5-8-2020

Helping the doubly vulnerable: A trauma and emotion regulation group for juvenile offenders

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A Trauma and Emotion Regulation Group for Juvenile Offenders

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A research project submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Educational Specialist

Department of Graduate Psychology

May 2020

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Abstract

This paper explores literature published about juvenile offenders including demographics, offenses and trauma experiences. It explores the high rates of trauma within juvenile facilities and how these rates of trauma impact mental health issues seen in juvenile facilities. It focuses on the mental health of juvenile offenders and the high prevalence of mental illness, specifically Post-Traumatic Stress Disorder (PTSD) among juvenile offenders. It provides an overview of evidenced based programs used with juveniles and juvenile offenders including Emotional Intelligence training and the Trauma Affect Regulation: Guide for Education and Therapy (TARGET) intervention. The paper provides a detailed program procedure to use with juvenile offender in the juvenile facilities that focuses on emotional education and intelligence, frustration tolerance, coping skill, decision making and consequence, and identify development. The activities in the group design are based on concepts or activities from Emotional Intelligence or Trauma Affect Regulation: Guide for Education and Therapy (TARGET) intervention but are not, to the knowledge of the author, copies of activities of either intervention.

Helping the Doubly Vulnerable: A Trauma and Emotion Regulation Group For Juvenile Offenders

A country's children are the future of that country, and it is the parent's and the country's responsibility to ensure that they become productive members of society. Unfortunately, some youth, for a multitude of reasons outside the scope of this paper, do not act productively and because of this are then arrested. Depending on the offense, the youth's record, and the family situation, some of these arrested youth end up spending time incarcerated in juvenile correctional facilities. Offenses vary but are split into misdemeanor offenses and felony offenses. According to Cornell Law School (2019), a misdemeanor is punishable by less than 12 months in jail. Probation, fines and community service are also possible punishments. Felonies are more serious crimes, such as murder, armed robbery, and drug possession with intent to distribute, and they carry sentences of more than 12 months in jail. The person's criminal record also impacts the possibility that they will be imprisoned, as the person's criminal record is often used to enhance the sentence severity (Hester, Frase, Roberts, & Mitchell, 2018). This means that if a person has a criminal record for shoplifting and is charged with shoplifting again, the sentence will be increased from what they received for the first shoplifting charge. The final consideration that can affect sentencing can also affect the youth before they are convicted of an offense. The youth's family situation can impact their ability to be released, because they need to be released to a stable place that accepts them back into the household.

Young peoples' time in the criminal justice system varies. They can be released to wait for court, retained at a juvenile facility until court and their case is decided, or required to serve out their sentence in a facility or other determined means. According to the American Civil

Liberties Union (2019), on any given day in the United States nearly 60,000 incarcerated youth are waiting for the resolution of their charge and serving out their sentences. In Virginia, 1,563 youth were incarcerated in 2013 and for every 100,000 youth in Virginia, 202 youth are incarcerated at any given time (American Civil Liberties Union, 2019). These youth are housed at juvenile facilities and are in the care of the state. Because of this they must be provided appropriate living conditions, sufficient food, schooling, and physical and mental health care through the facilities that house the youth, all of which are funded by the state.

The focus of this paper is on the mental health care provided to these incarcerated youth, specifically those with trauma symptoms. Incarcerated youth are more likely than the general population to have traumatic experiences as well as have a higher number of these experiences. It has been estimated that up to 90% of youth that are incarcerated have experienced at least one traumatic event, and the average number of traumatic incidences was 14 (Kretschmara, Tossonea, Butchera, & Marsh, 2018). This suggests that on average a child in juvenile facilities has experienced 14 different traumatic experiences in their lifetime which could include being abused physically, emotionally or sexually; witnessing violence such as domestic violence or assault; or being assaulted themselves. The average 14 also means that there are children in the department of corrections who have experienced even more than 14 traumatic events. These traumatic experiences can have lasting effects, especially if the child has not developed healthy coping strategies or is not in a supportive environment to express and process their emotions.

Traumatic experiences can and do affect each person differently. Responses vary, but one response can be a multitude of symptoms that constitute Post-Traumatic Stress Disorder (PTSD). A diagnosis of PTSD is assigned when a person has experienced, witnessed or learned of a death or has experienced the threat of death, an injury that is considered serious, or violence that is

sexual in nature (American Psychiatric Association, 2013). They must also have experienced it, witnessed it happen to others, learned it happened to close family, friend or have had continued exposure to details of traumatic events. Symptoms of PTSD can include reoccurring dreams, intrusive memories of the event, flashbacks, or psychological reactions and psychological distress from reminders of the event (American Psychiatric Association, 2013).

According to Ford, Chapman, Hawke, and Albert (2007), in a study conducted in juvenile detention facilities in California more than 1 in 3 youth met the criteria for Post-Traumatic Stress Disorder (PTSD) and another 20% met partial criteria. These numbers are staggering when compared to the lifetime prevalence of PTSD among Americans of 6.8% (National Institute of Mental Health, 2017). These numbers show a huge consequence when it comes to the needed mental health services in these facilities, in that serious mental health services for PTSD alone are needed for over 30% of the population. Based on how many youths are in facilities in a day, around 20,000 youth could statistically meet the criteria for PTSD and need services.

