Juvenile Justice Vision 20/20 October 2016 Training Event
Girls in Residential Treatment: Strategies, Risk Factors, and Best Practices
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Presenter: Katrina Brock

Just as with other areas of the juvenile justice system, girls that are placed in residential treatment have unique and different needs than their male counterparts. This highly-informative workshop addressed specific differences in working with girls in residential treatment. Participants explored treatment dynamics and strategies, and participated in hands-on activities designed to inform and help those that work in residential settings or recommend residential treatment for clients. The workshop provided opportunities to discuss areas in which girls may be especially affected or at risk; for example, interactions with peers, concerns about victimization and trauma, and awareness to trafficking vulnerability. In addition, Ms. Brock discussed her current involvement working with the Beck Institute on the 5-year Change Project to implement Cognitive Behavioral Therapy (CBT) as the evidence-based practice in residential treatment programs. This process includes receiving weekly clinical supervision from a Beck Institute supervisor while earning full CBT certification.

The dynamics of human trafficking involving teenage girls were reviewed to give additional context to the discussion of treatment strategies for teen victims given that trafficking victims often end up in residential placement as a result of the criminal activities they are forced to participate in and/or their criminal activities related or unrelated to their victimization. Some of the typical indicators of trafficking victims include the teens' inability to provide a fixed address or clearly describe family relationships, exhaustion, chronic truancy, substance use, living with their employer or in a crowded environment with others, signs of physical abuse, heightened fear of authority figures, and possession of large amounts of cash. Risk factors for becoming a trafficking victim include but are not limited to poverty, living in an unsafe place, being lesbian or transgender, having a disability, undocumented immigrants, being a member of some Native American or Alaskan Indian communities, and/or being homeless, a runaway, or a "throwaway" teen.

New laws have strengthened the penalties for traffickers and have provided some relief and funding for services for victims. Treatment responses are evolving but clinicians are cautioned to consider carefully how to respond to the labels placed on victims—and typically placed on juvenile delinquents of every ilk. Labels, such as Oppositional Defiance Disorder, Conduct Disorder, and Intermittent Explosive Disorder are commonly assigned to teens in the juvenile system as a result of assessments and evaluations.

These labels do not always align smoothly with a residential client's treatment needs, and historically elicited a punitive response. The "lens" used by clinicians when viewing the label can help inform the treatment response. A street thug that is oppositional and defiant *might* correctly be identified as someone needing a higher dosage of disciplinary response, while a human trafficking victim placed in residential treatment typically needs safety, and higher doses of trauma-informed treatment, life skills training, and likely significant treatment for PTSD, depression, and psychological and personality disorders—by the time a girl that has been trafficked reaches residential placement these issues have generally become severe.

Cognitive-Behavioral Treatment is considered a best practice for treatment of juveniles in placement. In simple terms, CBT is based on the premise that situations and thoughts lead to emotions that influence actions. The goal of CBT is to teach the client to react constructively and proactively to strong emotions, for example check and change thinking errors, problem solve, and/or use coping skills, often newly-learned coping skills. Ms. Brock explained one tool, "What's Your Speed" (for excess energy or distress), that uses the analogy of a speedometer—one that goes from 0 to 100 and is broken into four segments—as a useful tool for gauging where a youth is in a given moment, and suggesting effective responses. For example:

- In the zero to 25 mph range a girl might present as smiling, interacting with peers and adults, and maintaining appropriate boundaries. Normal activities such as crafts and routine activities occur.
- In the 25 to 50 mph range a girl might present as irritable, fidgety, and critical of self and/or others. CBT responses that might be effective include using the CBT chat form (a CBT interactive tool), encourage relaxation, reduce peer interactions and stimuli, and review or list coping tools and encourage their use.
- In the 50 to 75 mph range a girl might appear messy and disheveled, be swinging her arms, scratch and pick at skin, isolate, and also show symptoms from the 25-50 mph range. Responses here include having the girl sit down on a cool bathroom tile, offer ice cubes, have the girl hold her own wrists and take deep breaths, and/or allow the girl to isolate (with line of sight supervision by staff).
- In the highest speed range, 75-100 mph, a crash is likely. Symptoms include pacing the same route over and over, yelling, name calling, throwing objects, head banging, and/or aggression towards peers or staff. Responses include use of a weighted blanket, cushioning to prevent injury from head banging, and/or a standing physical restraint.

CBT strategies begin with the obligation to "first, do no harm", including both intentional harm and unintentional harm. Intentional harm is abusive and known to be harmful by clinicians, and includes slander, verbal abuse, physical/sexual abuse, isolation, and threats of removing contact with family. Less commonly recognized are responses and behaviors on the part of clinicians that can unintentionally harm clients. These include:

- Character generalization, "You are just like..."
- Statements such as "You're crazy", or "You don't want to succeed"
- Personalizing youth's moods, behaviors, and choices
- Dismissing or minimizing a youth's experiences
- Predicting future failure based on the youth's current behaviors and choices

Finding progress in things done right, instead of focusing only on youth failures and negatives, is essential. Other CBT strategies employed by clinicians include but are not limited to:

- Active listening
- Demonstrate hope and optimism
- Use grounding exercises whenever possible as alternatives to restraint and/or isolation
- Don't engage in power struggles with youths

- Present options (within limits) rather than ordering, for example “Do you think that it would be helpful to...” rather than “You need to...”
- Empathize with a youth’s anger or distress without sanctioning inappropriate behavior
- Re-direct the youth and come back to the issue when youth is more stable.

Clinicians *are* impacted by providing care to clients, and can experience compassion fatigue and burnout. This is less likely to happen when clinicians view difficult clients and situations through diagnostic lenses. Clinicians are encouraged to practice self-care, leave work at work at the end of the day, and build prevention practices into their daily routines. At the end of the presentation, session participants were invited to touch and use various tools, including a weighted blanket, that are used as part of CBT inventions to increase youth body awareness and tension reduction.