersonal disruption. They wrote, "traumatic victimization, as we shall see, teaches children to use often drastic means to cope and survive, which may include delinquency" (p. 17). Ford et al. (2006) further explained, "When exposed to coercion, cruelty, violence, neglect, or rejection, a child may cope by resorting to indifference, defiance of rules and authority as protective counter-reactions" (p. 17). In this way, antisocial and/or violent behavior may be recast and understood in part as adaptive skepticism toward authority, which can often go awry when combined with states of dysregulation and experiences of being psychically overwhelmed; interfering with traumatized adolescents' abilities to assess highly evocative situations.

In addition to the hostile attribution style, complex early trauma compromises the development of an array of neurobiological functions. During early childhood, a period that is characterized by exploration that is predicated on having a secure base, traumatized children were preoccupied with a surviving by "detecting and surviving threats" (Ford, Chapman, Connor, & Cruise, 2012, p. 696). If the brain spends most of its time in survival mode, there are permanent changes in the body's nervous system, which results in a reduced ability for distress tolerance and frustration, delayed gratification, and increased impulsivity (Neumeister, Henry, & Krystal, 2007). The executive functioning system is similarly compromised, making it difficult to identify and process information in order to make the kinds of decisions that become increasingly complex through adolescence.

The trauma coping model describes how traumatized adolescents can have out-of-control or absent emotions along with rigid thinking patterns and limited problem-solving skills, making ordinary decision-making processes fraught with difficulty. Even innocuous situations that may seem safe to others "may be riddled with potential threats based on their past experience being

exploited or harmed by other in the same or similar circumstances," adding that "what may seem like angry defiance may be self-protective assertions of an unwillingness to be further victimized" (Ford et al., 2006, p. 18). These youth develop externalizing problems, all of which may be an array of ways to manage trauma and are often diagnosed as conduct disorder or oppositional defiant disorder even though the central issue is complex trauma (Ford, 2010).

Ford et al. (2006) goes on to assert that understanding trauma and supporting improved emotion regulation are central features of delinquency prevention and making recommendations for court-involved youth. Even more so, appropriate treatment must "build competence in self-regulation" (Ford et al., 2012, p. 701). Ford asserts that building competence in self-regulation is a dual strategy where adults are there to model and coach self-regulation in response to stressors, while also providing limit setting in a sustained manner that will help adolescents increase their coping capacities without engaging in avoidant or impulsive behavior. The TARGET model includes specific strategies designed to build capacity among practitioners regarding how the symptoms of trauma are manifested in adolescents' behavior, including an emphasis on how working with traumatized adolescents can evoke significant distress in those working collaboratively to support the ability of traumatized adolescents to recognize feelings and to regulate affect (Ford, Chapman, Connor, & Cruise, 2012). Key areas of emphasis include (a) recognition of trauma reminders and triggers, (b) increasing the capacity to recognize feelings, (c) working with the adolescents to support their ability to observe their thoughts and the connection of these thoughts to their affect and behavior, (d) helping the adolescents to identify personal goals, (e) recognizing incremental progress towards identified goals, and (f) working with adolescents to help them see how they are able to offer empathic understanding to themselves and also to others.

As we will see in the following case, the trauma coping model and related ideas can help better understand the reasons why adolescents may commit violent acts that often seem confusing to people around them. The following case composite demonstrates how modes of coping with trauma may be a response to violence. The central role of affect regulatory processes will be explored in relation to how adolescents negotiate the world in interpersonal relationships and cognitive schemas. In addition, this trauma informed treatment focused on affect management, safety, and improved interpersonal engagement, demonstrating a positive outcome for this particular adolescent who experienced childhood trauma. (Ford et al., 2012; Zelechoski et al., 2013).

Clinical case composite: Hassan

To illustrate the use of the trauma coping model, I present Hassan, who represents a case composite designed to protect the confidentiality of the adolescents involved in this case.

Demographics

Hassan is a 15-year-old teenager most recently in ninth grade who was arrested on indecent assault charges stemming from incidents at his large suburban high school. His family was originally from Sudan, but he had grown up in a refugee camp in a neighboring country before immigrating to the United States with his mother, father, and siblings about 3 years ago. He was the second of five children, having a 21-year-old sister who lived at home and attended school, a younger 13-year-old brother, and two younger sisters, ages 9 and 7.

Hassan and his family were an ethnic minority within Sudan, not speaking the dominant language either there or among the Sudanese refugees in the United States. Hassan primarily identified himself as Sudanese. While his school identified him as a student of color, his own racial self-identification is less apparent and he does not describe any affiliation to other students of color in his diverse high school. Instead, Hassan discussed feeling alienated from his peers and wished he had remained in his previous high school with other Sudanese students.

