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Assessing Exposure to Psychological Trauma and Post-Traumatic Stress in the Juvenile Justice Population

**National Child Traumatic Stress Network
Juvenile Justice Working Group**

This project was funded by the Substance Abuse and Mental Health Services Administration,
U.S. Department of Health and Human Services

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From the

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National Child Traumatic Stress Network
www.NCTSNet.org

2004

The National Child Traumatic Stress Network is coordinated by the National Center for Child Traumatic Stress, Los Angeles, Calif., and Durham, N.C.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

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Introduction

Estimates of the prevalence of post-traumatic stress disorder (PTSD) in the juvenile justice population vary widely depending on several key factors (Abram et al., 2004). These factors include the type of instrument (e.g., one that asks about an adolescent's worst traumatic experience as opposed to all of a youth's traumatic experience[s]), the informant interviewed (e.g., child versus caregiver), and the time frame assessed (i.e., instruments that assess the current month or past year versus those based upon the child's lifetime experience of symptoms). Given all of these variables, estimates of PTSD prevalence in the juvenile justice population range between 3 percent and 50 percent (Arroyo, 2001; Garland et al., 2001; Teplin et al., 2002; Wasserman, et al., 2002; Cauffman et al., 1998). These rates are up to eight times as high as other community samples of similar-age peers (Saigh et al., 1999; Saltzman et al., 2001).

Thorough trauma assessment with children and adolescents is a prerequisite to preventing the potentially chronic and severe problems in biopsychosocial functioning that can occur when PTSD and associated or comorbid behavioral health disorders go undiagnosed and untreated (Nader, 1997). Although, like adults, most children who experience a traumatic stressor do not develop PTSD (Saigh et al., 1999), unresolved post-traumatic stress can lead to serious long-term consequences into and throughout adulthood (Briere, 1997). These long-term consequences can include, but are not limited to, problems with interpersonal functioning, cognitive functioning, mental health disorders, including PTSD, as well as substance abuse disorders, affective disorders, anxiety disorders, eating disorders, and conduct disorders (Briere, 1997; Nader, 1997; Saigh et al., 1999).

Clinical Considerations

Safety

Safety is paramount not just for the child but also for his/her caregiver(s) and significant others (e.g., siblings). Any assessment of a child or adolescent in the juvenile justice system must begin with an evaluation of the child's current environmental and contextual risk. Safety has both an objective (e.g., determining if the child or caregiver currently is experiencing, or is imminently at risk for, further trauma experiences) and subjective (e.g., the child and parent's sense of personal safety) dimension (Newman, 2002). Both objective safety and the subjective sense of safety can take on very different forms as children progress developmentally.

If a child is still living in a dangerous environment, the assessor must work to ensure that the child is safe. This may require evaluating the extent of the risk, availability of supports in the home or nearby, and the ability of the child to seek help if needed. Further, assessors should be prepared to advocate for children and involve additional resources if safety is of concern. Detention settings themselves may also be dangerous or unsafe for many children because of overcrowding or a lack of privacy. They may expose children to verbal or physical aggression from other children or staff and exacerbate fears or trauma symptoms that the child is already experiencing, such as hypervigilance, hyperarousal, or the re-experiencing of traumatic images. Assessors should be cognizant of children's perception of their environment and be ready to advocate for them when concerns related to safety arise.

Likewise, an assessor's ability to provide a genuinely safe setting while inquiring about emotionally painful and difficult experiences or symptoms depends upon knowledge of and sensitivity to the different ways children and adolescents may experience safety. In juvenile justice settings, safety also involves explaining clearly to the child and family, and reliably maintaining, definite boundaries and limits concerning confidentiality and sharing of clinical information (e.g., mandated reports or requests for information by courts, correctional staff, child welfare workers, or probation officers).

Multiperspective Assessment

Multiperspective assessment reduces the likelihood that unintended bias or distortion will occur due to information based on any individual informant. The perspective of the child or adolescent is important because other informants (e.g., parent, teacher) may overreport symptoms or only report overt symptoms (e.g., acting out behaviors) while ignoring more internalizing and covert symptoms (e.g., anxiety or mood disturbance). However, other informants are vital because children who are traumatized may underreport symptoms that caregivers recognize as problematic. Newman (2002) recommends a "multi-modal" approach to assessment (i.e., multiple informants and multiple forms of assessments, such as interviews and self-report instruments).

There is no one perfect measure for assessing trauma or PTSD. Measures vary in their sensitivity, specificity, and clinical utility for different settings and populations. Time permitting, the use of both self-report and interview-based assessments is recommended. Additionally, both structured (e.g., classroom or parent-child interaction) and semistructured observational assessments (e.g., play, drawing) can provide a unique source of potentially ecologically valid behavior samples (Newman, 2002).

Assessment Format

The format of the assessment may influence children's and caregivers' responses. For example, children's answers to structured interviews in which both the child or caregiver and the assessor can probe for clarification may be more complete than use of a questionnaire—but interviews may be more subject to expectancy biases by either the respondent or assessor than a more independently completed questionnaire measure. In addition, when children are interviewed in a group, they may answer in ways that they think conform with their peers' or parents' norms or expectations. Efforts should be made to interview children individually for this reason. Since children are impressionable and may respond to cues from the interviewer when answering questions, it is also important that the interviewer convey a willingness to hear any response and not rush into asking follow-up or probing questions until it is clear how the child intended to respond to the initial question (Nader, 1997).

