Trauma and Juvenile Justice
Responding to Students Affected by Trauma: Collaboration Across Public Systems

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Many youth involved with the juvenile justice system have been exposed to trauma and also struggle in school. Yet, success in school may help to mitigate the effects of trauma exposure and reduce the likelihood of engaging in high-risk behaviors. Building on the research connecting trauma and learning, this article draws out lessons learned from three initiatives in which public systems attempt to assess trauma and meet both the behavioral health and academic needs of students. Promoting a shared view of child development and an understanding of the impact of trauma on that developmental trajectory is an important step toward implementing an effective, coordinated system of care for high-risk youth.

Youth with high-risk behaviors present a challenge to educational and juvenile justice systems. Behaviors such as fighting, running away, cutting, or substance abuse are some of the more overt challenges, but inability to pay attention, overreacting to slights, and poor self-regulation skills can be equally problematic. Although they have different mandates, schools, child welfare, mental health and substance abuse agencies often deal with youth who present with the same difficult high-risk behaviors. Many of these youth have poor educational outcomes, and it can be difficult to disentangle whether the emotional and behavioral problems contribute to or stem from academic difficulties as theories support both hypotheses (Altshuler, 1997; Ayasse, 1995; Stein, 1997).

Juvenile courts have not been consistent in how they deal with acting-out youth (Griffin, Germain, & Wilkerson, 2012). Under the United States Constitution, states are given parental powers (parens patriae) to care for such

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vulnerable citizens such as children. This is a basis for child protection courts. States are also given police powers to protect their citizens from dangerous individuals. This is a basis for criminal courts. The dilemma arises when a citizen is both vulnerable and dangerous. Does the state punish or rehabilitate such a young person? The U.S. Supreme Court recognizes both as legitimate goals when dealing with criminals, but leaves the decision up to legislatures and public policy.

The public has vacillated on the question of punishment versus rehabilitation. Although juvenile courts were originally created so that acting-out youth were not treated like criminal adults, juvenile laws were later modified to allow automatic transfers to adult court, for example. More recently, however, in 2005 (Roper v. Simmons, 2005) and 2010 (Graham v. Florida, 2010) juvenile justice decisions, the U.S. Supreme Court has acknowledged new findings in adolescent development in holding youth less culpable than adults. These findings focused on normal child and adolescent development and applied to all youth.

Though not yet cited by the Supreme Court, a new body of research is developing regarding experiences that disrupt this normal development. This research, which focuses on child trauma, includes both privately funded studies, such as the initial Adverse Childhood Experiences Studies (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998) and publicly funded research, such as the projects of the National Child Traumatic Stress Network. Child trauma, “the emotionally painful or distressful experience of an event by a child that results in lasting mental and physical effects” (National Institute of Mental Health, cited in U.S. Department of Health and Human Services, 2005), can disrupt a child’s normal development and lead to physical, emotional, cognitive, learning and social problems. It can lead to earlier death. Behavioral manifestations of child trauma can include fighting, running away, cutting, substance abuse, inability to pay attention, overreacting to slights and poor self-regulation skills.

Findings from this growing body of research are being applied in the public child-serving sector as trauma-informed programs are introduced into educational, juvenile justice, child welfare, mental health and substance abuse programs. Each of these programs can help inform the other child-serving sectors and, in fact, the most effective approach will likely involve coordinating care for the difficult, high-risk youth that are served by multiple agencies.

A majority of high-risk youth served by public agencies has experienced trauma, and many of those youth may experience academic difficulties secondary to that trauma. The goal of this article is to illuminate the ways in which trauma impacts children across systems—education, child welfare

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and juvenile justice—and to underscore the importance of both a trauma-informed perspective and a collaborative approach in grappling with the challenges that these children present. In the remainder of this section, we highlight some research findings and key issues pertaining to trauma and the youth served by public institutions. In the next section, we draw on three evaluations of federally funded projects to discuss the experiences of professionals working with traumatized youth in the education and child welfare system. These qualitative evaluations were conducted at various points in the implementation of the initiatives, and the quotations provided here are intended to foster dialogue about the need for and challenges in fostering cross-system collaboration and providing trauma-informed assessments and services. In the final section, we conclude with a discussion of the value of developing a shared perspective across child-serving systems and institutions about the impact of trauma on children’s development and well-being.

TRAUMA, LEARNING AND EDUCATIONAL EXPERIENCES OF YOUTH SERVED BY PUBLIC SYSTEMS

Though prevalence rates of child trauma for system-involved youth vary with the definition of “trauma” being used, recent research suggests those rates are high. For example, 97 percent of youth taken into state custody by the child welfare system in Illinois for abuse or neglect experienced a traumatic event, and 25 percent had an identifiable trauma symptom (Griffin, Martinovich, Gawron, & Lyons, 2009). Prevalence of trauma within the juvenile justice system is also high. Studies suggest that at least 75 percent of youth in the juvenile justice system have experienced traumatic victimization (Abram, Teplin, Longworth, McClelland, & Dulcan, 2004; Cauffman, Feldman, Waterman, & Steiner, 1998), and as many as 50 percent may have some post-traumatic stress symptoms (for reviews of trauma and PTSD prevalence rates among youth in juvenile justice, see Arroyo, 2001; Ford, Chapman, Hawke, & Albert, 2007; Griffin & Studzinski, 2010; Hennessy, Ford, Mahoney, Ko, & Siegfried, 2004). Exposure to trauma may lead to risk taking, acting out, breaking rules and other behaviors that bring youth into the juvenile justice system and, absent appropriate interventions, trauma symptoms may worsen as a result of experiences while in the juvenile justice (Ford et al., 2007) or other child-serving systems.

The life experiences of children involved with juvenile justice and child welfare systems represent a critical context for understanding their school
experiences and educational progress. The impact of trauma on brain development can include compromising the cognitive abilities and skills acquisition that are key to school performance. Children affected by trauma may struggle with language, concentration, understanding, and responding to classroom instruction, problem solving, abstractions, participation in group work, classroom transitions, forming relationships, regulating emotions and organizing material sequentially (Cole, O'Brien, Gadd, Ristuccia, Wallace, & Gregory, 2005). Research consistently demonstrates a link between trauma and cognitive functioning, including sustained attention, memory, executive functioning, and verbal abilities, and cognitive impairment puts children at risk for school disengagement and academic failure (Overstreet & Mathews, 2011).

Just as trauma may impair cognitive functioning, it may also lead to difficulties with social and behavioral functioning that manifest as often-misunderstood behavioral problems in the classroom. Students may display behaviors that are impulsive, aggressive, or defiant. They may withdraw in the classroom, become frustrated and despondent when they encounter academic difficulties and struggle in relationships with school personnel or peers (see Cole et al., 2005). Such behavioral difficulties may result in harsh disciplinary practices, involvement of the justice system, or school dropout—particularly as schools struggle to accurately assess and identify trauma and the associated symptoms. Depending on the setting, behaviors of children who have experienced trauma may not be recognized as distinct from those of children with other developmental delays or mental health conditions (National Child Traumatic Stress Network Schools Committee, 2008).

**EVALUATION FINDINGS**

In this section, we draw on three evaluations of programs in which public systems are attempting to assess trauma and meet both the behavioral health and academic needs of students. The first—a trauma-informed, comprehensive assessment program—helps the public child welfare system to accurately determine the circumstances and needs of the children in its care in order to provide the most appropriate services. The other two initiatives were implemented through schools as part of the public school district’s efforts to provide behavioral and mental health services to students in schools in high-poverty, at-risk communities.
Comprehensive Assessments: Understanding Connections between Trauma and Educational Struggles

Traumatic experiences, family struggles and a child’s school experiences are intertwined. These connections are illustrated in case records from a study of the Illinois Department of Children and Family Services’ Integrated Assessment Program (Smithgall, Jarpe-Ratner, & Walker, 2010). The following excerpts from these assessments show how the life experiences of students can distract their attention from learning and contribute to behavioral problems in school settings.

[Child] exhibits difficulty with interpersonal relationships. She described being unable to get along with her teachers and feeling like they were blaming her for things which she did not do. She reported frequent worries about her safety and that of her siblings, and these worries were intrusive, distracting her from her schoolwork.

[Child] reported that she had a verbal altercation with a couple of young women that attend her school. [Child] reacted to something one of the girls said that reminded her of the abuse she had experienced with [father of sibling]. [Child] had a difficult time calming herself down and told the girls she would “kill them.”

[Child] would run away from home after incidents of physical punishments and the last time he ran away...he lived in a cardboard box under a viaduct for over a month.... [Child] has been absent 78 days for the last completed semester. ... [Child] did not attend school because he feared that the school would contact the police and he would be returned home... [Child] was suspended from school for breaking in to school, apparently to sleep while on run from home.

Adult and institutional responses to children’s behavior can impact the extent to which a child develops the ability to cope with traumatic experiences; therefore, creating trauma-informed school systems is vital to helping students develop adaptive behaviors and supporting their academic progress.
Although focused on their educational experiences and status in school, the integrated assessments were conducted by child welfare caseworkers, and the evaluators could not determine from the records whether sufficient information about the child and family circumstances was provided to school professionals to allow them to place the behaviors in context and to understand learning and behavioral issues from a trauma-informed perspective. Conducting trauma-informed assessments in public agencies is an important first step. Collaborating across systems to ensure that all of the youth's needs are met is an essential next step.

**Implementing a Three-Tiered Approach to School-Based Mental Health Services**

In 2007 and 2008, Chicago Public Schools launched two separate grant-funded initiatives that were designed to provide a set of social, emotional, and behavioral supports for students. The initiatives used a three-tier framework of universal supports:

- Tier 1. Social-emotional learning curricula and school-wide expectations
- Tier 2. Early intervention school-based services, such as small group counseling
- Tier 3. Intensive services that necessitated individual counseling or referrals to outside agencies with special expertise.

A set of evidence-based programs, including Second Step, Anger Coping and Cognitive Behavioral Interventions for Trauma in Schools (CBITS) were identified for use at Tiers 1 and 2, and implementation of the framework included teacher referrals and a team problem-solving process for students in Tiers 2 and 3. These initiatives incorporated several of the criteria Overstreet and Mathews (2011) list as being critical for a public health framework for school-based mental health services.

The following excerpts from interviews with school-based counselors and administrators provide insights into implementation as they worked to launch a coordinated school-based system to address the social emotional, behavioral and mental health needs of the students they served. These interviews were conducted as part of the evaluation for each initiative (Walker, 2010; Walker & Cusick, 2011).
Seeing Anger Rather than the Effects of Trauma

One theme that emerged from the evaluations was the need for a paradigm shift within the schools—from a focus on students’ anger to a focus on the trauma students may have experienced that may have caused that anger. Anger is often expressed in observable behaviors, while the psychological trauma underlying an expression of anger is not. As evidenced by the comment below, a school administrator perceived a student as angry when he or she overreacted to a minor incident.