Hassan and his family were devout Muslims with close ties to the Sudanese community in the area and attend a mosque in a nearby town. Because of the religious and cultural prohibitions, he and his family would not discuss his sexual identity. Hassan did not want to discuss his sexual feelings with me because I am a woman but did disclose that he had discussed sexuality with his peers.

Presenting issues

Hassan was referred for an evaluation to provide recommendations around treatment for his sexually aggressive behavior. After transferring schools about 6 months ago, Hassan, who had no reported history of physical and sexual violence, allegedly committed three separate sexual assaults at school. The judge, his guidance counselor, and his parents were concerned about this rash of violent sexual behavior and wanted a fuller picture about what precipitated these attacks.

According to court reports, Hassan had approached each girl, asking who they were and then asking their name. With the first girl, he asked if he could put his arm around her and when she agreed, he grabbed her buttocks and her crotch. The second time, he stuck his hand down her shirt. When she ran, he grabbed her again, before she was able to break free. During the third alleged incident, Hassan asked a girl a series of questions, like "Do you have an Instagram account?" She thought he was being friendly and she hugged him. He allegedly held her firmly and thrust his hips against her. When she ran away, he grabbed her buttocks. After the third incident, Hassan was

arrested and was held at the youth detention center while he was being evaluated and awaited trial.

History of treatment

Before arriving at youth detention, neither Hassan nor his family had received mental health treatment. They had received some supportive services through the Sudanese mutual aid association and Catholic Charities in their city, though that was more aimed at pragmatic aspects of assimilating to the United States. In fact, by virtue of Hassan and his family living for over a decade in a refugee camp, they had barely received any medical care, including regular visits with a pediatrician. Since he had never attended school, there was very little outside evaluation and intervention.

When Hassan was sent to youth detention about 6 weeks ago, he was assigned a therapist who would work within the context of the milieu, working with the staff to provide consistent structure and support to fulfill the dual function of juvenile detention—to protect the community and rehabilitate the youths sent there. Initially, his therapist reported that he often seemed to "look blank" or become "shut down" when he was distressed. Once his eyes "rolled up into his sockets." However, therapy eventually helped mitigate his symptoms and the creation of a warm therapeutic alliance seemed helpful, especially within the context of a highly structured setting. His therapist said that he stayed engaged where he had previously shut down. They had also begun to use a notebook to communicate some of the more painful feelings since it was less intense than talking face to face, which his therapist thought showed an ability to stay engaged with others. Overall, his therapist thought he made significant progress in a short amount of time, showing ability and a motivation to engage in the treatment process.

Family and developmental history

Hassan's parents had difficulty recalling and conveying information about his early childhood, so it was difficult to assess his early development. Their difficulty being interviewed is consistent with the experience reported by many refugees who have experienced war trauma. They often struggle with cognitive, particularly memory problems related to their trauma, and they may have difficulty with the assessment process itself, as it may evoke dynamics of traumatic reenactments with people in power who have inflicted violence on them (Ellis, Murray, & Barrett, 2014). It may be noted that at one point, when asking about the refugee camp, the translator became visibly distressed and said that they cannot discuss it anymore. However, they did provide significant information to complete the evaluation.

Hassan's parents are from Sudan originally and, like many people at the time, they fled during the war. His parents report that they grew up in stable intact families and had close relationships with their immediate and extended families. They were raised as devout Muslims and still pray and go to mosque regularly. They completed primary school and are literate. His parents married in their late teenage years and had their first daughter in Khartoum, living a relatively stable life before the war broke out in their country. However, eventually the fighting became severe enough that they had to flee to a refugee camp in a neighboring camp in an adjacent or nearby country, along with many extended family and community members.

Hassan's older sister was born in Khartoum in the context of an extended family, and while she grew up in the refugee camps, she has not had major developmental deficits despite her exposure to prolonged trauma. She was able to successfully graduate from high school and had no major behavioral difficulties. This may speak to the positive effects of fewer environmental insults prenatally and during early childhood.

Hassan's mother was pregnant when she left Sudan. She walked 13 days with her husband and oldest daughter, often without adequate food or water, until she reached the refugee camp. Hassan's mother had no prenatal care and was malnourished through her pregnancy. Hassan's condition at birth was described by his parents as "very bad" as he was exposed to malaria and dysentery and there was insufficient food or medicine in their refugee camp. His mother had been malnourished and otherwise experienced a great deal of stress during her pregnancy.

While in the refugee camp, Hassan developed a condition that his parents did not understand. He was never diagnosed or treated for anything on an ongoing basis because of the minimal medical care. He would "get sick, go to the hospital and come back and would cry for an hour and then laugh for no reason." His father remembered feeling significant anxiety when his son cried explicably and spent a lot of time trying to make him laugh.