It should also be noted that these numbers only include a diagnosis of PTSD and do not include other mental health issues such as Major Depressive Disorder, anxiety disorders or behavioral disorders. According to Development Services Group Inc. (2017), as much as 70% of youth in juvenile facilities have a diagnosable mental health disorder. These other disorders can be comorbid with PTSD or be diagnosable on their own, but even if a child is not diagnosed with PTSD, they could have experienced traumatic events and be affected by these events. Trauma-related symptoms and traumatic experiences can influence children for the rest of their lives and could potentially affect their behavior and rates of reoffending.

Trauma can have lasting impacts on the people it affects, especially children because it can negatively affect their development. Because many offenders grow up in extremely stressful

situations such as living in places that have large amounts of community violence, their stress response may not develop normally which can cause them to react disproportionately to the level of stress they experience. For instance, something that may seem minor to an individual without a trauma history can cause someone with trauma to respond as if the stressor is extreme (The National Child Traumatic Stress Network, 2018). These children are living in a heightened state of arousal and therefore it takes very little for them to reach the point of intolerance of an event or emotion. Because it takes very little to provoke them they seem to overact in relation to the stimulus (Dvir, Ford, Hill & Frazier, 2014). Simply put, if a child that has not experienced these events functions at a base arousal of 10 and their frustration tolerance is a 60, then a child that has experienced a traumatic event might have a base arousal of 30 and either have a similar frustration tolerance of 60 or often have a lower frustration tolerance. It takes the child with traumatic experiences much less frustration with an event or emotion to reach the point of intolerance.

Along with the disproportionate stress response, many individuals with trauma also experience trouble recognizing, expressing, and controlling their emotions and can react inappropriately or violently to situations. These reactions can lead to difficulties in relationships and with authority figures (Substance Abuse and Mental Health Services Administration, 2014). This trend is multifaceted in that it can affect the youth in many ways. First, if they struggle to recognize and discuss their emotions then they and their emotions are not being heard or validated. This could lead to these feelings building up until the person lashes out, which could lead to criminal charges if they lash out physically. Their inability to express themselves could also lead them to feel disconnected and depressed because of their inability to communicate their emotions. Because they struggle to discuss their emotions, they may have difficulties forming

meaningful relationships and developing positive support systems. They may also struggle with authority, which can cause difficulties in school, at home, and with the police, judge, and correctional staff, possibly leading to more trouble for the youth. These youth need help to work through their trauma and its effects and change their behavioral patterns.

Services are needed for these youth, but provisions of service are complicated by the fact that they are a doubly vulnerable population and the juvenile justice setting itself is extremely restrictive. These young people are considered doubly vulnerable because they are both minors and prisoners. Because of this, specific ethical stipulations must be adhered to when working with them. The setting also impacts the serviceability as security and safety concerns in juvenile facilities are paramount and all services given within these facilities must adhere to these guidelines. These guidelines could impact who can receive service, how services are provided, what supplies are allowed to be used, and who is allowed to provide services. Because of security, some youth may not be allowed to participate in services or be allowed to participate with certain other youth, such as rival gang members. The facility could also control the space that is used and when it can be used as well as what modification can be made to the space to make it more therapeutic. Certain materials may also be limited or completely denied such as scissors or other materials that might be dangerous. Lastly, the person that conducts the service will have to pass security checks, and guest speakers may not be allowed. These difficulties must be surmounted, though, because research has documented several concerning relationships between trauma and offending.

The first of these is traumatic experiences and other adverse experiences, especially early childhood trauma, are associated with offending. As mentioned above, juvenile offenders often have more traumatic events beginning earlier in childhood than the general population, which is

correlated with higher rates of early delinquency, and this early delinquency is then correlated to becoming a consistent and chronic offender (Dierkhising, Ko, Woods-Jaeger, Briggs, Lee & Pynoos, 2013). This means that early childhood trauma can influence a person's potential long-term criminal behavior. This makes sense, given that trauma reactions and symptoms can mirror behavioral problems and lead to emotional dysregulation that can lead to behaviors that are arrestable offenses, such as fighting. A child hitting another person because they have reached their frustration tolerance over something such as being called a name and then being charged with assault is an example of how their trauma experience affects their ability to regulate and then their lower tolerance then causes a reaction that then leads to involvement with the criminal justice system. As the youth gets older and has more involvement with the criminal system, the multitude of previous offenses affect punishment, as discussed earlier. Another possibility is that as the child also ages the ability to commit more serious crimes increases such as escalating from a fistfight as a child to a stabbing as a teenager, which could be seen by the courts as assault with a deadly weapon or attempted murder.