I think I have a lot [of] students who are just mentally unstable. Angry….they don’t know how to handle issues. … It’s always me against everybody else … Like, I have a lot of volatile kids who if you take their pencil they’re screaming and yelling. “Somebody stole my pencil.” …it rolled off on the floor. I picked it up. I don’t know who it belonged to; … I have a lot of very angry children. [School administrator]

As Griffin and Studzinski (2010) note, however, it is important to understand that a traumatized child may exhibit reactions seemingly out of proportion to the situation or may misperceive cues as threatening, particularly if coming from authority figures. Viewed from a trauma-informed perspective, the student’s response may have actually reflected feelings of being unsafe or even threatened. At least one school-based counselor felt that the tendency to perceive students as being angry was relatively common among school personnel.

A lot of times students who have gone through trauma, their teachers aren’t always aware of it, or if they are aware of it, they minimize it and don’t think it’s a big deal and they just think, “Oh, this kid’s just really angry.” So we get tons of referrals for anger, but sometimes anger’s just the symptom that’s coming out fromm the actual trauma. So it’s a little challenging. [School counselor]

The counselor’s perception was consistent with the pattern that emerged in the referrals for school-based services. The number of students referred for anger management programs was three times the number of referrals for the evidenced-based trauma intervention available for students in Tier 2.
Providing Universal Supports

Creating a school environment with clear behavioral expectations, supportive relationships and established routines can help enhance a student’s sense of safety. In 2005, Massachusetts Advocates for Children released Helping Traumatized Children Learn, in which they present a flexible framework for creating trauma-sensitive school environments (see Cole et al., 2005). Wolpow, Johnson, Hertel, and Kincaid (2009) build on this framework as well as that of the National Childhood Traumatic Stress Network Attachment, Self-Regulation and Competency (ARC) model, offering principles and strategies for instruction that further help schools create an environment of respect and compassion to support learning.

A compassionate or trauma-sensitive learning environment—in addition to enhancing a student’s sense of safety—lays the foundation for other school-based services. One of the school-based counselors reflected on the connection she saw between universal supports at her school and the group-based work she was trying to do with students who needed a more targeted approach.

I cannot do my job the way I do my job if I do not have that universal support in place. I really couldn’t. I'd be ineffective as a counselor. In groups, kids would be all over the place. Something as simple as taking them from the classroom to my office could be a disaster ... Kids come into my group prepared. They already have that universal foundation. They have the language. They understand the concepts. We're just reinforcing a lot of what they're doing in the classroom, but just in smaller groups.

Trauma-informed school environments benefit not only the children for whom exposure to trauma is identified as an immediate concern but also those whose trauma is not identified, and classmates who may be impacted by the sharing of experiences or behavioral responses of their trauma affected peers.

Working with Families

Challenging family circumstances may be one reason children are traumatized or otherwise affected by trauma, and some parents may need support in coping with and responding to their children's behaviors. One of the school-
based counselors talked about telling a mother that it is “not okay” for her son to be “punching holes in the walls at home” or acting very aggressively toward her. “You need to be safe and you need to feel safe and those are not normal okay behaviors that should happen at home.” She provides referrals for both the parent and student in such a case.

Although the family must often play a role in the response to their traumatized children’s behavior, schools generally do not have the expertise or capacity to engage hard-to-reach families. Schools often struggle with balancing the needs of one high-risk student and the needs of other students affected by his or her behaviors in the classroom.

We have, for some of the students, kind of tracked their behavior, and we know that there is a concern. One parent who says, yes, my child has been diagnosed with something, but I don’t give the child the medicine because I don’t want to medicate him because he acts a certain way when he’s medicated…. We’ve had no choice in some instances to give [them student] an out-of-school suspension, and the behavior continues. We talked to the grandparents, and the grandparents are saying they’re limited in the help that the parent will receive from them, so that’s an issue. So unfortunately because mom is not cooperative, the only thing we can deal with is out-of-school suspension as a means of trying to help the student because you have to help the student, but you have to protect the other students as well. [School administrator]

Families in crisis and may not seek out or voluntarily engage in school or community-based programs. Moreover, there may be few, if any, school-based programs designed to serve or intervene with hard-to-reach families. School outreach to families tends to reflect the universal purposes and capacities that are characteristic of education in general. On the other hand, juvenile justice, child welfare, and substance abuse and mental health agencies often work with hard-to-reach or involuntary clients and their families. This underscores the need for—and potential benefits of—collaborative discussion between the education system and other public systems about how best to avoid exclusionary practices and support the family in meeting students nonacademic needs and keeping them engaged in school.
DISCUSSION

Promoting a shared view of child development and an understanding of the impact of trauma on children's developmental trajectory is an important step toward implementing an effective, coordinated system of care for high-risk youth. High-risk youth served by public agencies have both academic and nonacademic needs that are intertwined. We can neither expect public agency caseworkers to educate youth nor educators to be therapists or social workers; cross-system collaboration is essential. Each system may develop its own trauma-informed assessment and service models; however, discussion among key stakeholders is important in achieving consensus regarding common concerns and intervention priorities.

As noted earlier, public sector child serving systems have struggled to deal with youth who act out. Some systems focus more on public safety and punishment while others focus on rehabilitation and support. Traditionally, the court system has focused more on public safety while schools have focused more on support. However, this is not always the case. Some schools focus more on public safety and punishment with policies such as zero tolerance. Some juvenile courts focus on becoming more trauma informed (Buffington, Dierkhising, & Marsh, 2010).

The education and juvenile justice systems overlap at multiple points. Arguably, coordinating their approach to acting out youth would be more beneficial to the youth and the systems that serve them. One critical point of overlap is when schools decide to refer an acting-out young person to the juvenile justice system. Another point centers on how youth are educated within the juvenile justice system. A third critical point of overlap concerns how youth are transitioned back into educational settings from juvenile justice. Each of these decisions dramatically affects the life of the youth.

A trauma-informed approach on the part of both the educational and juvenile justice settings could address not only issues of safety and risk behaviors but also issues of family and protective factors. For youth in juvenile detention or child welfare placements, the family is a large part of the environment a child may transition back to after return and/or exit. Family involvement is believed to be correlated with successful transition from correctional settings and reduced recidivism (Brock, Burrell, & Tulipano, 2006). A recent survey by the Center for Juvenile Justice Reform (2009) revealed family engagement to be both one of the most important and most difficult-to-address operational issues facing juvenile justice systems. For youth with mental health problems, family involvement may be critically important across all stages of the justice system, as families can
provide information necessary for the safety and stability of the youth and a supportive family may lessen a youth's anxiety and reinforce needed treatment (Osher & Hunt, 2002). The same is likely to be true when addressing trauma-specific needs. To the extent that treatment for trauma directly involves family members, engaging a child's family or others in his/her social environment will be important to the effectiveness of treatment (Saxe, Ellis, Fogler, & Navalta, 2012). As juvenile justice systems increasingly recognize both the importance of family and the need to address trauma, how to involve and engage families in trauma-focused assessment and treatment will become all the more critical to juvenile justice practice.

Research also suggests that the development of children’s strengths—relationship permanence, education, family support, talents and interests—may be a key factor in mitigating the effects of trauma exposure and reducing the likelihood the child will engage in high-risk behaviors (Griffin et al., 2009). Schools can provide youth with stable, caring adult relationships and the opportunity to experience success and mastery of both academic content and social relationships.

There is a growing body of literature addressing the application of child trauma concepts to the field of juvenile justice (Maschi, Bradley, & Morgen, 2008; Mahoney, Ford, Ko, & Siegfried, 2004) and education (Perry, 2009). The efforts of the National Childhood Traumatic Stress Network and recent federal grants issued by the Administration on Children and Families will hopefully continue to spur knowledge development regarding the impact of trauma and the use of trauma assessments and interventions in public systems. Given the significant impact of trauma on learning and educational experiences, the field will benefit from further work examining how public agency assessments can inform educational interventions and how educational assessments can inform public agency interventions.

REFERENCES


http://wwwncmbjj.com/pdfs/Trauma_and_Youth.pdf


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Ten Things Every Juvenile Court Judge Should Know About Trauma and Delinquency

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Introduction

The majority of youth who develop a pattern of delinquent behaviors and experience subsequent juvenile court involvement have faced both serious adversities and traumatic experiences. Research continues to show that most youth who are detained in juvenile detention centers have been exposed to both community and family violence and many have been threatened with, or been the direct target of, such violence (Abram et al., 2004; Wiig, Widom, & Tuell, 2003). Studies also demonstrate that youth who have multiple exposures to violence or victimization are at higher risk for mental health problems, behavioral problems, substance abuse, and delinquent behaviors (Ford, Chapman, Hawke, & Albert, 2007; Ford, Elhai, Connor, & Frueh, in press; Saunders, Williams, Smith, & Hanson, 2005; Tuell, 2008).

The mission of the juvenile court is complex. The court is tasked with protecting society, safeguarding the youth and families that come to its attention, and holding delinquent youth accountable while supporting their rehabilitation. In order to successfully meet these sometimes contradictory goals, the courts, and especially the juvenile court judge, are asked to understand the myriad underlying factors that affect the lives of juveniles and their families. One of the most pervasive of these factors is exposure to trauma. To be most effective in achieving its mission, the juvenile court must both understand the role of traumatic exposure in the lives of children and engage resources and interventions that address child traumatic stress. Accordingly, the purpose of this technical assistance bulletin is to highlight ten crucial areas that judges need to be familiar with in order to best assist traumatized youth who enter the juvenile justice system.
1. A traumatic experience is an event that threatens someone's life, safety, or well-being.

Trauma can include a direct encounter with a dangerous or threatening event, or it can involve witnessing the endangerment or suffering of another living being. A key condition that makes these events traumatic is that they can overwhelm a person's capacity to cope, and elicit intense feelings such as fear, terror, helplessness, hopelessness, and despair. Traumatic events include: emotional, physical, and sexual abuse; neglect; physical assaults; witnessing family, school, or community violence; war; racism; bullying; acts of terrorism; fires; serious accidents; serious injuries; intrusive or painful medical procedures; loss of loved ones; abandonment; and separation.

KEY DEFINITIONS

Acute Trauma: “A single traumatic event that is limited in time. An earthquake, dog bite, or motor vehicle accident are all examples of acute traumas” (Child Welfare Committee (CWC)/National Center for Child Traumatic Stress Network (NCTSN) 2008, p. 6).

Chronic Trauma: “Chronic trauma may refer to multiple and varied (traumatic) events such as a child who is exposed to domestic violence at home, is involved in a car accident, and then becomes a victim of community violence, or longstanding trauma such as physical abuse or war.” (CWC/NCTSN, 2008, p. 6).