Hassan and his family remained in the camps for about 13 years before they were granted passage to the United States. While Hassan and his siblings received little to no formal schooling, their parents are literate and were able to provide some education to their children, which aided them in their transition to the American school system. Their parents also provided emotional nurturance and care to their children, though they said it was difficult since Hassan (and likely his siblings) directly and indirectly witnessed people being physically and sexually assaulted and killed. It is unclear whether Hassan was assaulted himself, but he said that the camps were "tough" because there was "violence everywhere." Hassan's parents admitted they did not have direct conversations about the violence their children witnessed. They had difficulty discussing trauma because of their own difficulties contending with the past, and there was a cultural prohibition against discussing

any sexual matters. However, that prohibition made it difficult to discuss in the assessment as well, so most of my information about Hassan's sexual history came from him directly. Hassan learned what he knew from his friends and he obliquely referenced experiencing sexual trauma, though he did not discuss this in detail.

Hassan was raised Muslim; his family's religious and cultural identity helped the family through very difficult times His parents said that he had some close relationships with his peers, many of them who emigrated to the United States with him, though he was always considered vulnerable and was protected by the other boys in the camp.

When Hassan and his parents entered the United States a few years ago, they lived in a community with a significant Sudanese population (including people from the same refugee camp) and a high crime rate. Hassan was able to manage within his peer group. His parents reported that that his peers understood his limitations and were generally supportive. There were no reports of interpersonal violence or any significant school-based behavioral issues. Then Hassan and his parents gained housing in a nearby city. While it may seem problematic that they moved away from their supportive community, their new place was closer to their parents' work and was in a safer neighborhood and the school system was one of the best in the state. While not having a Sudanese community at his high school involved a major loss, his parents' decision to move had significant benefits.

Hassan seemed to adjust well to the bilingual classroom in his new school, slowly making friends and showing academic progress. According to his guidance counselor, he was not tested because there are not psychological tests normed to his ethnic group. As a result, he was not eligible to receive additional support services beyond being enrolled in a bilingual classroom. As a result, there was no documentation of his specific strengths and weaknesses, nor was there any assessment of his mental health. His parents were reared in a cultural background where they would not seek mental health services, and his pediatrician never expressed any concerns about him, even about the times when he went "blank."

Hassan's parents remain employed in their community and report that their other children have no major behavioral problems at school. They also said that they are committed to ensure that Hassan receives whatever probation conditions or treatment is prescribed by the court, including participating in treatment themselves.

Biopsychosocial assessment

Hassan presented in the evaluation as a thin 16-year-old teenager who looked his stated age. He was oriented to person, place, and time. He did not at any point seem to become disoriented. While his expression was blank, he was

eager to answer questions, becoming more engaged as the interview progressed. Given his language limitations and that he was evaluated at a juvenile detention center, we were unable to assess his cognitive functioning in this evaluation, including adequately examining his capacity for abstract thought, his ability to concentrate, and many of the finer points of assessment.

Hassan's mystery condition of blanking out combined with his experience of trauma has resulted in a set of symptoms that seem both consistent and inconsistent with our conceptualization of posttraumatic stress disorder. While he no longer passes out, according to his father, he "looks away and looks down," acting like he does not know what his parents are saying, perhaps in response to unclear triggers. He refuses to talk during these incidents. His father reports that he has nightmares every night and seems "absent-minded." He does not become violent but rather gets "very quiet."

Even if Hassan was not personally assaulted, witnessing violence is traumatizing and puts him at high risk of inflicting violence on others later in life (Ford et al., 2012). While he may not meet the DSM's criteria for posttraumatic disorder, much of his behavior can be explained through the lens of complex trauma.

Hassan has had difficulty interpersonally and is vulnerable to emotional dysregulation. He has shown difficult managing negative feelings, often appearing to others to be either happy or blank. When he faced fear or perhaps even anger, he became frozen, blank, and withdrawn, consistent with the frozen symptoms of trauma. In the context of this vulnerability, Hassan was placed then placed in an entirely new social environment when he began attending his new school. He was forced to manage complex interpersonal interactions while coping with intercultural misunderstandings and communications. The rigid thinking patterns and limited problem solving, which are part of trauma, as described by Ford et al. (2006), left Hassan with limited means to manage developmental and psychosocial tasks. When he experienced the combined total of these significant frustrations, he appeared to strike out with surprising aggression and without much understanding of the effects of his actions.