The second concerning relationship is that as the number of traumatic experiences increases the potential of becoming a serious, violent, chronic offender (SCV) also rises. According to Fox, Perez, Cass, Baglivio and Epps (2015), for every traumatic event that happens to a juvenile offender, their risk of becoming a SVC offender increases. This means that a youth's risk continues to rise with every event and does not level out after a certain amount of exposure. Because youth can live in places that experience community violence or other forms of traumatic events, these youths' risks will continue to rise because of where they live or their home lives. Without intervention, their risk will continue to rise and the likelihood of them offending increases. If these youth can receive services to lower their trauma reactions and teach

them healthy coping skills, it is possible that not only will they be healthier individuals who are better prepared to handle stressors and future trauma, their reoffending risk may also decrease.

A shift has begun to happen in juvenile corrections towards trauma care, but there are many limits. This project is intended to develop a group specifically designed to address the high rates of trauma within the juvenile justice system. This group addresses many different facets of trauma and trauma reactions, including explaining trauma and the impact it can have on a person; emotional work such as emotion regulation and self-esteem building; and skill building with a specific focus on coping skills. The idea for the group is to focus on the effects of trauma and help youth get to the point where they are able to express themselves openly in healthy ways. Specific trauma experiences will not be directly discussed unless a member brings them up themselves or uses them as an example for the activities. This is because many of these youth might not be prepared to address their trauma directly but could be open to addressing the effects of the trauma.

Overall, the hope is that by helping the youth develop the tools needed for emotional regulation, as well as develop the coping skills needed to deal with their trauma and future stressful situations, youth offenders can be empowered to realize that they can make better decisions and define who they are as individuals.

Literature Review

A Real Look at Incarcerate Youth

Juvenile offenders can be as different as their experience. They differ in offenses committed, race and age. According to Sawyer (2019), generally the juvenile system houses youth under 18 years old, but there are exceptions such as youth being transferred to adult facilities. Further, although 69% are 16 years and older, it is important to note that more than

500, 1.1% of the total incarcerate youth population, were under 12 years old at the time of recording. These younger youth do not necessarily have shorter sentences as it was found that 13% of these 12 and younger offenders had been incarcerated for over 6 months (Sawyer, 2019). To give this number perspective, most 12-years-olds are in sixth or seventh grade, yet they have been removed from their families and imprisoned in facilities that often mirror jails with locked cells. This is important when considering developmental levels and decision-making capabilities, and whether the youth at 12 or younger is able to understand the consequences and the seriousness of those consequences. Also, most facilities do not separate by age when housing, so the 12-year-olds mentioned above can be housed with 17-year-olds, which could lead to the younger youth being taken advantage of, such as in the phenomenon of "schools of crime" or "learning new tricks of the trade"(Samenow, 2011), in which young people who are incarcerated learn from more experienced criminals and leave the facilities more experienced and better criminals.

Another difference is in race and ethnicity. In relation to the total population, African Americans and American Indians were overrepresented in facilities, and Caucasians were underrepresented. In juvenile facilities, 42% of male offenders were African American even though they only make up 14% of the general population (Sawyer, 2019). This raises questions about why there is a difference in incarceration rates. Although this topic is beyond the scope of this paper, if this difference is due to the environment such as the community, it is important to remember that these youth are more than likely returning to this environment and any treatment should understand that and work with this in mind.

The youth in juvenile facilities are also charged or convicted of a variety of offenses. In 2017, the most common type of offense (37%) was person offenses, followed by property crimes

(29%), public order crimes (25%), and then drug crimes (8%) (Sickmund, Sladky, and Kang, 2019). The data shows a wide range of convictions, considering that people who have committed these crimes are under 18 years old. These numbers and the seriousness of crimes these numbers convey may be misleading, though, according to another article (Sawyer, 2019). Another data set broke the data down differently and included status offenses and technical offenses. Technical offenses are offenses such as not reporting to a probation officer or not doing community service. Status offenses are offenses that include truancy, running away and other minor specific crimes. According to Sawyer (2019), the most serious crime some juveniles in these facilities have committed are technical offenses (15%) and status offenses (4%). This means that youth are detained in facilities for offenses that are minor, and if they were adults they may not be detained for at all (status offenses). It is surprising to think that children are being taken out of their homes and away from their family and put into locked facilities for as little as truancy or not doing their community service.

The question often posed when discussing offending is the rate of reoffending and the risk of the youth reoffending. The prevalence of offending tends to mirror a bell shape curve and is known as the age-crime curve. This curve suggests that juvenile delinquency tends to increase and peak at age 15-19 and then decrease in the 20s (National Institute of Justice, 2014). It should be noted that this curve does have variations based on race, gender, and crime type. Reoffending numbers are often difficult to determine. Reoffending rates vary based on the definition of reoffending. When the definition is based on rearrests the rate is often higher than reincarceration rates due to charges being dropped, options other than incarceration, etc. To showcase this difference, in the same 1-year time period when defined by rearrests, 55% of juvenile offenders reoffended but when defined by reincarcerated, 24% reoffended (Office of Juvenile Justice and

Delinquency Prevention, 2017). The variance makes it difficult to determine rates, but even with the lower number, 1 in 4 youth will reoffend after being released.