Complex Trauma: “Complex trauma is a term used by some experts to describe both exposure to chronic trauma—usually caused by adults entrusted with the child’s care, such as parents or caregivers—and the immediate and long-term impact of such exposure on the child.” (CWC/NCTSN, 2008, p. 7).


Resiliency: “A pattern of positive adaptation in the context of past or present adversity” (Wright & Masten, 2005, p. 18).

Traumatic Reminders: "A traumatic reminder is any person, situation, sensation, feeling, or thing that reminds a child of a traumatic event. When faced with these reminders, a child may re-experience the intense and disturbing feelings tied to the original trauma.” (CWC/NCTSN, 2008, p. 12).
2. Child traumatic stress can lead to Post Traumatic Stress Disorder (PTSD).

While many youth who experience trauma are able to work through subsequent challenges, some display traumatic stress reactions. The impact of a potentially traumatic event is determined, not only by the objective nature of the event, but also by the child's subjective response to the event; something that is traumatic for one child may not be for another. The degree to which a child is impacted by trauma is influenced by his or her temperament; the way the child interprets what has happened; his or her basic coping skills; the level of traumatic exposure; home and community environments; and the degree to which a child has access to strong and healthy support systems.

Rates of PTSD in juvenile justice-involved youth are estimated between 3%-50% (Wolpaw & Ford, 2004) making it comparable to the PTSD rates (12%-20%) of soldiers returning from deployment in Iraq (Roehr, 2007). PTSD is a psychiatric disorder defined in the DSM-IV-TR, and several conditions or criteria must be met for an individual to receive the diagnosis. These criteria include: having been exposed to a threatening event, experiencing an overwhelming emotional reaction, and developing symptoms causing severe distress and interference with daily life. Further, individuals also must experience a sufficient number of the following three symptoms for more than one month: avoidance (i.e., avoiding reminders of the trauma); hyperarousal (i.e., being emotionally or behaviorally agitated); and re-experiencing (e.g., nightmares or intrusive memories). Since the PTSD diagnosis was developed initially to describe an adult condition, the definition is not a perfect fit for what professionals often see with children and youth who have experienced trauma. It is also important to understand that not all youth who are impacted severely by traumatic stress develop PTSD. Some youth may experience partial symptoms of PTSD, other forms of anxiety or depression, or other significant impairments in their ability to meet the demands of daily life (e.g., emotional numbness or apathy).
3. Trauma impacts a child’s development and health throughout his or her life.

Traumatic experiences have the potential to impact children in all areas of social, cognitive, and emotional development throughout their lives. Trauma that occurs early in life, such as infancy or toddlerhood, strikes during a critical developmental period. The most significant amount of brain growth occurs between birth and two years of age. Exposure to child abuse and neglect can restrict brain growth especially in the areas of the brain that control learning and self regulation (DeBellis, 1999). Exposure to domestic violence has also been linked to lower IQ scores for children (Koenen, Moffitt, Avshalom, Taylor, & Purcell, 2003). In addition to critical periods of brain development, it is during early childhood that children develop the foundations for their future relationships. When young children are cared for by parents who protect them, interact with them, and nurture them, they can learn to trust others, develop empathy, and have a greater capacity for identification with social norms (Putnam, 2006). Loss of a caregiver or being parented by a significantly impaired caregiver can disrupt children’s abilities to manage their emotions, behaviors, and relationships. Youth who experience traumatic events may have mental and physical health challenges, problems developing and maintaining healthy relationships, difficulties learning, behavioral problems, and substance abuse issues (Ford et al., 2007; Saunders et al., 2005). In other words, what occurs in the lives of infants and young children matters a great deal and can set the stage for a child’s entire life trajectory.

The experience of either acute trauma (a single traumatic event limited in time), or chronic trauma (multiple traumatic events) can derail a child’s development if proper supports or treatment are not accessed (Garbarino, 2000). It is not likely just one traumatic event will lead a youth to become violent or antisocial, rather it is both a series and pattern of traumatic events – occurring with no protection, no support, and no opportunities for healing – that places youth at the highest risk (Garbarino, 2000). It is this pattern of chronic trauma that affects many youth who come before the juvenile court system. Research also suggests that the impact of trauma can persist into adulthood and can increase risk of serious diseases, health problems, and early mortality (Felitti et al., 1998). Given that child traumatic stress can impact brain development and have such a profound influence throughout a person’s lifespan, it is essential for courts and communities to work together to prevent traumatic events where possible (such as child abuse and neglect) and to provide early interventions to treat traumatic stress before a youth becomes entrenched in a pattern of maladaptive and problematic behavior.
4. Complex trauma is associated with risk of delinquency.

The effect of trauma is cumulative: the greater the number of traumatic events that a child experiences, the greater the risks to a child’s development and his or her emotional and physical health. Youth who experience complex trauma have been exposed to a series of traumatic events that include interpersonal abuse and violence, often perpetrated by those who are meant to protect them. This level of traumatic exposure has extremely high potential to derail a child’s development on a number of levels. Youth who are victimized by abuse, and are exposed to other forms of violence, often lose their trust in the adults who are either responsible for perpetrating the abuse or who fail to protect them. Victimization, particularly victimization that goes unaddressed, is a violation of our social contract with youth and can create a deep disregard both for adults in general and the rules that adults have set (Cook, Blaustein, Spinazzola, & van der Kolk, 2003; Cook et al., 2005). Distrust and disregard for adults, rules, and laws place youth at a much greater risk for delinquency and other inappropriate behaviors.

Danny, a runaway who was interviewed in a residential treatment program, expressed anger and frustration with the fact that the juvenile court’s first response was to quickly issue punitive consequences for his delinquent behavior, while being very slow to act and protect him from the physical abuse that he was suffering at the hands of his parent. He asserted that courts need to ask the questions, “Why is this kid running away? Why is he acting out like this?” It does not go unnoticed by youth when their safety and well-being is not addressed but their delinquent behavior is. These kinds of paradoxes and frustrations can increase the likelihood that youth will respond defiantly and with hostility to court and other professionals who are in positions of authority. System professionals would benefit from recognizing that imposing only negative or punitive consequences will likely do little to change the youth’s patterns of aggression, rule breaking, and risky behaviors because such a response does not address the impact of traumatic stress on the child. By recognizing and addressing the role of trauma in the lives of youth, the court and other systems can become more effective in meeting the needs of the justice-involved youth and the needs of the community.
5. Traumatic exposure, delinquency, and school failure are related.

A cademic failure, poor school attendance, and dropping out of school are factors that increase the risk of delinquency. Success in school requires confidence, the ability to focus and concentrate, the discipline to complete assignments, the ability to regulate emotions and behaviors, and the skills to understand and negotiate social relationships. When youth live in unpredictable and dangerous environments they often, in order to survive, operate in a state of hypervigilance. Clinical dictionaries typically describe hypervigilance as abnormally increased physiological arousal and responsiveness to stimuli, and scanning of the environment for threats. Individuals who experience hypervigilance often have difficulty sleeping and managing their emotions, and because they often see people or situations as a threat they are more likely to react in aggressive or defensive ways. The mindset and skills involved in hypervigilance fundamentally conflict with the skills and focus needed to succeed in school academically, socially, and behaviorally.

Unfortunately, school performance and attendance issues (whether trauma related or not), can be exacerbated by involvement in the juvenile justice or child protection systems. Studies in New York City and the State of Kentucky found that after being released from juvenile justice facilities, between 66%-95% of youth either did not return to school or dropped out (Brock & Keegan, 2007). Youth may experience absences while waiting for records to transfer, a delay in specialized services, inadequate educational planning, and poor service coordination between school systems, child welfare agencies, and juvenile justice systems. Also, it may be easier for youth to act out or give up than to continue failing in school. It is essential that the juvenile justice system work with other community partners to ensure that youth have the supports they need to attend and succeed in school. Without these supports and resources, uneducated youth face further adversities such as poverty, unemployment, and ongoing justice system involvement.
6. Trauma assessments can reduce misdiagnosis, promote positive outcomes, and maximize resources.

"Sixty percent of youth involved in the juvenile justice system suffer from diagnosable mental health disorders" (Wood, Foy, Layne, Pynoos, & James, 2002, p. 129). Many of these youth have extensive histories of mental health treatment that may also include the use of psychotropic medication. Often youth who are exposed to chronic or complex trauma receive a diagnosis of Attention Deficit Disorder, Oppositional Defiant Disorder, Conduct Disorder, or other mental health disorders. These diagnoses are predominantly based on observable behaviors and symptoms. When there is a lack of thorough assessment, youth are provided treatment based on these behavioral diagnoses, without addressing the traumatic experiences that are contributing to the symptoms. In order to avoid this disconnect, trauma screenings and standardized assessments should be implemented at intake and at other points of contact. There are a number of assessments that assist in both identifying and tracking trauma histories, such as the Traumatic Events Screening Inventory (Daviss et al., 2000; Ford et al., 2000) and the Child Welfare Trauma Screening Tool (Igelman et al., 2007). There are also validated, standardized assessment tools that assist with identifying both mental health and behavioral symptoms and disorders related to traumatic experiences such as the UCLA Posttraumatic Stress Disorder Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004) and the Trauma Symptom Checklist for Children (Briere, 1996). With such a strong body of knowledge and tools available, and so much at stake for youth and society, it makes good sense and is also ethically imperative to use evidence-based assessment tools to make accurate diagnoses that can inform appropriate responses and treatment for trauma-exposed youth.
There are mental health treatments that are effective in helping youth who are experiencing child traumatic stress.

A number of evidence-based practices (EBPs) are available to courts and communities for treating youth who are impacted by trauma. EBPs are practices that have been evaluated through rigorous scientific studies and have been found to be effective. It is a service provider's ethical responsibility to provide the highest standard of care and to use evidence-based practices whenever possible. It is also imperative that referrals for treatment be made to service providers that use trauma-focused EBPs, so that youth may receive both the best care and the most positive outcomes. The Centers for Disease Control indicates that the most highly effective treatments for traumatic stress are cognitive behavioral treatment models (Centers for Disease Control, 2008). Typically, trauma-focused, evidence-based treatments include the following components: psychoeducation, caregiver involvement and support, emotional regulation skills, anxiety management, cognitive processing, construction of a trauma narrative, and personal empowerment training. Judges can and should discuss the availability of EBPs with their treatment providers and advocate for the development of trauma-specific programming. (Please visit www.nctsn.org for a list of evidence-based trauma treatments and respective evidence, treatment components, and target populations.)

EVIDENCE-BASED TREATMENTS FOR WORKING WITH YOUTH WHO HAVE EXPERIENCED TRAUMA

There are a variety of treatments that research suggests are effective in working with youth who have experienced trauma. A comprehensive list of such treatments and supporting documentation is available at https://www.nctsn.org/nctsn_assets/pdfs/CCG_Book.pdf. Some of the more common evidence-based treatments, however, include (in no particular order):

Cognitive Behavioral Intervention for Trauma in Schools (CBITS): Tested with youth who have experienced violence and complex trauma. CBITS is provided in a group format in schools, residential programs, and other similar environments.