Hassan had to make sense of what it means to be an adolescent male in an American high school without peers from the same cultural background and without parents who understood this new environment. He experienced layers of cultural oppression in these cross-cultural exchanges. Some of the oppression is due to western constructions of race and immigrant status but he is contending with intercultural oppression as well. He is a member of an ethnic minority group, being oppressed in the context of war and displacement. While Hassan may not have the language to articulate his understanding of these vectors of oppression, his marginalization likely contributes to low self-esteem, anger, shame, and alienation.

Hassan's special educational coordinator saw him as a "nice enough kid," who was often successful in school and able to work well with adults. However, he was also seen as isolated and unable to connect with peers. Hassan may have always struggled with self-esteem because he was seen as more vulnerable than other teenage boys in his own community. All the other teenage boys had significant histories of trauma but usually they did not have the same neuropsychological struggles as Hassan. When he entered a new high school, he may have felt at an even further disadvantage because there were no fellow students from the refugee camps that he could use as cultural touchstones. Even more so, having friends from the same cultural background, who knew his vulnerabilities well and were protective, may have served to help regulate him and help him manage social situations and masked the severity of the effects of trauma. Because of these needs, having a clinician help him with affect regulation in interpersonal interactions, while in a culturally responsive therapeutic holding environment, may help prevent him from resorting to violent behavior.

When asked about the incidents in question, Hassan said that he had approached the girls because "I thought they liked me." When asked how he knew they liked him, Hassan said, "They laughed and talked with me." He felt "sad" about what he allegedly did and that the attention was unwanted by the girls. Some of Hassan's behavior seems genuinely motivated in part by a real lack of knowledge, rather than just defensive behavior. He had few avenues to discuss his feelings either about sexuality or his transition into adulthood and he may lack the language to be able to articulate these thoughts and feelings in a helpful way. However, some of the more violent aspects of his behavior may be ways that he is reenacting past trauma or has unarticulated and unprocessed rage, stemming from the maelstrom of unregulated emotion and psychic numbing that is at the core of the experience of complex trauma.

Hassan's lack of knowledge around social cues combined with his hostile attribution style and lack of well-regulated problem-solving capacities may have caused challenges interpersonally. This failure to successfully negotiate these adolescent tasks may have resulted great deal of shame. That shame could compel him to lash out at girls when he experienced feelings of failure (Stuewig & McCloskey, 2005) . He may *initially* have shown a misinterpretation of the signals due to trauma-based and cultural factors, but the girls' attempts to pull away and openly protest his overt sexual behavior may have triggered a shame–rage spiral, while also being a reenactment of behavior he had seen or experienced as a young child. This same shamerage spiral may have accounted for the fact that he committed three sexual assaults within a short span of time (even though he does not have a reported history of sexual misbehavior), likely demonstrating an escalation of behavior. Triggered by earlier memories and with reduced problem-solving capacities and regulatory

capacities, he may have felt hostility and rage, resulting in sexual aggression toward female students.

Despite Hassan's long history of trauma, he does show significant amenability to treatment and an ability to engage well with a responsive clinician. Perhaps this speaks to some psychosocial strengths of Hassan. While he grew up in very difficult circumstances, the nurturance, guidance, and attentiveness his parents showed, particularly striking given the stress the entire family was experiencing, was very much a mitigating force. Not only does it likely account for the relatively smooth adjustments that his siblings experienced, but the seeds of empathy and understanding were planted by his parents during those crucial developmental years. In addition, the fact that his parents were literate and able to educate their children made it easier for their children to succeed in school.

Hassan's parents were supported as well by people in their community. During every court appearance, numerous people from his community came as a show of support. Similarly, many volunteered to monitor his behavior and help probation provide the type of structure they would need in order to have him remain in the community. Hassan and his family were connected to a religious faith, being active Muslims, which provides a transcendent sense of meaning and purpose and a positive bond with their culture that survives despite multiple displacements.

While pointing to these strengths, I am not intending to minimize the traumas and the difficulty the entire family has faced both in the refugee camp, emigrating and integrating into the United States. Instead, highlighting the positive influences provided by his family and community might explain much of the success that Hassan demonstrated in treatment. With these relative strengths in mind, highly structured, trauma-informed therapy, based on the trauma coping model, was recommended.

Treatment recommendations

With Hassan, containment, support, and education were recommended, which is consistent with ideas around trauma-based treatment. He needed external boundaries because of his high levels of reactivity and the early neurobiological effects of trauma. Not only is he more vulnerable because of early trauma, but he experiences much greater stress because of oppression due to his race, ethnicity, and immigrant identity. Because of early environmental insults, his threshold of managing stress is likely lower than that of his peers, making him even more vulnerable in a mainstream school environment, especially when he is culturally isolated.