Assessors need to remember that many children and adolescents and their caregivers may be non-readers and may be intimidated by or unable to use questionnaires. Studies consistently show that

significant numbers of children and adolescents in the juvenile justice system are reading below grade level and/or have learning disabilities or developmental disabilities that may inhibit or confound their comprehension and ability to respond to written instruments. Some researchers have found that adolescents tend to be more comfortable reporting to a computer, rather than a person, on issues that are highly sensitive and may be illegal (e.g., sexual behavior, drug use, violence) (Turner et al., 1998).

Developmental and Ethnocultural Factors

Developmental and ethnocultural factors should be taken into consideration when establishing rapport with children and their caregivers. The optimal wording and order of questions may vary for children of different ages, developmental levels, ethnicities, and cultural backgrounds. What constitutes a *symptom* (versus expected age-appropriate behaviors) may differ developmentally and ethnoculturally. For example, the behavior of an American Indian adolescent who averts his eyes when speaking to an adult should not necessarily be perceived as insubordinate, but as consistent with Native cultural norms of respectful communication. Children of different ages and ethnocultural backgrounds also may respond differently to interview versus questionnaire formats, as well as to assessors with different styles and backgrounds.

Assessors may find that many assessment tools have not been translated into other languages or normed on members of minority groups. Furthermore, since children and adolescents in the justice system average two years behind expected grade level (Wasserman et al., 2002), cognitive and developmental delays should also be considered in the assessment process, as this will impact their performance and may also impact their behavior in the juvenile justice setting.

Children and adolescents from cultural and ethnic minority groups are overrepresented in juvenile justice settings, with the overrepresentation growing as they move deeper into the system. Snyder (1996) found that while black children and adolescents represented only 15 percent of the population in 1993, they were involved in 28 percent of all arrests and 50 percent of all violent crime arrests. Snyder's (1996) metaanalysis of the literature on minority children and adolescents in the juvenile court also found that racial and ethnic status influenced decisions made about individuals at every stage of the juvenile court process. There have been many recommendations and strategies put forth for addressing overrepresentation of minorities and racial bias in the juvenile justice system (e.g., Juvenile Justice and Delinquency Prevention Act of 2002; Leonard et al., 1995).

The Juvenile Justice Environment

Juvenile justice contexts include a variety of settings (e.g., police contacts, detention or incarceration sites, diversion and community-based rehabilitation programs, probation offices, courts) and legal issues (e.g., minor deviance, violent crime, victimization, court or probation mandates) that may influence the child, adolescent, or parent's willingness and ability to disclose information about traumatic experiences or post-traumatic symptoms.

Both underreporting and overreporting are of potential concern. A primary consideration for the assessor is by whom and for what purposes the assessment information will be used. The extent to which children and parents can make an informed consent (versus having to defer to coercive pressure due to legal requirements) is important. To the extent that the assessor can factually assure children and parents that the information will be used in ways that will be helpful and not inadvertently harmful to them—and that this will be the case regardless of what they disclose, so that

neither more or less severity of trauma history and post-traumatic symptomatology will affect them adversely—their reports are likely to be more complete and accurate. However, this often is not possible, and the assessor should note the possibility of underreporting, overreporting, or misreporting due to actual or perceived (by children or parents) legal or other coercion.

Problems of confidentiality and self-incrimination also confound assessment within juvenile justice settings. Assessors need to think about how certain types of information might be used as part of the legal case against a child or the child's family. For example, a child or adolescent's admission of substance abuse may carry sanctions; an admission of serious mental health problems or symptoms may carry the consequence of an involuntary hospital admission or involuntary commitment to mental health treatment; a child's admission of domestic violence in the home may result in a case being filed with Child Protective Services or police and removal of the child from the home. Assessors should be careful to inform children and adolescents of the limitations of confidentiality. Juvenile justice facilities should also carefully consider the timing of the assessment. For example, if the assessment occurs preadjudication, questions regarding substance use may need to be asked at another point in processing. One possible option is that a window could be created between adjudication and disposition, during which time a comprehensive mental health assessment could be conducted to inform service planning.

Assessment Approaches

There are three basic approaches to the assessment of trauma and post-traumatic sequelae in children and adolescents. Each has been used with children and adolescents in juvenile justice settings. First, there are a number of instruments designed to directly measure traumatic experiences or reactions in children and adolescents. Second, there are several omnibus child diagnostic instruments that include PTSD subscales. Third, there are a number of instruments that assess symptoms (e.g., dissociation, see Carrion and Steiner, 2000; anxiety, see March et al., 1997; and depression, see Kovacs, 1985) that are not trauma-specific but are related to other aspects of trauma symptoms in children and adolescents. A number of assessment instruments have been reviewed and will soon be included in a database on the website of the National Center for Child Traumatic Stress (www.NCTSNet.org). Included in the review of each instrument is information about its previous use with juvenile justice populations and its availability in different languages, age ranges, comprehension levels, and administration times.

Summary and Conclusion

A number of approaches and instruments are available for the clinician and researcher seeking to conduct trauma and PTSD assessment with children and adolescents in juvenile justice settings and their caregivers. Relatively few instruments, however, have been used, let alone systematically evaluated, with juvenile justice populations. Also, no studies have systematically examined potential differences by assessment format or respondent gender, age, or ethnocultural background in the assessment process or outcomes related to trauma history or PTSD in juvenile justice settings. Given the high prevalence of trauma exposure and PTSD in juvenile justice populations, careful clinical application and scientific study of the trauma history and PTSD assessment instruments is an important step toward enhanced services and outcomes for this large, high risk, and typically underserved population.

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