Trauma Affect Regulation: Guide for Education and Therapy (TARGET-A): TARGET-A shows evidence of effectiveness with youth who are in correctional facilities, residential settings, and community-based programs. This model can be practiced in group, individual, and family formats, which helps both youth and families to better understand trauma and stress, and to develop skills that help them to think through, and regulate, their emotional, cognitive, and behavioral responses to stress triggers.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): Youth (and their parents, possibly) are taught to process the trauma; manage distressful thoughts, feelings, and behaviors; and enhance both personal safety and family communication. It can be provided over a relatively short period of time in virtually any setting.

Sanctuary Model: The Sanctuary Model promotes system change based on the creation and maintenance of a nonviolent, democratic, productive community to help individuals heal from trauma. The model provides a common language for staff, clients, and other stakeholders, and can be adapted to several settings and populations.
8. There is a compelling need for effective family involvement.

Youth who do not have helpful and consistent family support are at higher risk of violence and prolonged involvement in the court system (Garbarino, 2000). If juvenile courts are to enhance their success in rehabilitating juveniles who commit delinquent acts, they need to maximize opportunities to engage and partner with their caregivers. This means working to develop meaningful involvement of biological parents, extended family members, kinship caregivers, adoptive families, foster parents, and others.

Families may need education about traumatic stress and treatments that work so they can be more supportive of their children, and for some families, this education will help them address their own traumatic experiences. Kinship caregivers, foster parents, and adoptive families often regret not being involved sooner in a child’s life so they could have prevented earlier traumatic events. Often out-of-home caregivers need more information about what specific traumatic events or adversities a child may have experienced prior to becoming part of their family so they can make sense out of the child’s behaviors and find helpful ways to respond.

There can be obstacles and challenges to achieving successful family involvement. Sometimes families avoid interactions with the court system because of feelings of shame and fears of being criticized. Therefore, courts might wish to engage families in ways that can help them feel more valued, respected, and invited to participate in the court processes and their child’s rehabilitation. Practical and economic issues can also play a significant role in limiting family involvement, including: too much distance from the child’s home to the juvenile correction center, lack of reliable transportation, language and cultural barriers, and feelings of being overwhelmed and intimidated about interacting with a large public institution. When courts collaborate with community organizations and families, they may be able to find some practical ways to locate the resources that enable increased family participation. The best strategy to improve family involvement and partnerships is for the courts to take the time to ask them for guidance and solutions.
Resiliency is the capacity for human beings to thrive in the face of adversity – such as traumatic experiences. Research suggests that the degree to which one is resilient is influenced by a complex interaction of risk and protective factors that exist across various domains, such as individual, family, community and school. Accordingly, most practitioners approach enhancing resiliency by seeking both to reduce risk (e.g., exposure to violence) and increase protection (e.g., educational engagement) in the lives of the youth and families with whom they work. Research on resiliency suggests that youth are more likely to overcome adversities when they have caring adults in their lives. Through positive relationships with adults, youth experience a safe and supportive connection that fosters self-efficacy, increases coping skills, and enhances natural talents. Parents and other important familial adults can help increase their children’s ability to heal from trauma and promote prosocial behaviors by spending time at home together, talking, sharing meals, and “setting clear boundaries for behavior and reasonable disciplinary actions” (National Youth Violence Prevention Resource Center, 2007). Further, schools, courts, and communities can enhance resiliency by providing opportunities for youth to make meaningful decisions about their lives and environment, as well as investing in recreational programs, arts, mentorship, and vocational programs. The Search Institute, in Minneapolis, Minnesota, has developed a variety of tools to identify and promote developmental assets (www.search-institute.org).
10. Next steps: The juvenile justice system needs to be trauma-informed at all levels.

Trauma-informed systems of care understand the impact of traumatic stress both on youth and families, and provide services and supports that prevent, address, and ameliorate the impact of trauma. It is essential that juvenile courts work to provide environments that are safe and services that do not increase the level of trauma that youth and families experience. For example, a trauma-informed juvenile justice system understands that youth who are chronically exposed to trauma are often hypervigilant and can be easily triggered into a defensive or aggressive response toward adults and peers. Such a juvenile justice system makes system-level changes to improve a youth’s feelings of safety, reduce exposure to traumatic reminders, and help equip youth with supports and tools to cope with traumatic stress reactions. The provision of or referral to evidence-based trauma-informed treatment is essential within a trauma-informed system, as youth are less likely to benefit from rehabilitation services if the system they are involved in does not respond to their issues of safety and victimization.

Trauma-informed systems require successful and respectful partnerships between youth, families, professionals, and other stakeholders. To help sustain and ensure effectiveness of a trauma-informed juvenile justice system, data needs to be collected, evaluated, and used to determine the quality, fidelity, and effectiveness of the system changes. For example, there needs to be supervision and evaluation to ensure that trauma-informed interventions are being practiced the way they were designed in the particular evidence-based treatment model. Clinical outcome measures need to be used at least pre- and post-treatment to determine if a decrease in symptoms and/or increase in healthy coping have occurred during and after completion of the therapy model. Often juvenile detention centers have looked at rates of aggression, self-injury, and restraint and seclusion as data to help determine if the trauma-informed treatments are effective or in need of modification. All stakeholders need to be regularly informed on the status and quality of the outcomes of the system change efforts (Fixsen, Blase, Naoom, & Wallace, 2007). There are many resources that describe trauma-informed care in various service systems, such as juvenile justice, that can help guide interested systems through a transformation process.
Summary

Juvenile courts can benefit from understanding trauma, its impact on youth, and its relationship to delinquency. Research has repeatedly shown that the majority of youth in the juvenile justice system have experienced traumatic events; the juvenile court is disadvantaged if this fact is overlooked. By becoming trauma-informed, juvenile justice personnel aid the juvenile court in its mission of protecting and rehabilitating traumatized youth while holding them responsible for their actions. Rehabilitation resources also can be maximized by utilizing effective assessment and treatment strategies that reduce or ameliorate the impact of childhood trauma. Ultimately, such efforts will help promote improved outcomes for youth, families, and communities most in need of our help.

Research has repeatedly shown that the majority of youth in the juvenile justice system have experienced traumatic events; the juvenile court is disadvantaged if this fact is overlooked.
Resources

For more information about trauma, delinquency, or other issues of interest to juvenile and family courts, please contact the National Child Traumatic Stress Network (NCTSN) at info@nctsn.org or the National Council of Juvenile and Family Court Judges (NCJFCJ) at (775) 784-6012; e-mail jflinfo@ncjfcj.org. Other resources are available online at:

www.safestartcenter.org/cev/index.php
www.ojjdp.ncjrs.gov
www.search-institute.org
www.nctsn.net.org
www.ncjfcj.org
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Trauma Among Youth in the Juvenile Justice System:
Critical Issues and New Directions

Julian D. Ford¹, John F. Chapman², Josephine Hawke³, and David Albert⁴

Introduction

Child traumatic stress occurs when children and adolescents are exposed to traumatic events or situations, and this exposure overwhelms their ability to cope with what they have experienced [1]. Traumatic events can include physical abuse, sexual abuse, domestic violence, community violence, and/or disasters [2]. Although estimates vary, it is believed that the prevalence of trauma among children and youth in the general population is substantial. In one nationally representative survey of 9–16 year olds, 25% reported experiencing at least one traumatic event, 6% in the past 3 months [3]. The National Center on Child Abuse and Neglect reports that more than 2% of all children are victims of maltreatment, 13% are victims of neglect, and 11% are victims of physical, sexual, or emotional abuse [2].

For youth involved with the juvenile justice system, the prevalence of youth exposed to trauma is believed to be higher than that of community samples of similarly aged youths [4]. Studies report varying rates of Post-Traumatic Stress Disorder (PTSD) among youth in the juvenile justice system, with estimates ranging from a low of 3% to a high of 50% [5]. One study found that over 90% of juvenile detainees reported having experienced at least one traumatic incident [6]. While few studies have focused exclusively on girls, PTSD has been found to be equally [5] or more common among juvenile justice-involved girls than boys [7] [8].

Youth exposed to traumatic events exhibit a wide range of symptoms, presenting with not just internalizing problems, such as depression or anxiety, but also externalizing problems like aggression, conduct problems, and oppositional or defiant behavior [2]. Although trauma does not necessarily cause these problems, traumatic stress can interfere with a child’s ability to think and learn, and can disrupt the course of healthy physical, emotional, and intellectual development [9]. Further, traumatic stress among children and youth is associated with increased utilization of health and mental health services [10] and increased risk of involvement with the child welfare and juvenile justice systems [1].

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Visit the NCMHJJ website at www.ncmhjj.com
The use of standardized mental health assessment instruments is increasingly common in juvenile justice systems [11][12], and this increase has led to a greater awareness of the nature and prevalence of psychiatric disorders, including PTSD, among the juvenile justice population [5]. In addition, new trauma-focused screening instruments, as well as tools for effective treatment interventions, have been developed to assist the field in identifying and treating traumatic stress-related disorders among youth [4]. Many of these instruments and interventions could be used in the juvenile justice system to help youth deal with past trauma, recognize its current impact, and teach them ways to manage or overcome the emotional and behavioral problems caused by PTSD. Yet, despite the availability of these tools and resources, very few juvenile justice agencies, facilities, or programs are routinely screening for trauma or offering trauma-specific treatment interventions to the youth in their care. The purpose of this paper is to discuss the prevalence and impact of trauma and traumatic stress among youth in the juvenile justice system and to describe emerging responses for identifying and treating these problems.

**Trauma Among Youth in the Juvenile Justice System: Scope of the Problem**

Estimates of the prevalence of PTSD among youth in the juvenile justice population vary widely, and these variations are attributable to the lack of standardized instruments used across studies and differences in study methodologies [4]. Despite these variations, evidence suggests that many youth involved with the juvenile justice system have experienced traumatic events and suffer from PTSD [4]. Selected studies conducted among youth involved in the juvenile justice system have found that:

- More than one in three youth in the California Youth Authority met full criteria for PTSD, and 20% met partial criteria for PTSD [6];
- The incidence of PTSD among youth in the juvenile justice system is similar to youth in the mental health and substance abuse systems [13], but up to eight times higher than comparably aged youth in the general, community population [5];
- Among non-incarcerated youth seen in juvenile court clinics, one in nine met criteria for PTSD [14];
- The prevalence of PTSD is higher among incarcerated female delinquents (40%) than among incarcerated male delinquents (32%), and higher than among youths in the community (<10%) [6][7].