The treatment he received while at the Department of Youth Services demonstrated how he was able to use the type of therapeutic interventions recommended by Ford et al. (2012). He participated in individual therapy,

which allowed him to better understand his emotional states and find ways of connecting with others, particularly with caring adults. The staff at the youth detention center was involved in his therapeutic care, consistently modeling and encouraging the type of well-regulated problem solving that Ford et al. (2012) asserts helps to build self-regulation and problem-solving capacities. While he still struggled with reading social situations, which was a block to making relationships, he showed considerable progress while in treatment. For example, he was better able to identify his negative feelings and ask his peers and clinicians for support rather than lashing out or withdrawing.

Given the success he had in juvenile detention and the need for him to have numerous therapeutic opportunities; Hassan was placed in intensive therapy and in a highly structured therapeutic school environment with community-based monitoring. He was also not allowed to be alone with female peers, per his court order, while he remained in treatment. We also recommended that he receive a comprehensive psychological evaluation by a clinician who was knowledgeable about his culture. We found a psychologist who teamed up with a Sudanese clinician to evaluate him and provide recommendations to the school, which they did, largely around the need for Special Education supports. They also provided the types of culturally sensitive recommendations to his parents that would help them become more involved in treatment.

For the year that we followed him at his therapeutic school, Hassan had no other sexually violent incidents and was reported to be more emotionally connected to the staff at school and his therapist. His self-esteem improved and he was better able to discuss his emotional and social difficulties with his parents. Hassan was better able to identify when he was becoming dysregulated and could ask for help or utilize coping skills to calm himself down. Overall, he emotionally connected with other people and was more aware of his own emotional states, which increased his sense of self-efficacy and competence.

Discussion

Given the high incidence of childhood trauma and delinquency among our adolescent population, understanding the interactive effect is important. These already vulnerable adolescents are much more likely to be impulsive and reactive because of their phase in development and the influence of trauma, which, in turn, can lead to violence and other forms of delinquency. Hassan appears to struggle with regulatory processes, which can lead to shame and rage or avoidant behavior; problem-solving and other executive functioning abilities may be compromised as well. Rage and avoidance have clear links to aggression. For example, people who use avoidance as a strategy

do not directly try to manage the dysregulation. They just avoid certain stimuli. As a result, significant aggression may be directed or displaced toward relatively innocuous people or events, which provides some relief from the negative emotions.

There is significant link between dysregulation and aggression (Stinson, Robbins, & Crow, 2011), including in the domains of cognition and emotion. This may in part explain Hassan's behavior and provide some potential ways of helping adolescents struggling with the twin struggles of trauma-related responses and the normative deficits in regulatory capacities of adolescents. Treatment needs to be trauma informed and support improved regulatory capacities. Additionally, improving self-control and self-regulation may have cognitive, emotional, and interpersonal benefits. If nothing else, people with heightened self-control experience less shame and guilt (Tangney, Baumeister, & Boone, 2004). With improved self-control comes the likelihood that adolescents will demonstrate stronger self-confidence and will make more prosocial decisions, which, in turn, will enhance self-esteem.

Understanding Hassan through a trauma and developmental lens helps provide a fuller picture of behavior and motivations compared with an exclusive focus on antisocial beliefs and actions. An exclusively cognitive-behavioral approach would recommend treatment that would shore up Hassan's regulatory capacities and help him manage as an adult in the world, without resorting to sexual violence.

One limitation of the trauma coping model is that it does not necessarily attend sufficiently to the complexity of internal working models that adolescents who experienced interpersonal violence often express, including those who may have witnessed violence as well as directly experienced traumatic events. Twemlow and Sacco (1995) uses a psychoanalytic model to explain interpersonal aggression through discussing the triadic relationship of the victim, the victimizer, and the bystander. Their relationship is dynamic, where any disruption in their relationship often causes roles to shift. In Hassan's case, being placed in the role of the victim (when spurned by his peers) may prompt him to switch places to become a victimizer, a likely enactment of an earlier trauma that has been internalized. When witnessing traumatic events in the refugee camp, he may have been a passive bystander, unable to either help the victimized and fearful for his own safety. Such a passive and helpless bystander or victim role is internalized as well, setting the stage for seeing others as victims, victimizers, and bystanders and/or engaging with other individuals in reenactments of the earlier scenario in the here-and-now. Becoming a victimizer or actively supporting a victimizer may have given him relief at the costs of other's safety.

Relational psychoanalysis emphasizes a therapist's use of self to help people identify and learn to work through the dynamics of past traumas by analyzing, highlighting, and helping to change the nature of these types of

traumatic enactments. Hassan's clinician, for example, can help him identify ways that he is enacting previous traumatizing scenarios within a safe environment where his acts of aggression are far less serious. (Malove, 2014) His clinician may also assume one of the roles of victim, victimizer, or bystander, but by being reflective and resisting the reenactment of this dynamic, Hassan would also have an opportunity to think about his role as well. For example, he would not necessarily have to become aggressive toward his therapist if he feels vulnerable or hurt by her but would have an opportunity of an array of responses, which is usually the case when people have not had to focus primarily on survival.