The question then becomes how many of these youth continue to offend into adulthood. This also is a difficult number to determine, but according to the National Institute of Justice (2014) between 52-57% offend up to age 25 and then this number drops to 16-19% for those who are 25-30-year-olds. For the youth who do transition to adult offenders, the offenses often increase in severity and increase in violence (National Institute of Justice, 2014). Reoffending and the causes of reoffending are complex, but research has shown that there is a link between trauma and offending.

High rates of trauma have been associated with juvenile offenders as mentioned above. Several articles have looked at Adverse Childhood Experiences (ACEs) in juvenile offenders and found striking results in both the numbers found and in how these experiences affect offending. ACEs encompass many different experiences, including abuse, neglect, parental mental illness, substance use, divorce, and parental incarceration (Child Welfare Information Gateway, 2020). When assessing for ACEs, the child is given a score based on which of these categories they have experienced. The higher the score, the more adverse experiences they have had. Based on a study in a Florida juvenile facility, 67.5 percent of the youth scored 4 or higher and 24.5 percent scored 6 or higher (Baglivio & Epps, 2016). The number of ACEs also has an impact on youth offending. According to Baglivio., Wolff, Piquero and Epps (2015), the number of ACEs increases the youth's likelihood of offending earlier in their life, as mentioned above, and has an impact on their likelihood of becoming a long-term offender. Also stated in this article, was that a higher ACEs score also was associated with more offending. Basically, this means that when

looked at juvenile offenders have more trauma and the more trauma they have the more likely they are to offend early and often.

It follows that if the youth can learn about how their trauma affects them and is able to manage these reactions then they may be able to better regulate themselves and potentially lower their rates of recidivism. A study was done in three juvenile facilities using the Trauma Affect Regulation: Guide for Education and Therapy (TARGET) intervention. TARGET focuses on emotional regulation and understanding trauma and how it affects the person (Advanced Trauma Solutions Professionals, 2019). The study found that after the intervention there were fewer disciplinary incidents and less total time for youth in seclusion. While it did not study recidivism, recidivism rates were also found to decline after the implantation of the intervention (Ford & Hawke, 2012). The intervention was able to impact the youth's ability to regulate their emotions and actions and affect their overall functioning by helping the youth to learn about trauma impact and emotional regulation. It is possible that similar programs will also have success in these areas as well.

Another program that also has effects on youths' ability to understand their emotions and regulate them is Social and Emotional Learning. Social Emotional learning focuses on helping a youth to learn about self-awareness, self-management, social awareness, relationship skills, and responsible decision-making (Collaborative for Academic, Social, and Emotional Learning, 2015). This program is often offered in schools and research has been done to examine how this program effects conduct issues as well as emotional distress. According to the National Institute of Justice (2018), students who go through the program have fewer conduct issues and lower emotional distress when compared to the control group. It would make sense that if this program

is effective in schools with the same age group then it could also have the potential to be effective with juveniles in the justice system.

The group design that follows is designed based on concepts and ideas from both the TARGET program and the Social and Emotional Learning programs. The activities are either based on the concepts from these programs or are modified activities with similar ideas. To the knowledge of the author no activities are directly from either program.

Group Design

A Trauma-Informed Group for Juvenile Offenders

Purpose: The plan for the group outlined in this paper is to address the high rates of trauma in juvenile facilities.

Activities: The group includes activities that focus on trauma education, emotional learning and regulation as well as identify building and learning coping skills. Activities include developing identifiers of emotion such as using a color to express emotion; making an individual emotion wheel and discussing what makes each person feel each emotion; discussing emotions and decision making based on scenarios and the youth's own stories; teaching relaxation techniques; discussing labels and how they make each person feel; and enjoyable activities for emotion regulation and coping.

Limitations: The activities offered in the group are limited due to the security risk, and any material or activities will be approved by the administration before the group begins.

Length: There will be nine meetings, each an hour and a half long, and an individual session for each participant at the end of the group. The group is designed to meet twice a week so that the course of the group will last 45 days or less. The length was set intentionally so that

youth with shorter sentences could also participate in the full group. This group is also closed due to the nature of the material, which builds on the work from previous works.

Size: The group is limited to 15 youth to allow for small group dynamics to form but also allow the amount of youth able to join the group to be maximized due to the need.

Accommodations: The clinician is expected to describe multiple ways an activity could be done to accommodate different levels of available resources, different security levels, and different levels of involvement.

Materials: Materials required for the group include markers, crayons, pencils, colored pencils, cardboard boxes, cards, and paper of various sizes.

Selection: Selection for this group will be made using the Massachusetts Youth Screening Instrument-2 (MAYSI-2) which is commonly used in juvenile justice programs. This instrument is often administrated during admission to assess for a variety of issues, including traumatic experience (The National Child Traumatic Stress Network, 2019). Using the data from this, the clinician will identify possible group candidates who have scored high on the trauma experiences section of the instrument. The clinician will then interview each candidate and give the youth the Trauma Symptom Checklist for Children to complete (The National Child Traumatic Stress Network, 2020). Part of the interview will include questions about the youth's trauma reactions as well as about possible symptoms of trauma and other mental health issues. The clinician will use the interview, the MAYSI-2 data, and the checklist to determine which youth will be offered to join the group.