While the prevalence of PTSD is high, the prevalence of self-reported exposure to traumatic experiences is much higher, as high as 93% in juvenile detention centers [5]. A number of sources note that traumatic experiences symptoms are higher among girls than boys in the juvenile justice system [4], [7]. [12], [8]. Additionally, different types of traumatic experiences are reported by boys and girls, with girls more likely than boys to report sexual abuse and physical punishment. While boys more often report witnessing violence, girls are more frequently report experiencing violence [5] [8].

African-American and Latino/Hispanic youth are disproportionately placed in the juvenile justice system, but are not more likely than white youth to report exposure to traumatic stressors [5]. Among boys in a representative sample from an urban juvenile detention facility [5], white youth were more likely than African-American youth to report having been physically assaulted or severely beaten (53% vs. 32%), with 44% of Hispanic boys reporting violence exposure.

**Trauma and Its Impact on Youth**

Traumatic experiences can include not only physical or sexual abuse or assault but also serious accidents, illnesses, disasters, and the loss of important relationships or caregivers. When trauma occurs early in childhood, critical aspects of brain and personality development may be disrupted [9][10]. The ability to self-regulate, which is critical to success in late childhood and adolescence, can be compromised [9]. Trauma in adolescence is often layered on earlier life trauma. Traumatized youth can be from any background, but those who experience significant early life trauma often come from environments in which they are subjected to more stress and have fewer resources to help them develop than children who do not suffer early life trauma. Such children may place themselves in harm’s way for traumatic accidents or violence because of impulsivity and poor supportive relationships [15]. Traumatized adolescents typically do not lack a sense of self or values, but are often too anxious, angry, or confused to rely upon these psychological resources while struggling with a sense of being in constant danger.

Although most youth who experience psychological trauma recover healthy functioning, as many as half of the youth in the juvenile justice system experience chronic health and psychological impairments related to trauma [6]. The reasons why youth in the juvenile justice system seem vulnerable to traumatic stress disorders are complex, and just beginning to be fully understood through scientific research.

Trauma involving victimization by others is more likely than other forms of trauma to lead to impairment in psychosocial functioning and physical health [16]. Although not every
delinquent youth has experienced traumatic victimization, clinical and epidemiological studies indicate that at least three in four youth in the juvenile justice system have been exposed to severe victimization [5] [6] [7].

While most professionals agree that no single risk factor or experience leads a youth to delinquency, the likelihood of offending appears to increase when a teenager is a witness or victim of violence and experiences traumatic stress as a result [9]. When exposed to trauma or mistreatment, a youth may cope by resorting to indifference, defiance, or aggression as self-protective reactions. In these cases, risk taking, breaking rules, fighting back, and hurting others who are perceived to be powerful or vulnerable may become a way to survive emotionally or literally. It is often these behaviors that bring youth into the juvenile justice system.

It is possible that traumatic stress symptoms may worsen as a result of juvenile justice system involvement. Court hearings, detention, and incarceration are inherently stressful, and stressful experiences that are not traumatic per se can exacerbate trauma symptoms. Girls in particular may be susceptible to trauma after incarceration due to their high rates of exposure to traumatic stress and the possibility of retraumatization [8]. Seclusion and restraint in psychiatric units is cited as an example of a practice that can be retraumatizing, [17]. Prescott [18] discusses a cycle of escalating interventions at times of crisis which can lead to increased self-injury and the use of physical restraints by custodial personnel. These interventions include the presence of male security personnel, being strip-searched, force medication, seclusion, precautions which force disrobing, forced physical exams, and invasive body searches.

Theories regarding retraumatization also extend to males. It has been suggested that patterns of retraumatization may contribute to angry acting out among adult men who have experienced trauma as children [19]. While clear empirical evidence is elusive and at times contradictory [20], the potential for retraumatization exists for both boys and girls in the juvenile justice system — especially in confinement settings.

Addressing Trauma Among Youth in the Juvenile Justice System

For the most part, juvenile justice systems have not routinely responded to the trauma histories of youth who come into contact with their system. It has only been within the past decade, as the collective knowledge base on youth exposure to psychological trauma has grown, that there has been a push to improve the juvenile justice system's response to traumatized youth. At the same time that our knowledge of trauma among the juvenile justice population has grown, new approaches for identifying and treating traumatic stress disorders among youth have emerged in the field. While we have much to learn, these developing tools and approaches provide the juvenile justice system, for the first time, the opportunity to intervene with these youth to diminish the impact of traumatic experiences and PTSD [21]. These new resources for assisting traumatized youth are described below.

Trauma Screening. Because behaviors associated with trauma often look very similar to common delinquent behaviors, it is important for juvenile justice staff (and mental health staff working within juvenile justice systems) to recognize that there are multiple pathways to similar symptom patterns [9]. As such, all youth entering the juvenile justice system should undergo a standardized mental health screening to identify the possibility of psychiatric conditions [11] [12], including traumatic stress disorders [4], which require immediate attention or further clinical assessment [22] [23].

Trauma screening typically focuses on two core issues: 1) trauma exposure and 2) traumatic stress symptoms. In terms of exposure, it is important to determine what specific traumas have occurred at what ages, and in what circumstances, in each youth’s life. In terms of symptoms, it is important to determine what specific PTSD or associated traumatic stress reactions or trauma-exacerbated symptoms are interfering with a youth’s ability to think clearly and demonstrate healthy choices and positive growth.

Screening for trauma history and traumatic stress should be performed by appropriately trained staff. Most instrument developers provide guidelines for the level of training and/or education needed to appropriately administer the instrument [23]. Examples of existing screening instruments that can be used to screen for trauma exposure and traumatic stress among youth in the juvenile justice system include:

- **MAYSI-2.** This is a mental health screening instrument frequently used in juvenile justice programs. It is a 52-item self-report instrument that includes a Traumatic Experiences scale, which is used to provide an indication that the youth may have had traumatic experiences and may be experiencing traumatic stress symptoms [24].

- **Traumatic Events Screening Inventory (TESI).** This is a structured clinical interview that briefly assesses a youth, parent or guardian's report of the youth's past or current exposure to a range of traumatic events, including life-threatening or severe accidents, illnesses, disaster, threats, violence or abuse. It has
been shown to reliably and validly identify exposure to traumatic events in children and adolescents in psychiatric and pediatric healthcare samples [20] [25] [26].

PTSD Reaction Index (PTSD-RI). This is a self-report symptom inventory based closely on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for PTSD. Twenty of the items assess PTSD symptoms, and two items assess the associated features of fear of recurrence and trauma-related guilt. The measure has shown evidence of reliability and validity in psychiatric and school samples [27].

Trauma Symptom Checklist for Children (TSCC). This is a 54 item self-report symptom inventory made up of six scales and four subscales designed to evaluate acute and chronic traumatic stress symptoms. The instrument has been found to be reliable and valid in child psychiatric samples [28].

PTSD Checklist for Children/Parent Report (PCL-C/PR). This is a brief measure of PTSD symptom severity completed by parents or other adults who have daily contact with the youth (e.g., detention or probation staff). It has been shown to be reliable and valid with child and adolescent psychiatric and pediatric healthcare samples [25] [26].

**Trauma Assessment.** Trauma assessments are more thorough and time consuming than trauma screenings, and are indicated when a screening suggests that a youth may be suffering from a trauma-related disorder [4]. These assessments typically involve focused, clinical interviews that include, whenever possible, several components:

- A diagnostic interview with the youth [29];
- Interviews with persons who know the youth;
- A review of pertinent collateral (e.g., school, probation) information;
- Observations of the youth within their home or school environment;

In order to be qualified to conduct in-depth traumatic stress assessments with youth in the juvenile justice system, a mental health professional should have specialized training and experience in child and adolescent traumatic stress assessment as well as in the assessment of psychiatric disorders, psychosocial factors and resources.

**Treatment and Rehabilitation of Traumatic Stress Disorders.** Several therapies and interventions currently being adapted and field tested with youth in the juvenile justice system emphasize the development of self-regulation and interpersonal effectiveness skills in their present lives as a way to reduce PTSD symptoms and enhance psychosocial and educational attainment. These include:

- **Trauma Affect Regulation: A Guide for Education and Therapy (TARGET).** TARGET is a strength-based approach designed to enhance self-regulation capacities that are compromised by psychological trauma in childhood [10]. The goal is to help survivors understand how trauma changes the body and the brain's normal stress response into an alarm response, which can become PTSD. TARGET teaches a sequence of practical self-regulatory skills with creative exercises designed to enhance youths' self-esteem and ability to manage anger, impulsivity, grief, shame, and guilt [42] [43].

- **Trauma Recovery and Empowerment Model (TREM).** TREM focuses on long-term cognitive, emotional, and interpersonal consequences of physical and sexual abuse in a supportive skill-building curriculum designed to enhance strengths [44] [45]. TREM was originally designed for women with serious mental health and substance use disorders, but later adaptations of the model include one specifically for adolescent girls (G-TREM).

- **Seeking Safety** [46] [47]. Seeking Safety is a present-focused therapy designed to help people attain safety from trauma, PTSD, and substance abuse. It comprises 25 topics that are divided among cognitive, behavioral, and interpersonal domains. While originally designed for women, the treatment was developed for flexible use and can be used with adolescent females and males. A recent study with substance abusing women found better outcomes with Seeking Safety than treatment as usual in reducing substance use PTSD symptoms [48].

- **Brief Eclectic Therapy.** This is a manualized approach that combines a variety of theoretical viewpoints into five basic components: psychoeducation, image exposure, writing tasks, meaning and integration, and a farewell ritual [49]. Traumatic events are not only imagined but meaning is sought from the event using an approach that integrates cognitive-behavioral, psycho-educational, and psychodynamic therapies [50]. The sharing of traumatic experiences with sympathetic peers and adults was reported to be helpful by incarcerated male delinquents in group treatment [51].
Cognitive-behavioral approaches are frequently used PTSD treatments. Cognitive behavioral therapies combine therapeutic techniques designed to alter problematic beliefs and patterns of thinking (cognitive therapy) and interventions designed to elicit and reinforce adaptive behaviors (behavior therapy). Examples of cognitive behavioral therapies for youth experiencing traumatic stress disorders include:

- **Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)**, which is a short-term, clinic-based treatment for children and youth who are experiencing PTSD as a result of physical or sexual abuse or traumatic violence or losses. TF-CBT utilizes one to one counseling to develop cognitive and behavioral self-management skills, as well as “exposure” therapy in which trauma memories are recalled by the child and then shared by the child with the parent. [32] [33] [34]. However, exposure therapy has not been tested with juvenile-justice involved youth and has been found to be associated with high rates of treatment dropout in some adult studies [35]. Additionally, most research participants in studies of exposure therapy have more stable and secure life circumstances than are possible for many juvenile justice-involved youths and their families [36]. Therefore, caution should be used when using treatments that involve exposure therapy with youth in the juvenile justice system.