Models of treating sexual offenses, for example, like the Good Lives Model (Ward & Gannon, 2006), can help address these complex needs by focusing through a trauma lens and the symbolic world of psychoanalytic theory . Hassan's impulsive behavior combined with ruminations and limited problem-solving capacities can result in sexual violence. His actions can be understood within the context of negative feelings around lack of agency that may increase his likelihood toward using violence. He also has internal working models that make it difficult for him to understand ways of resolving problems that do not result in violence, withdrawal, or other potentially dangerous ways. Focusing on improving his sense of self-efficacy, helping him gain knowledge about his internal states, improving his interpersonal interactions, and increasing insight may guide him toward more adaptive responses.

For Hassan, the twin needs of self-regulatory support within the context of a validating environment would likely most benefit him as he grows into adulthood. These needs highlight the importance of mental health treatment being available in juvenile justice settings because of prevalence of trauma and its role as a contributing force to delinquency. Trauma-informed treatment may steer them to more prosocial directions in young adulthood and more stability in work and relationships throughout their lives.

Summary

Providing treatment to adolescents within the context of the court system is a complex task, given the competing needs of the juvenile justice system to protect the community and show that their interventions have demonstrable outcomes. Treating traumatized adolescents is challenging because of the intersection of the tasks of normative development and their multiple domains of vulnerabilities related to the effects of trauma. However, by failing to adequately address the mental health needs of these youth, they are not only difficult to manage in the community and in juvenile detention, but they are also at higher risk to reoffend. Because of these pressures, Ford et al.'s (2006) trauma coping model is promising as it relies on clinical evidence to provide a framework for understanding trauma-reactive violence.

One central idea expressed in the trauma coping model is that deficits in affect regulation are a central issue for traumatized youth, resulting in responses that often confound treatment providers and other adult authority figures. Hassan's dysregulated behavior had confused his parents throughout his life, making him inaccessible, as he became avoidant and adopted a reactive coping strategy that masked his vulnerability. When he was placed in a much less supportive environment (i.e., his new school), these vulnerabilities became more apparent, his behavior escalated and he became aggressive. By focusing on the need for a multisystemic response that was hinged together by an understanding of the effects of childhood trauma on self-regulation, Hassan received much more effective treatment at his stay at Youth Detention. In fact, his subsequent treatment and monitoring were much more rehabilitative than probation usually would have been. As his providers were provided with a road map to understanding him more effectively, Hassan was able to engage in treatment.

In conclusion, understanding the complexity can help clinicians, teachers, judges, juvenile detention personnel, and child advocates better understand the needs of traumatized youths, rather than repeatedly placing them into environments that may reinforce their behavior. By modeling self-regulation, the likelihood will increase for these adolescents to develop significant connections with others and proceed in interpersonal interactions in a well-regulated manner. While more research is certainly needed to clearly establish the pathways associated with trauma, delinquency, and adult criminal behavior, Ford et al.'s (2006) work provides a compelling evidence-based framework that increases understanding of these troubled and adaptive youth.

Notes on contributors

Jillian Graves, MSW, LCSW, is a doctoral student (PhD candidate) and instructor at the Bryn Mawr Graduate School of Social Work and Social Research. Her doctoral dissertation was a qualitative study of emerging adult siblings of people with schizophrenia. She received a faculty appointment at Eastern Michigan University, where she will be an assistant professor this fall. She has worked as a clinician in agency practice with court-involved adolescents and adults with severe mental illness in Boston and Philadelphia. Her research interests include developmentally informed family research, sibling research, trauma-reactive violence, and ethics in researching adolescents and emerging adults.

Janet Shapiro, PhD, is professor of social work, Bryn Mawr Graduate School of Social Work and Social Research, and director, Center for Child and Family Wellbeing. Dr. Shapiro's interests are focused on developmental pathways of risk and resilience for children and adolescents in vulnerable family and community contexts. Particular areas of expertise include clinical work with children and adolescent, secondary effects of early trauma exposure, research on vulnerable attachment relationships and the impact of disrupted attachment on the capacity for self-regulation and other indicators of developmental well-being, and the translation of research in developmental neurobiology to clinical social work practice.