Admittance: The clinician will then discuss with each individual what the group is and how it will work. Each young person is free to decide whether they wish to join, and if they decline to join the group then there will not be any penalties from the facility. If the youth agrees

to join the group, then the parent will be contacted about the group. The choice to wait until the child has consented is due to the clinician wanting to make sure the youth is the one that wants to join the group and the parent is not pressuring the child to do so. This is for two reasons: the first is that if the child is feeling pressured to do the group then they may not be ready and open to the group and to change, which could make the group ineffective for them. The other reason is that since the group has to do with trauma reactions, the clinician does not want the child to feel pressured to discuss or approach that topic in any way until they are ready to do so.

Risks: While discussion of their trauma is not the focus, the group could potentially bring up emotions and experiences that the youth is not prepared for. If the youth is not ready for this to happen, it could lead to farther emotional distress.

Group 1

The clinician will have the chairs in a circle.

Activity 1

Topic: Reviewing confidentiality and its limitations

Preparation: The clinician will develop the rules and expectations of the group

Description:

- The clinician will introduce herself
- Confidentiality and its limitations will be reviewed by the clinician including clarifying that the clinician will not discuss issues talked about with other staff unless the limitations of confidentiality have been met.
- Rules and expectations of the group will be discussed with the group.

Activity 2

Topic: Introductions and ice breaker

Reason: The purpose of the activity is to create openness and connections within the group members as well as with the clinician.

Time:15 minutes

Preparation: The clinician will either buy a premade volleyball with questions or make one to use. Examples of questions included are a favorite food, dream vacation, favorite singer or group, favorite movie, and favorite activity.

Description:

- Group members will then introduce themselves and have the opportunity to share something about themselves.
- An icebreaker in which a beach volleyball, with questions that are fun or interesting on it, is thrown around the circle.
- The group members will throw the ball to each other and where a person's right thumb lands is the question they must answer.
- The clinician will participate with the group members in this activity.

Activity 3

Topic: Trauma Discussion

Description:

- The clinician will discuss different trauma types and what trauma reactions and symptoms are.
- She will explain frustration tolerance and how trauma affects frustration tolerance.

- The group members may ask questions as needed and any questions asked should be answered to the extent that the clinician deems fit.

Activity 4

Topic: Frustration Tolerance demonstration

Reason: The idea is that this activity will explain to the group how having traumatic experiences and/ or lower frustration tolerances can impact the youth and how they react to events. It will also provide a transition into the next groups topic of coping skills and why they are important to learn and use.

Preparation: The clinician should bring sheets of paper.

Disclaimer: It should be stated by the clinician that this activity can be activating and any feelings about the activity can be discussed after the activity with the group or after the group with the clinician.

Description:

- The group members will be asked to volunteer to participate in the activity. As many of the group members who want to may participate, but at least three participants are needed to make this activity work.
- The volunteers are separated into three groups, no trauma, trauma with lower frustration tolerance and trauma with higher frustration tolerance.
    - The clinician asks which of the two volunteers would like to represent the person with trauma.
    - The two representing people with trauma are separated into one that has frustration tolerance that is the same as the no-trauma group and higher base level

of activation and one with a lower frustration tolerance than the other two and a higher base level.

    - If more than three people volunteer, the numbers for each group should be as close to even as possible.

- The clinician will use a paper put on the floor to mark when frustration tolerance for each group is reached.
    - For the lower frustration tolerance group, the paper will be three-fourths of the way through the room
    - For the other two groups it will be the end of the wall.
    - The clinician will then have the no-trauma group start at the back of the room
    - Both trauma groups will start four steps ahead.
- The members of the group that decided not to volunteer will then be asked to state events that frustrate, annoy or make them angry that happen on a regular day.
    - Events presented could be being called a name, getting yelled at by someone, or struggling with a hard assignment.
    - The clinician will then ask the group if they think the event is a one-step frustration or a two-step frustration with two-step meaning a large frustration and one being a small frustration.
- The volunteers then take the decided-on number of steps.
- This continues for each event until the first group reaches the frustration tolerance marker on the floor.
- The number of events it took is written on the paper.

- This then continues until the next group reaches their paper and that number is written, and then finally until the last group reaches their paper.

Activity 5

Topic: Activity 4 discussion

Description:

- The discussion begins with the clinician inviting the group to share any reactions they wish about the activity.
- She reminds them that if they do not wish to talk in front of the group, then she is available after the group.
- After reactions are discussed, the group shifts to talking about how the number of events is different for each group and how trauma affects the number of events it took to reach frustration tolerance.
- The clinician discusses with the group that people cannot change the trauma they have experienced but can change how they manage that trauma and work to change their reactions.
- The group leader then discusses how the youth can consider how trauma may impact them and learn techniques and skills that can help them manage their emotions, thus changing their starting point and endpoint to be closer to someone without trauma.

Group 2

The thought behind this day is that many of these youth may not understand their emotions and struggle to communicate them to others effectively.

The group will be set up in a circle.

Activity 1

Topic: Emotional vocabulary identification

Reason: To help the youth learn emotion words.