- **Eye Movement Desensitization and Reprocessing Therapy (EMDR)**, which is a somewhat controversial technique involving recalling traumatic memories while focusing on personal strengths and engaging in distracting behaviors such as lateral eye movements. EMDR generally is conducted for fewer sessions than TF-CBT, and has shown preliminary evidence of efficacy with conduct-disordered boys [38], child disaster survivors [39], and girls who experienced sexual abuse [40]. EMDR [41] is generally conducted as only one part of a multimodal therapy program rather than a stand-alone treatment.

- **Skills Training in Affective and Interpersonal Regulation (STAIR)**, which is a 16-session one-to-one clinic-based cognitive behavioral therapy targeting emotion management and interpersonal skills. [37] The first eight sessions in STAIR teach a set of self-regulation and interpersonal effectiveness skills, in order to prepare for the final eight sessions in which exposure therapy is conducted. The provision of skills training in affective and interpersonal regulation was found to enhance the efficacy of exposure therapy among women with severe PTSD and histories of childhood abuse [37].

**Pharmacological Treatment.** Clinical trials that support the efficacy of pharmacological treatment of PTSD have been conducted primarily with adults [52]. Medications approved to treat adults with PTSD include selective serotonin reuptake inhibitors (SSRIs), mood stabilizers such as lithium or divalproex sodium (which also has shown promise with youths with explosive temper problems [53]), and medications that help with sleep problems. Anti-depressant medications such as SSRIs are most frequently used [52]. Because of well-publicized concerns regarding potential increases in suicidality associated with the use of SSRIs in children and adolescents, juveniles who are prescribed SSRIs must be carefully monitored (FDA Public Health Advisory, October 15, 2004; FDA Public Health Advisory, June 30, 2005).

**Phase-Oriented Treatment.** Ford and colleagues recommend a three-phase approach to PTSD treatment, employing multiple interventions in stages [43]. In Phase I, emotional regulation and basic coping skills are taught with a primary emphasis on safety and gaining control over intense reactions, impulsive behavior and self-destructive thoughts. Seeking Safety, T.E.A.M., T.A.R.G.E.T., the first phase of STAIR, and Brief Eclectic Therapy are examples of Phase I PTSD interventions. These skill-building interventions are designed to enhance the ability to manage impulses, think clearly, and act effectively in peer, family, school, and institutional (e.g., detention or probation) relationships.

Phase II is more directly “trauma-focused.” Patients begin to explore trauma memories at a pace that is safe, manageable, and not overwhelming. TF-CBT, EMDR, and the second phase of STAIR are examples of Phase II PTSD interventions. Phase II interventions typically require skilled mental health professionals to guide the work on trauma memories and are not truly portable into juvenile justice settings unless managed by clinical staff. Phase III involves confronting the challenge of sustained recovery, including gaining a stable, satisfying, and productive life and also fine-tuning self-regulation skills to manage PTSD symptoms and deal effectively with daily life.

**Implementing Trauma Services within the Juvenile Justice System**

It is important to note that the issue of trauma among children and youth has received attention only recently within the general children’s services field. Concerted efforts to promote the idea of routinely identifying trauma-related disorders specifically among youth in the juvenile justice system and offering appropriate services to address their trauma-specific needs are only now being initiated. As a result, very few juvenile justice settings systematically screen for trauma-related symptoms among youth, very few
have procedures for determining when and how to provide PTSD treatment services or referrals and very few actually provide trauma-informed care. The only exceptions have been in isolated programs [23]. As a positive counterpoint, recent innovations in two state juvenile justice systems and by a national network of traumatic stress programs provide examples of possible new directions for improving the juvenile justice system’s response.

In the state of Connecticut, a systematic screening protocol for traumatic stress and associated behavioral and socio-emotional impairments based upon the TARGET model has recently been implemented [54], TARGET is serving as a foundation for making every detention center, every probation officer working with girls (those working with boys expected to soon follow), and other youth programs trauma-informed. Administrators, line staff, health care staff, probation officers, and community program providers and consulting clinicians have received ongoing consultation to enable them to adapt the TARGET model to each distinct setting with gender sensitivity and cultural competence. Several presentations at national meetings and in national journals [55] have been given by the juvenile justice, judicial, and health care professionals and administrators who are leading this effort. These presentations have documented and described the state’s efforts to promote trauma-informed care for youth in the juvenile justice system.

Florida has a vastly larger juvenile justice system than Connecticut and is implementing a trauma initiative incrementally due to the size of the system. Florida’s Department of Juvenile Justice has determined that trauma exposure is of sufficient prevalence that trauma-informed services are a top priority for all youth involved in the system. Staff within six programs, ranging from large residential detention or treatment centers to smaller specialized girls’ detention and rehabilitation centers to out-bound programs, have received intensive training in the TARGET model, and are beginning to receive ongoing consultation as they revize their policies and procedures and implement milieu and group programs using the self-regulation skills taught in TARGET. A quasi-experimental evaluation study comparing similar programs that do not adopt the TARGET curriculum and clinical model is under review for funding based on a collaboration involving the Florida Department of Juvenile Justice, the University of South Florida, and the University of Connecticut.

On a national level, the Substance Abuse Mental Health Services Administration (SAMHSA)-funded National Child Traumatic Stress Network (www.netsnet.org) has established a juvenile justice work group involving six sites within the 50 plus site network. The Learning Collaborative Model for Innovation and Implementation of Evidence-Informed Practices was used by the Network in a year-long intensive training and consultation process to prepare the six juvenile justice Network sites to implement the TARGET model within probation settings, detention centers, correctional facilities, child protective service units, and court programs serving justice-involved youth. The TARGET model has been adapted for large and small settings of varying degrees of security, as well as in milieu, group, family, and individual counseling and education formats, and at one site as a preparation for Stage II Trauma Focused Cognitive Behavior Therapy.

From a fiscal perspective, the development of trauma services in existing programs and settings need not be expensive. Trauma-informed service delivery may be as cost effective as other prevention and education programs when one considers that a disorder discovered and treated early will have less fiscal impact than one left to be treated later. Shared services and blended funding strategies provide further alternate cost saving [56]. Other strategies for funding include utilization of Medicaid, mental health block grants, Temporary Assistance to Needy Families (TANF), Title IV-E waivers, and state children’s health insurance programs [57].

Summary

Exposure to trauma is often overlooked in the assessment and treatment of youth involved in the juvenile justice system [58]. Given the reported high rates of incidence, screening for trauma should be routinely performed on youth at their earliest point of contact with the juvenile justice system. Further, programming for treating trauma disorders among youth now exists and should be available to youth involved with the juvenile justice system who have histories of traumatic experiences—particularly (but not exclusively) for those who meet criteria for PTSD and complex associated behavioral and self-regulation problems. Efforts in several states to provide trauma-informed care and services to youth suggest that there is growing interest on the part of the juvenile justice community to offer these kinds of services and interventions. Traumatic stress services have the capacity to relieve the suffering caused by psychological trauma and PTSD for youth and families involved in the juvenile justice system, as well as to potentially reduce future health, mental health, and correctional costs. Increased emphasis within the juvenile justice system on trauma treatment, outcomes, and research is a fiscally sound and clinically responsible idea whose time has come.

This Research and Program Brief was edited by Kathleen Skowyr, Senior Consultant for the National Center for Mental Health and Juvenile Justice.
References


About the National Center for Mental Health and Juvenile Justice

Recent findings show that large numbers of youth in the juvenile justice system have serious mental health disorders, with many also having a co-occurring substance use disorder. For many of these youth, effective treatment and diversion programs would result in better outcomes for the youth and their families and less recidivism back into the juvenile and criminal justice systems. Policy Research Associates has established the National Center for Mental Health and Juvenile Justice to highlight these issues. The Center has four key objectives:

- Create a national focus on youth with mental health disorders in contact with the juvenile justice system
- Serve as a national resource for the collection and dissemination of evidence-based and best practice information to improve services for these youth
- Conduct new research and evaluation to fill gaps in the existing knowledge base
- Foster systems and policy changes at the national, state, and local levels to improve services for youth

For more information about the Center visit our website at www.ncmhhj.com.

—Joseph J. Cocozza, PhD, Director
Trauma-Focused Interventions for Youth in the Juvenile Justice System

From the 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
Trauma-Focused Interventions for Youth in the Juvenile Justice System

From the

National Child Traumatic Stress Network
Juvenile Justice Working Group

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Trauma-Focused Interventions for Youth in the Juvenile Justice System

Introduction

Each year, over two million young people come into contact with the juvenile justice system, and hundreds of thousands of children and youth enter correctional facilities of some type. Numerous studies document that many of the youth in the juvenile justice system have been exposed to myriad traumatic events, either as victims or as witnesses. Because of this exposure, many of these youths have developed post-traumatic stress disorder (PTSD) and other stress-related disorders (Arroyo, 2001; Abram et al., 2004; Cauffman et al., 1998; Steiner, 1997; Wasserman et al., 2002; Wood et al., 2002a; Wood et al., 2002b). In addition, arrest and detention experiences themselves can be traumatic events for some children, can expose children to risks for additional trauma, and can also trigger memories and reactions to previous traumatic experiences.

A number of effective trauma-focused treatments have been either designed or adapted for adolescents. Unfortunately, few of these trauma-focused treatments are used much in juvenile justice settings, due to lack of clinical resources in these settings, underidentification of trauma symptoms, and a greater focus on behavioral management issues. Below, we review trauma-focused, family-based, and group-based interventions that show promise for use with youth in the juvenile justice system.

Pretreatment Assessment

Prior to beginning trauma treatment with a youth in the justice system, the therapist should evaluate the youth’s environmental and contextual risk and safety. Trauma-focused treatments are designed to address traumatic stress with youths who are not in imminent danger due to living in unsafe environments. Trauma-focused therapy typically involves teaching skills to reduce hypervigilance, hyperarousal, and intrusive re-experiencing. However, these symptomatic reactions are often appropriate or necessary in currently dangerous environments. Teaching such skills to someone living in a dangerous environment could be harmful in that it may desensitize them to real danger, putting them at greater risk in the future. Exposure to trauma cannot be entirely eliminated in many youths’ lives, but an acceptable level of safety should be established prior to trauma-focused treatment.

Family-focused interventions are widely used as an approach to treatment for youths with PTSD, but there are limitations to their effectiveness if family members are unable or unwilling to invest themselves (Glynn et al., 1999; Copping et al., 2001). Assessment of the parent’s perception of the youth’s traumatic experience(s) and post-traumatic symptoms gives the assessor information about potential strengths or weaknesses in the youth’s family support system, and potential obstacles to parental engagement. Family members may also need to be assessed for their own distress at
having witnessed, caused or failed to prevent the victimization or traumatization of their child. Assessment of parental perceptions, primary or secondary PTSD symptoms or associated distress, and stage of readiness to change is essential to the formulation of a treatment plan.