References

Ardino, V. (2012). Offending behaviour: The role of trauma and PTSD. *European Journal of Psychotraumatology*, *3*, 1–4. doi:10.3402/ejpt.v3i0.18968

Baer, J., & Maschi, T. (2003). Random acts of delinquency: Trauma and self-destructiveness in juvenile offenders. *Child & Adolescent Social Work Journal*, *20*(2), 85–98. doi:10.1023/A:1022812630174

Barr, S. C., Hanson, R., Begle, A. M., Kilpatrick, D. G., Saunders, B., Resnick, H., & Amstadter, A. (2012). Examining the moderating role of family cohesion on the relationship between witnessed community violence and delinquency in a national sample of adolescents. *Journal of Interpersonal Violence*, *27*(2), 239–262. doi:10.1177/0886260511416477

Becker, S. P., & Kerig, P. K. (2011). Posttraumatic Stress symptoms are associated with the frequency and severity of delinquency among detained boys. *Journal of Clinical Child & Adolescent Psychology*, *40*(5), 765–771. doi:10.1080/15374416.2011.597091

Benight, C. C., & Bandura, A. (2004). Social cognitive theory of posttraumatic recovery: The role of perceived self-efficacy. *Behaviour Research and Therapy*, *42*(10), 1129–1148. doi:10.1016/j.brat.2003.08.008

Briere, J., & Rickards, S. (2007). Self-awareness, affect regulation, and relatedness: Differential sequels of childhood versus adult victimization experiences. *The Journal of Nervous and Mental Disease*, *195*(6), 497–503. doi:10.1097/NMD.0b013e31803044e2

Christopher, M. (2004). A broader view of trauma: A biopsychosocial-evolutionary view of the role of the traumatic stress response in the emergence of pathology and/or growth. *Clinical Psychology Review*, *24*(1), 75–98. doi:10.1016/j.cpr.2003.12.003

Cloitre, M., Stolbach, B. C., Herman, J. L., Kolk, B. V. D., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress*, *22*(5), 399–408. doi:10.1002/jts.20444

Coleman, D. (2005). Trauma and incarcerated youth. *Journal of Evidence-Based Social Work*, *2*(3–4), 113–124. doi:10.1300/J394v02n03_08

Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, *64*(5), 577–584. doi:10.1001/archpsyc.64.5.577

D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., & van der Kolk, B. A. (2012). Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *American Journal of Orthopsychiatry*, *82*(2), 187–200. doi:10.1111/j.1939-0025.2012.01154.x

Davis, M., Banks, S., Fisher, W., & Grudzinskas, A. (2004). Longitudinal patterns of offending during the transition to adulthood in youth from the mental health system. *The Journal of Behavioral Health Services & Research*, *31*(4), 351–366. doi:10.1007/BF02287689

Ellis, B. H., Murray, K., & Barrett, C. (2014). Understanding the mental health of refugees: Trauma, stress, and the cultural context. In R. Parekh (Ed.), *The Massachusetts General Hospital textbook on diversity and cultural sensitivity in mental health* (pp. 165–187). New York, NY: Springer.

Espinosa, E. M., Sorensen, J. R., & Lopez, M. A. (2013). Youth pathways to placement: The influence of gender, mental health need and trauma on confinement in the juvenile justice system. *Journal of Youth and Adolescence*, *42*(12), 1824–1836. doi:10.1007/s10964-013-9981-x

Feiring, C., Taska, L., & Lewis, M. (2002). Adjustment following sexual abuse discovery: The role of shame and attributional style. *Developmental Psychology*, *38*(1), 79–92. doi:10.1037/0012-1649.38.1.79

Ford, J. D. (2002). Traumatic victimization in childhood and persistent problems with oppositional-defiance. *Journal of Aggression, Maltreatment & Trauma*, *6*(1), 25–58. doi:10.1300/J146v06n01_03

Ford, J. D. (2010). Complex adult sequelae of early life exposure to psychological trauma. In R. A. Lanius, E. Vermetten, & C. Pain (Eds.), *The hidden epidemic: The impact of early life trauma on health and disease* (pp. 69–76). Cambridge, UK: Cambridge University Press.

Ford, J. D., Chapman, J., Connor, D. F., & Cruise, K. R. (2012). Complex trauma and aggression in secure juvenile justice settings. *Criminal Justice and Behavior*, *39*(6), 694–724. doi:10.1177/0093854812436957

Ford, J. D., Chapman, J., Mack, J. M., & Pearson, G. (2006). Pathways from traumatic child victimization to delinquency: Implications for juvenile and permanency court proceedings and decisions. *Juvenile and Family Court Journal*, *57*(1), 13–26. doi:10.1111/j.1755-6988.2006.tb00111.x

Ford, J. D., Courtois, C. A., Steele, K., Hart, O. V. D., & Nijenhuis, E. R. (2005). Treatment of complex posttraumatic self-dysregulation. *Journal of Traumatic Stress*, *18*(5), 437–447. doi:10.1002/jts.20051

Ford, J. D., Grasso, D., Hawke, J., & Chapman, J. (2013). Poly-victimization among juvenile justice-involved youth. *Journal of Child and Adolescent Trauma*, *1*, 75–92. doi:10.1016/j.chiabu.2013.01.005

Kerig, P. K., & Becker, S. P. (2010). From internalizing to externalizing: Theoretical models of the processes linking PTSD to juvenile delinquency. In S. J. Egan (Ed.), *Post-traumatic stress disorder (PTSD): Causes, symptoms and treatment* (pp. 33–78). Hauppauge, NY: Nova Science.