Preparation: A chalkboard or whiteboard can be used if available but if not the clinician should bring large easel-sized paper.

Description:

- The clinician will either tape the paper on the wall or use the board to write on.
- The clinician will ask the different group members to name different emotions that they have felt.
- This will continue until the group cannot name anymore or until the basic emotions sad, mad/angry, happy, frustrated, annoyed, fear, worried, surprise, and love have been identified.

Activity 2

Topic: Emotional vocabulary description

Reason: For the youth to learn how they feel their emotions and identify how they respond to their emotions.

Preparation: The clinician will have a blank emotion wheel printed for each individual as well as crayons and colored pencils.

Description:

- The participants will be instructed to develop their own emotion wheel using eight emotions that they feel most often.
    - They are instructed to label the emotion and then draw that emotion.
    - The drawing can be something that makes them feel that emotion, a depiction of how they feel when they experience that emotion, or how they act when they feel that emotion.

- The emotion wheels will be discussed and shared with the group. A member can choose how much of their wheel they wish to share, but they must share at least one of the emotions and how and why they depicted it the way they did.

Activity 3

Topic: Emotional vocabulary extension

Reason: To hope is that the youth learn more descriptive emotional language to help them better communicate their emotional world.

Preparation: The clinician will have a completed emotion wheel that has different levels of emotions.

Note: These emotion wheels will stay with the clinician until the sixth group day when they will be incorporated into an activity and then will stay with the group members.

Description:

- The clinician will discuss how the basic emotions can be broken into even more descriptive emotions that are more true to what the person is feeling.
- The group members will compare words on the emotion wheel that have the same base emotion.
    - For example, enraged and disgusted are both rooted in anger but are very different when described and evoke very different reactions.
- Participants will practice describing these more descriptive words and when they could use them instead of the base word.
- The clinician will discuss with the group how having a broader emotional vocabulary helps them communicate to others how they are feeling in more detail. It also allows others to offer help that is more appropriate for the level of emotion they are feeling.

Group 3

Note: The second and third group days are flexible in ending points due to the continued content from one group to the next. If at the end of the third group the content has not been completed, then the content can be continued into the fourth group and the fourth group content on coping skills can be started when the emotional content is completed.

Activity 1

Topic: Review

Reason: To determine previous days comprehension and to prime for the coming activities.

Description:

- The clinician will ask the group to review the emotions discussed in the previous group and to name as many as possible.
    - Reminders of the emotional wheel and the opportunity to use more descriptive language for emotions can be given to assist the group members.
- If any of the core emotions are missing, then the clinician will provide them.

Activity 2

Topic: Emotional Identification

Reason: To help the youth discuss emotions and have multiple ways of communicating their emotional world

Preparation: The clinician needs to bring large easel sized paper

Note: The clinician can also make this activity into a smaller paper for the members to take with them to help them talk about their emotions with others. This could be given to them on the sixth day when they do the coping skills box activity.

Description:

- The clinician will have the group decide on a color for each of the core emotions on the emotion wheel.
    - The colors should be different enough that they are easily discernable, such a blue, green, yellow, and orange.
    - The group should discuss the colors and why they think each emotion should be that color until each emotion has an agreed-upon color and reason for that color.
- This should be recorded by the clinician on a big piece of paper so that it can be used by the group to help them discuss their emotions throughout the rest of the group.

Activity 3

Topic: Emotion levels

Preparation: The clinician will have a stoplight drawn with a red, yellow and green light.

Description:

- The clinician will ask the group to identify which emotions would be green emotions for them.
    - Green would mean that they are emotions that would have little to no consequences most of the time.
    - Emotions that are often identified here are often considered positive emotions and would include joy and happiness.
- Yellow emotions are then identified.
    - Yellow emotions are emotions that most likely will not have negative consequences but could escalate to have negative effects.
    - They can also cause emotions that the person may want to talk about but that may not be obvious to others or cause obvious consequences.

  - Examples of this are sadness, which could lead to the person not being able to focus on school, leading to them having difficulty learning. These emotions can include surprise and sadness.

- The last ones identified are red emotions, such as fear and anger.
  - These often can have negative consequences if the emotion and reaction are not controlled.
- It should be discussed that all of the emotions are acceptable, even red light emotions, but red light emotions need to be the most monitored because they often cause the most consequences if the emotions cause excessive negative reactions.

Activity 4

Topic: Anger hierarchy

Reason: The idea is to have a scale of anger that the youth can look at to determine where their level of anger might be at any given time.

Preparation: The clinician will need to bring a large piece of paper as well as a smaller sheet for each group member as well as pencils for each person.

Description:

- The group then will focus on red emotions, specifically anger.
- The clinician will explain that they are going to make a hierarchy of anger.
  - This means that things that make participants a little angry will be at the bottom and things that make them really angry will be at the top.
- The clinician will have a big piece of paper and pass out smaller papers to each member.
- The clinician will ask them to identify events that make them angry talk about how angry that event makes them on the hierarchy.