Trauma-Focused Interventions

Research studies done with the juvenile justice population over the past 10 years show generally that the most effective programs with this population are highly structured, emphasize the development of basic skills, and provide individual counseling that directly addresses behaviors, attitudes, and perceptions (Altschuler, 1998). Cognitive behavioral approaches have been shown to be particularly effective for youth in the juvenile justice system, as well as for children with more general anger and disruptive behaviors.

The US Department of Justice recently published guidelines for the treatment of victims of physical or sexual trauma (Saunders et al., 2003). Given the limited outcome data available on adolescent trauma interventions, all the treatments considered were rated based upon their theoretical bases, clinical-anecdotal literature, acceptance among practitioners, and risk of causing harm.

The only trauma-focused therapy that received a high rating for adolescent trauma treatment was Cohen, Mannarino, and Deblinger’s (2003) Cognitive Behavioral Therapy (CBT) for PTSD (Saunders et al., 2003). This therapy is designed to reduce negative emotional and behavioral responses and correct maladaptive beliefs and attributions related to traumatic experiences. To date there are no known research studies on the use of CBT for trauma with youth involved in the juvenile justice system. But this therapy has been proven effective for youth exposed to a variety of traumatic events and has received the strongest empirical support from studies with abused children (Saunders et al., 2003). This therapy can be used in individual, family, and group therapy and in office- or school-based settings.

Other widely utilized trauma treatments include Cognitive Processing Therapy and Eye-Movement Desensitization and Reprocessing (EMDR). These trauma treatments lack empirical validation with adolescents. Several other therapies that do not address PTSD directly, but do target symptoms and functional problems that are relevant to PTSD, have empirical support and are widely used to address behavioral health problems of youths in the juvenile justice system. These therapies include: Behavioral Parent Training, Multisystemic Therapy (MST), Functional Family Therapy, Treatment Foster Care, Brief Family Therapy (Borduin et al., 2000; Chamberlain and Moore, 2002; Ford et al., 2003; Kashani et al., 1999). Most of these interventions do not report data on cultural differences in technique or outcomes.

Most of the trauma-focused treatments share an emphasis on teaching several key skills including:

1. emotion identification, processing, and regulation;
2. anxiety management;
3. identification and alteration of maladaptive cognitions; and
4. interpersonal communication and social problem solving.

Some interventions also seek to enhance parent-child relationships by promoting positive interactions, reducing negative interactions, and using effective behavior management skills.
Treatment of Co-occurring Disorders

About one-half of juvenile detainees have at least two mental health disorders, and about one in 10 have both a major mental disorder and a substance use disorder. (Abrams et al., 2004). A number of studies indicate that PTSD is commonly comorbid with major depression and to a lesser extent with substance abuse or dependency. (Kilpatrick et al., 2003). In fact, there is some evidence to suggest that some forms of interpersonal violence may heighten the risk for diagnostic comorbidity. Clinicians evaluating youth in the juvenile justice system for mental disorders should also screen for alcohol and drug use and for history of trauma exposure and experience. Integrated substance abuse and mental health treatment should be used for youth who have comorbid disorders.

Family-Based Interventions

Evidence suggests it is important to involve family members in the treatment and rehabilitation of their traumatized children for reasons related both to child and family functioning and to delinquency (Sherman et al., 1998). However, a variety of barriers may exist when involving the families of youth in the juvenile justice system (Ko et al., 2004).

Some juvenile facilities are located far from the home communities of children they detain, making family participation impossible; many families need transportation or other assistance in order to participate in treatment. Families may feel angry, ashamed, or burdened by their child's delinquent behavior and the additional hardship it has brought to the family.

If the parent was a perpetrator (e.g., domestic violence, sexual or physical assault) and the child is still living with or in regular contact with that parent, the parent may not yet have accepted responsibility for the traumatic event(s). Nonoffending parents may experience loyalty conflicts between the victim and the perpetrator. They also may feel significant distress and helplessness due to not having been able to prevent the victimization. Parents who witness their children's exposure to trauma may experience significant post-traumatic stress, and this has been shown to be associated with traumatized children's levels of PTSD (Winston et al., 2002). Finally, caregivers themselves may be victimized or abused, or suffer from depression, anxiety, or traumatic stress. They may feel unable to help their children.

There is growing evidence from studies of children exposed to different types of trauma that less parental distress and more familial support mitigates the negative impact of trauma on children. For example, several studies have directly examined the impact of including a parent component in trauma-focused cognitive behavioral therapy sessions. These studies have demonstrated that interventions that help the parent resolve emotional distress about the child's trauma, and which optimize the parent's ability to be supportive of the child, are likely to improve the child's outcome (Cohen, Mannarino, and Deblinger, 2003).

There are different approaches to conducting clinical intervention with families. These approaches include shared family sessions in conjunction with individual or group treatment for the child, group or individual treatment with adjunctive family/parent sessions, family therapy, and family group therapy.

Therapists need to be especially alert to family members who were together during a traumatic experience. Not only do family members have very different psychological needs and different courses of recovery, but family members can actually serve as traumatic reminders to each other. One goal of therapy is to help family members anticipate, identify, and manage trauma and loss reminders. The family also needs to be aware of and be respectful of the differences in psychological
needs and course of recovery. Another goal of therapy should be to improve understanding, timely support and tolerance among family members, and to repair trauma-related estrangement.

Beyond post-traumatic stress responses, it is critical for families to develop a plan to address the secondary adversities, including demands on parents and children, changes brought about by the trauma or loss, continued medical care, and skills needed to cope with what happened.

Group-Based Interventions

Two controlled studies indicate that grouping delinquent or high-risk youth may inadvertently reinforce problem behaviors (Dishion, 1999). This research finding is most relevant to adolescents ages 11 to 14. It is important to note that not all interventions with peer groups have shown adverse effects. Some strategies to guard against these potential adverse effects include involving parents in treatment, mixing antisocial and prosocial youth in groups, limiting group size, and using cofacilitators in groups so that inappropriate behaviors can be addressed immediately prior to peers’ reinforcement of the negative behavior.

Summary

Juvenile justice facilities have an opportunity to raise the standard of care for youth by providing effective trauma-focused treatments and family-based interventions. Additionally, since some youth express trauma symptoms behaviorally, treatments that address trauma symptoms can also be expected to assist juvenile justice staff with issues related to behavioral management.
References


Victimization and Juvenile Offending

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
Victimization and Juvenile Offending

From the

National Child Traumatic Stress Network
Juvenile Justice Working Group

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Victimization and Juvenile Offending

Introduction

Children of all ages in the United States are increasingly being exposed to violence and victimization. While the types of violence and levels of exposure differ for children of different ages, rates of interpersonal violence and victimization of 12-to-17-year-olds in the United States are very high. In fact, Department of Justice statistics show that teenagers experience rates of violent crime far higher than other age groups do. Witnessing violence is even more common than victimization.

Violent victimization can have a number of deleterious and long-lasting affects on how teenagers see the world and the way they function socially, interpersonally, and academically. It can affect their behavior, their problem solving skills, and their ability to modulate their feelings and reactions, and it can eventually give rise to patterns of conflict and aggression toward others.

While the relationship of child maltreatment to later arrest and offending has been understood for a number of years, researchers are now beginning to better document and understand the significant connection between other forms of violent victimization and juvenile offending as well.

Judges, teachers, counselors, juvenile justice personnel, and other professionals need to understand the significant effect that victimization has on the behavior, attitudes, and functioning of adolescents, and what they can do to mitigate its effects.

Rates of Adolescent Victimization Are High

Over the past 10 years, a number of large adolescent and general population studies have confirmed the high prevalence rates of victimization and violence exposure among children and adolescents. For example:

- In 2002, the Department of Justice reported that the violent crime rate for adolescents ages 16 to 19 was over twice the rate for people ages 25 to 34 and three times the rate for adults ages 35 to 49 (Finkelhor and Dziuba-Leatherman, 1994).

- The National Survey of Adolescents, a general population survey of over 4,000 adolescents ages 12 to 17, found that 13 percent of females and 3.4 percent of males reported being sexually assaulted at some point in their lives, 21.3 percent of boys and 13.4 percent of girls reported experiencing lifetime physical assault, and 43.6 percent of boys and 35 percent of girls reported having witnessed violence (Kilpatrick et al., 2003b).
• Boney-McCoy and Finkelhor (1995) conducted a national telephone sample of over 2,000 youth ages 10 to 16 and found that over 35 percent reported having been the victim of an assault and another 5.4 percent reported an attempted assault.

• Lewis et al. (1997) found that as many as 91 percent of youth in low-income, inner-city neighborhoods have witnessed at least one incident of community violence.

• The National Women’s Study found that 62 percent of forcible rapes reported by adult women occurred before the age of 18 (Kilpatrick and Acierno, 2003).

• Schwab-Stone et al. (1995) reported that over 40 percent of the youth in an urban school district reported being exposed to a shooting or stabbing in the past year, and 74 percent reported feeling unsafe in one or more common environmental contexts.

Victimization Can Have Profound and Long-Lasting Effects

While some children survive victimization with relatively few adverse consequences, many studies show that victimization can disrupt the course of child development in very fundamental ways and can contribute to problems over the course of a life span. Numerous studies over the past 10 years have shown a clear relationship between youth victimization and a variety of problems in later life, including mental health problems, substance abuse, impaired social relationships, suicide, and delinquency (OVC, 1999; Kilpatrick et al., 2003a; Wood et al., 2002). Violent victimization during adolescence is acknowledged as a risk factor for violent crime victimization, domestic violence perpetration, and problem drug use in adulthood (Ford, 2002).

Observing violence—as opposed to being the direct victim of violence—also can severely traumatize a child and bring on a cascade of negative consequences. Research shows that childhood exposure to domestic and community violence, for example, can cause children to engage in aggressive behavior, suffer from problems such as depression and anxiety, have lower levels of social competence and self-esteem, experience poor academic performance, and exhibit posttraumatic stress symptoms such as emotional numbing and increased arousal (Colley-Quille et al., 1995; ABA, 2000; Osofsky, 1999).

Some researchers report that chronic environmentally pervasive violence, such as living in violent neighborhoods, affects children in ways similar to living in war zones. They develop symptoms such as anxiety, helplessness, futurelessness, numbness, and difficulties concentrating. Furthermore, children in such environments may become desensitized to threat and engage in high levels of risk taking and participate in dangerous activities (Schwab-Stone et al., 1995).

Adolescents may respond to traumatic victimization in ways that differ from younger children. Fears or memories of traumatic events may intrude and may trigger angry or avoidant responses. Adolescents may respond to their experience through dangerous reenactment behavior, recklessness, or protective aggression. Because of their age and stage of moral development, some adolescents experience feelings of shame and guilt about a traumatic event and some may express fantasies about revenge and retribution.