Malove, S. C. (2014). Using relational theory to treat adolescent girls victimized by social aggression. *Clinical Social Work Journal*, *42*(1), 1–12. doi:10.1007/s10615-012-0424-z

McMackin, R. A., Leisen, M. B., Sattler, L., Krinsley, K., & Riggs, D. S. (2002). Preliminary development of trauma-focused treatment groups for incarcerated juvenile offenders. *Journal of Aggression, Maltreatment & Trauma*, *6*(1), 175. doi:10.1300/J146v06n01_09

Neumeister, A., Henry, S., & Krystal, J. H. (2007). Neurocircuitry and neuroplasticity in PTSD. In M. J. Friedman, T. M. Keane,&, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 151–165). New York, NY: Guilford.

O'Connor, L. E., Berry, J. W., & Weiss, J. (1999). Interpersonal guilt, shame, and psychological problems. *Journal of Social and Clinical Psychology*, *18*(2), 181–203. doi:10.1521/jscp.1999.18.2.181

Puzzachera, C. (2013). *Juvenile arrests, 2011*. (NCJ 244476). Washington, DC: US Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

Shelton, D. (2005). Patterns of treatment services and costs for young offenders with mental disorders. *Journal of Child and Adolescent Psychiatric Nursing*, *18*(3), 103–112. doi:10.1111/j.1744-6171.2005.00013.x

Silvern, L., & Griese, B. (2012). Multiple types of child maltreatment, posttraumatic stress, dissociative symptoms, and reactive aggression among adolescent criminal offenders. *Journal of Child & Adolescent Trauma*, *5*(2), 88–101. doi:10.1080/19361521.2012.671799

Silvers, J. A., McRae, K., Gabrieli, J. D., Gross, J. J., Remy, K. A., & Ochsner, K. N. (2012). Age-related differences in emotional reactivity, regulation, and rejection sensitivity in adolescence. *Emotion*, *12*(6), 1235–1247. doi:10.1037/a0028297

Singer, M. I., Anglin, T. M., Song, L. Y., & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of the American Medical Association*, *273*(6), 477–482. doi:10.1001/jama.1995.03520300051036

Steinberg, L., Albert, D., Cauffman, E., Banich, M., Graham, S., & Woolard, J. (2008). Age differences in sensation seeking and impulsivity as indexed by behavior and self-report:

Evidence for a dual systems model. *Developmental Psychology*, *44*(6), 1764–1778. doi:10.1037/a0012955

Stinson, J. D., Robbins, S. B., & Crow, C. W. (2011). Self-regulatory deficits as predictors of sexual, aggressive, and self-harm behaviors in a psychiatric sex offender population. *Criminal Justice and Behavior*, *38*(9), 885–895. doi:10.1177/0093854811409872

Stuewig, J., & McCloskey, L. A. (2005). The relation of child maltreatment to shame and guilt among adolescents: Psychological routes to depression and delinquency. *Child Maltreatment*, *10*(4), 324–336. doi:10.1177/1077559505279308

Tangney, J. P., Baumeister, R. F., & Boone, A. L. (2004). High self-control predicts good adjustment, less pathology, better grades, and interpersonal success. *Journal of Personality*, *72*(2), 271–324. doi:10.1111/j.0022-3506.2004.00263.x

Twemlow, S., & Sacco, F. (1996). A clinical and interactionist perspective on the bully-victim-bystander relationship. *Bulletin of the Menninger Clinic*, *60*(3), 296–313.

Ward, T., & Gannon, T. A. (2006). Rehabilitation, etiology, and self-regulation: The comprehensive good lives model of treatment for sexual offenders. *Aggression and Violent Behavior*, *11*(1), 77–94. doi:10.1016/j.avb.2005.06.001

Zelechoski, A. D., Sharma, R., Beserra, K., Miguel, J. L., DeMarco, M., & Spinazzola, J. (2013). Traumatized youth in residential treatment settings: Prevalence, clinical presentation, treatment, and policy implications. *Journal of Family Violence*, *28*(7), 639–652. doi:10.1007/s10896-013-9534-9