    - The clinician will ask the group to identify a number from 0 to 10 for each event going up the scale, with 0 indicating no anger and 10 indicating the most intense anger they can imagine.
- Each person will put that event on their own hierarchy in the place that fits their anger level, and the clinician will identify the group average on the big piece of paper.
    - This number can be different for each person and is marked on their personal paper.
- This will continue until 10- 15 events are put on the hierarchy that represents a range of anger levels.
- Numbers can be skipped or used more than once.
- The conversation will then move into instances when the anger reaches a point that the youth lashes out or has consequences. These consequences are discussed, and the clinician talks to the group about knowing when they are reaching their anger point and being able to decide to use interventions to help them manage the emotion.
- The clinician will discuss that these are the times when the youth needs to use skills to prevent these negative reactions. The clinician explains that these skills will be talked about in the next group.

Group 4

Activity 1

Topic: Check in

Description:

The clinician will check-in about the previous content and about how the group is feeling.

Activity 2

Topic: Coping skill education

Description:

- The clinician will explain to the group what coping skills are and how they are used.
- The clinician will explain how people can develop positive and negative coping skills to help them regulate their emotions and will clarify what makes a coping skill either positive or negative.
- The group will spend time talking about negative coping skills and how they may help in the short term but how they are harmful in the long term.
    - Alcohol, self-harm and drugs will be touched on as negative coping skills that they can have a larger, long-term impact.

Activity 3

Topic: Coping skill discussion

Preparation: The clinician will bring paper with her to give to the members for them to keep lists of positive coping skills.

Description:

- The clinician will provide several examples of coping skills and ask the group to determine if they are positive or negative and why.
- The group members will then be asked to name coping skills that they have used in the past and what about that coping skill helped them.
- The group will then determine if each coping skill that is talked about is positive or negative and why.
- The clinician will encourage the group members to keep their own individual lists of positive coping skills.

Group 5

The fifth group day will focus on learning new healthy coping skills.

Activity 1

Topic: Coping skill examples

Description:

- The clinician will review what makes coping skills positive
- She will explain that positive coping skills include breathing techniques, grounding techniques, talking to others, and distraction activities.
    - Examples of each of these types of coping skills will be explained by the clinician.
- The clinician will also ask the group for examples that they have used or can think of.

Activity 2

Topic: Coping skills practice

Description:

- Different coping skills will be learned by the group and practiced.
    - Coping skills practiced will include a breathing technique focused on taking ten deep breaths, a grounding technique that has the youth identify something through each of their senses, emotional awareness skills gained through identifying emotions and practicing asking to talk to others and describing how they feel, and distraction activities that the youth enjoys such as writing or coloring/drawing.
    - Exercise is another option that will be discussed.
        - Exercises that can be done in a cell are specifically discussed, as movement could be limited due to being confined to a cell.

Group 6

Note: The fourth through sixth group day are flexible in their ending points as they are all on coping skills, so if all the activities are not completed then they can be done the following day.

Activity 1

Topic: Coping skills review

Description:

- The sixth group will begin by reviewing the coping skills discussed in the previous group.
- The group members will be asked to name the ones they remember and the clinician will provide any that are missed.
- The clinician will ask the group if they have thought of any since the past group.
    - If the members have, they will be asked to explain their coping skills.
- The group will practice each coping skill again.
    - The skills can be practiced as many times as needed for the members to be able to use them on their own.

Activity 2

Topic: Coping skill toolkit

Preparation: The clinician will need to get and bring small cardboard boxes for each member and bring markers, glue, construction paper and magazines.

Description:

- The group members will take a box and decorate it.
- After 15 minutes of decorating, the clinician will talk about filling the box with coping skills options to use when upset.

- The clinician will encourage them to pick different types of activities and at least 5 different coping skills.
    - Participants will be encouraged to include 2 distraction activities that can be done in their cell.
    - They will also be asked to consider including a person who they feel that that they can talk to and who is helpful to them. This should be a realistic person such as a counselor, a guard, or a facility pastor.
    - Participants will also be encouraged to put their emotions charts and anger hierarchy from the previous groups in the box.

Activity 3

Topic: Coping skill toolkit discussion

Note: The boxes will be inspected if needed by administration or guards before being taken to the cells by the members.

Description:

- Any leftover time will be spent discussing each person's box to the extent that they feel comfortable.
    - Each person will be asked to share at least one activity from their box, and each group member would take their box back with them to their cell.
- The facilitator will explain that using coping skills is a choice and that the members now have the skills to make the choice to use their coping skills when needed.

Group 7

The seventh group day will focus on decision making and conflict resolution.

Activity 1

Topic: Understanding autonomy

Description:

- The clinician will emphasize that the youth have the ability to make decisions in their life.
- Group members will be encouraged to discuss things they are able to make decisions about.
    - This can and should go beyond the facility and into their lives in the community.
    - If the members struggle to provide examples or express that they do not have choices, then the clinician will provide examples.
        - These examples could include how they behave in the facility, if they use their coping skills or lash out, or how they respond to peers in the community when they are angry.
        - Both good and bad choices should be presented to the group.
- What makes a choice good or bad will be discussed, and the consequences of decisions are discussed for each choice.
    - It is important for the clinician to validate that there are real things in the members' lives that complicate this decision-making process that other people would not consider.
        - An example of this could be a situation in which a member sells an illegal substance to provide food for his siblings.