Adolescents understand issues of justice and accountability. A traumatic event, especially one that goes unaddressed, may foster a radical shift in the way an adolescent thinks about the world and his or her belief in safety, protection, and the social contract.
The Relationship of Child Maltreatment to Later Delinquency and Violence Is Clear

There also appears to be a significant relationship between victimization and later delinquency and perpetration of violence. A growing body of research indicates that victims of violence are more likely than their peers to also be perpetrators of violence, and that individuals most likely to be victims of personal crime are those who report the greatest involvement in delinquent activities (ABA, 2000; Shaffer and Ruback, 2002; Wiebush et al., 2001).

Much of the research on the relationship between victimization and later offending has focused on child maltreatment, and researchers generally have used two basic approaches to conduct the research. The first approach is to sample maltreated children and follow them to observe rates of subsequent offending. Studies using this approach have yielded consistent and profound results.

Cathy Widom’s research, for example, has reported that people who experience any type of maltreatment during childhood—whether sexual abuse, physical abuse, or neglect—are more likely than people who were not maltreated to be arrested later in life, either as a juvenile or an adult. Being abused or neglected as a child increased the likelihood of arrest as a juvenile by 59 percent and as an adult by 28 percent, and for a violent crime by 30 percent. The abused and neglected cases were younger at first arrest, committed nearly twice as many offenses, and were arrested more frequently (Widom, 1995; Widom and Maxfield, 2001).

Data from the Rochester Youth Development Study show that a history of maltreatment significantly increases the risk of being arrested for violent, serious, and moderate forms of delinquency and the frequency of arrests, even when controlling for race, sex, social class, family structure, and mobility (Smith and Thornberry, 1995).

Of course, it is important to remember that the majority of maltreated youth are not arrested and do not report involvement in serious delinquency.

The second approach is to sample juvenile or adult offenders and measure the rate at which they experienced maltreatment in childhood. In numerous studies, delinquent and criminal populations have strikingly higher rates of childhood abuse and neglect than do members of the general population (ABA, 2000; Harlow, 1991; cited in Ososky, 2001; Haapasalo and Kankkonen, 1997; Harlow, 1999; cited in Wiebush et al., 2001; Haywood et al., 1996; Menard, 2002; Ryan et al., 1996).

Research Also Connects Other Types of Victimization to Delinquency and Violence

Other studies have focused on victimization more broadly and its relationship to later violence or delinquency. These studies have looked at a variety of types of physical and sexual assault, rape, severe corporal punishment and discipline, as well as exposure to various forms of domestic and community violence.

Data from the National Survey of Adolescents (Kilpatrick et al., 2003b) is particularly striking:

- 47.2 percent of the sexually assaulted boys reported engaging in delinquent acts, compared with only 16.6 percent of those not sexually assaulted.
- The rate of girls who had been sexually assaulted and then committed delinquent acts was 19.7 percent, five times higher than the rate of girls who had not been sexually assaulted (4.8 percent).
- The percentage of boys who were physically assaulted and had ever committed an Index offense was 46.7 percent, compared to 9.8 percent of boys who were not assaulted.
- 29.4 percent of physically assaulted girls reported having engaged in serious delinquent acts at some point in their lives, compared with 3.2 percent of nonassaulted girls.
- About one third (32 percent) of boys who witnessed violence reported ever engaging in delinquent acts, compared with only 6.5 percent of boys who did not witness violence.
- About 17 percent of girls who witnessed violence reported lifetime delinquent behavior, compared with 1.4 percent of girls who did not witness violence.

Schwab-Stone et al. (1995) conducted a comprehensive survey with over 2,200 students in an urban school system. They found that students who reported committing violence or serious aggressive acts against others also reported significantly greater violence exposure.

DuRant et al. (1994) found that self-reported use of violence by black adolescents was significantly correlated with three indications of previous exposure to violence: self-reported exposure to violence and victimization in the community, degree of family conflict, and severity of corporal punishment and discipline. This study also looked at age, mental health problems, and other variables and found that previous exposure to violence and victimization was the strongest predictor of use of violence.

Several studies found that violence exposure was linked with adolescent criminal activity, including both general delinquency and Index offenses, even after controlling for demographic characteristics and protective factors (Brown et al., 1999; Menard, 2002).

**Why Are Victimization and Committing Offenses Related?**

Various researchers have studied this issue and come up with different explanations for the relationship. Some researchers point out that violent victimization and violent offending share many of the same risk factors (Shaffer and Ruback, 2002). Other researchers note that victims and victimizers share many homogenous social, situational, and environmental characteristics and lifestyles (Fagan, Piper, and Cheng, 1987).

Some researchers, especially those who study gang behavior, suggest that criminal behavior evolves in the context of a subculture and is learned through interaction with others, especially delinquent peers. Social learning theory suggests that violence may be learned through experiencing it or observing it and that it may be transmitted from one generation to the next in a "cycle of violence."

**Many Researchers Believe Trauma to Be an Explanatory or Contributing Factor to the Development of Aggressive Behavior**

Some researchers believe that victimization and oppositional-defiance involve similar breakdowns in a child’s capacities required to regulate emotions and process social information (Ford, 2002). Others have cited the role PTSD plays in perpetuating violence, particularly through interfering in daily living, causing inappropriate reactions, fostering intrusive reliving of trauma, and avoidance (Steiner et al., 1997). Still others describe a pathway where violence exposure and pervasive feelings of not being safe develop into a state of chronic threat which in turn requires a youth to adjust his or
her behavior, feelings and self-concept and makes the youth more willing to use physical aggression (Schwab-Stone et al., 1995).

The question of whether or not victimization predicts offending or vice versa has not been addressed in many studies on the subject, but was explored by Shaffer and Ruback (2002). They found that, indeed, violent victimization is a warning signal for future violent offending. It is also a precursor to being a repeat victim of violence.

**What Can Be Done to Short-Circuit this Cycle of Victimization and Subsequent Violence?**

*Target Interventions to those Groups Most Likely to Be Victimized*

Neither victimization nor offending are normally distributed across the general population. Clearly, some groups are at higher risk than others for violent victimization, including minority adolescents (Kilpatrick et al., 2003b; Finkelhor and Ormrod, 2000), children living in single-parent families (Lauritsen, 2003), adolescents living in urban areas (Horowitz et al., 1995), children who have been victimized previously, children with disabilities (Charlton et al., 2004), and children living in disadvantaged communities (Lauritsen, 2003). Prevention efforts, public education efforts, and early intervention efforts are best targeted to these groups.

*Improve Reporting of Youth Victimization*

Numerous studies point to the fact that a majority of victimizations of juveniles, including serious violent victimizations such as aggravated assault, murder, forcible rape, and robbery, are not reported to police or other authorities (Lauritsen, 2003; Kilpatrick et al., 2003b; Finkelhor and Ormrod, 1999; Boney-McCoy and Finkelhor, 1995; Osofsky, 2001; Shaffer and Ruback, 2002). Contributing factors for not reporting may include adolescent concerns about personal autonomy, fears of being blamed or not taken seriously, fears of retaliation, fears of being punished for engaging in risk-taking behavior or associating with deviant peers, family concerns about involving their child in the justice system, and the perception of both youth and adults that offenses against youth are not real crimes. The justice system needs to increase youth reporting by emphasizing its interest in assisting juvenile victims, removing the disincentives to reporting, making staff more available and accessible, and changing the way people think about crimes against juveniles. Communities need to provide incentives to report, including information to help youth protect themselves from future victimization or from retaliation.

*Intervene Early with Juvenile Victims*

Violent victimization is a warning signal for future violent offending among juveniles and also a precursor to additional violent victimization (Shafer and Ruback, 2002). This means that focusing counseling and other early interventions on victims and repeat victims is important. Given that there is some evidence to suggest that offending and subsequent victimization occur fairly soon following violent victimization, interventions may be most successful in preventing future offending and victimization if they are applied relatively soon after the initial victimization.

*Screen Youth in Substance Abuse and Delinquency Programs for Violence and Trauma Exposure*

Given the connection between victimization and both substance abuse and delinquency, adolescent alcohol and drug use programs and juvenile justice programs should screen youth entering for a history of violent assault and witnessing violence.
Increase Awareness that Various Kinds of Juvenile Victimization Are Crimes
Professionals must try to educate parents and their children about the importance of reporting victimization. Too many youth still believe that reporting is a sign of weakness or betrayal. Too many adults are still unaware of the profound ramifications of youth victimization.

Publicize the Availability of Crime Compensation Funds for Juvenile Victims
Communities need to do more to publicize the availability of crime compensation funds and supportive services for adolescent victims. They also need to expedite and simplify the processing of crime compensation awards for juveniles.

Summary

While most professionals agree that no single risk factor or experience leads a young person to delinquency (Wasserman et al., 2003), the chances of offending clearly increase when a teenager is a witness or victim of violence and experiences traumatic stress as a result. Being victimized increases the likelihood of committing later offenses and engaging in aggressive and violent behavior. It also increases the likelihood of being victimized again.

Protecting juveniles against violent victimization of all types needs to be a priority for community leaders, policy makers, and professionals. Along with preventing future problems like substance abuse, suicide, and mental health problems, reducing rates of victimization and responding early to young victims to offset the adverse consequences of victimization may actually lessen the severity of juvenile violence and crime in society as a whole.
References


Resources

Trauma & Juvenile Justice

National Child Traumatic Stress Network
- Home page www.netsn.org
- Juvenile Justice page http://www.netsn.org/resources/topics/juvenile-justice-system
- Empirically Supported Treatments and Promising Practices for traumatic stress/PTSD http://www.netsn.org/resources/topics/treatments-that-work/promising-practices

Special Issues of Journal of Child and Adolescent Trauma on Trauma and Delinquency http://www.tandfonline.com/toc/wcat20/current
- Part I: Trauma and Juvenile Delinquency: Dynamics and Developmental Mechanisms (2012, volume 5, issue 2)
- Part II: Trauma and Juvenile Delinquency: New Directions in Interventions (2012, volume 5, issue 3)

Evidence-Based Practices for Working with Juvenile Offenders

National Center for Mental Health & Juvenile Justice http://www.ncmhjj.com/resources/default.shtml
This site includes several reports outlining practice guidelines for working with offenders with mental health problems and developing partnerships between the JJ and mental health systems.

Models for Change http://www.modelsforechange.net/index.html
Funded by the MacArthur Foundation, this initiative supports efforts to reform the juvenile justice system through the development and sustainability of effective new strategies. Website includes reports on best practices.

This database of over 200 evidence-based programs for juvenile offenders covers the entire continuum of youth services from prevention through sanctions to reentry.

Reclaiming Futures http://www.reclaimingfutures.org/
The website for this Robert Wood Johnson-funded initiative includes regular updates on innovative models for working with juvenile offenders and juvenile justice reform efforts around the country.