Activity 2

Topic: Understanding choices and consequences

Description:

- The clinician will provide scenarios and ask the group members to provide their response and their reasoning for their response.

- The group as a whole will determine if the choice was positive or negative and why.
    - If a negative choice is made, then the group will be asked what a positive choice could have been.
- The group members will then be invited to discuss events from their lives and the choices they made, and if the choices were negative, what positive choices they could have made.

Activity 3

Topic: Conflict resolution

Description:

- The group will then shift to discussing what some positive choices can be for conflict resolution.
    - The clinician will talk about alternatives to hands-on others such as walking away, talking to the person about how they are feeling and why, talking to someone else about it, and coping skill use.
    - These skills will be practiced by the members in groups of two or three if there is an off number.

Group 8

The eighth group will focus on identity and what identity and labels the youth wants to have.

Activity 1

Topic: Identity explanation and discussion

Description:

- The group will start with the clinician explaining what is meant by identity and why thinking about their identity is important.

    - It should be emphasized that their identity is how they see themselves and how they want to see themselves.
- It will be explained that how we see our identity can impact how we act and how others see us.
- The group will be asked to discuss their individual identities and what they would like those to be.
    - These identities can include what they see themselves doing, what type of person they see themselves as, and their strengths and weaknesses.

Activity 2

Topic: Labels

Description:

- Labels will be discussed as part of an identity.
    - It will be explained that labels are how individuals describe themselves and how others might describe them.
    - Examples of labels can be given if the members do not understand.
- The group will be asked to provide labels they would give themselves and then labels that have been given to them by others.
- Each person is expected to give at least one of each label.
- The discussion will then focus on what about those labels fits and what does not fit with how they see themselves and how they want to see themselves.
    - There may be overlap in labels. This overlap can be discussed and could include what about the group member's behavior could cause this overlap in labels.

Activity 3

Topic: Identity development

Description:

- The clinician will then ask them what labels they would like to have and why.
- The group will process what each person needs to do for them to feel that they have obtained those labels.

Activity 4

Topic: Preparation for last group

Description:

- The last few minutes of the eighth group will be spent reminding the members that the next group will be their last meeting.
- The group will be asked to think about their time in the group and bring any questions they have or any material they want to review.
- The clinician will explain how the last group day will be different than the previous group.

Group 9

The ninth group will focus on the completion of the group.

Activity 1

Topic: Comprehensive review

Description:

- The clinician will provide an overview of everything learned in the group
- She will discuss with the group anything that they wish to revisit
- She will answer any questions they have on the content.

Activity 2

Topic: Check-in and structure reminders

Description:

- A final check-in with the group will be done to see how they are feeling about the information and about the group ending.
- The group will be reminded that they will meet with the clinician individually to discuss the group and any other things that they wish to talk to her about.
- She will remind them that individual sessions are available beyond that if they chose.

Activity 3

Topic: “Graduation”

Preparation: The clinician will design and print a certificate for each member.

Description:

- The clinician will give each member a certificate that says “I can tell you how I feel.”

Activity 4

Topic: Coping skill practice

Description:

- During the time remaining, the clinician will practice with the group members their coping skills.
    - Depending on the group size and variety of opinions, 2-3 coping options can be given or multiple can be practiced throughout the time.

Individual Sessions

- The clinician will have an individual session with each group member in the week following the end of the group to process any emotions or content the youth wishes.
- The Trauma Symptom Checklist for Children will be given during the individual session again to assess group effectiveness.

    - This will allow the clinician to assess if there are areas that need to be added to the group that are not being addressed, adjust activities or topics that are not being effective, and assess the overall success of the group.

- The clinician will also offer individual counseling services to each group participant so that they can continue to work on the skills learned in the group or process their trauma if the youth wants.
    - These individual sessions will not be mandatory beyond the one debrief session that is required.

Conclusion

The hope is that from this group, the members will be able to have a better understanding of how trauma effects their reactions and have a better understanding of their emotions and how to manage these emotions. This group gives the members the tools, such as coping skills, to help with this emotional regulation. The thought is that the members will take the knowledge with them and use it to regulate themselves and that this learned ability will help the member stay out of the criminal justice system and lower their likelihood of reoffending.

Overall there needs to be more services offered to these youth both before they are incarcerated and while they are incarcerated. In juvenile facilities, these youth have a high need and based on the minimal research found they are underserviced. Also based on the minimal research found, there seems to be few evidenced based pre-trial or diversionary programs. While there was ample research for adult programs there was minimal research for these programs for youth. The clinician acknowledges that there may be programs that are being used but that they are either not being researched and therefor are not evidenced based or not being used by the justice system. This calls for more research on the programs that have been developed to

determine if they are evidenced based and to also use the research that is available to develop program for use with this population. It also calls for the juvenile justice system to use these developed programs both within facilities and as diversionary or pretrial programs.

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