NCTSN The National Child Traumatic Stress Network

Assessing Exposure to Psychological Trauma and Posttraumatic Stress Symptoms in the Juvenile Justice Population

National Child Traumatic Stress Network
Center for Trauma Recovery and Juvenile Justice
And the Network Juvenile Justice Working Group

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

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National Child Traumatic Stress Network
www.NCTSNet.org

2014

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

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

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Introduction

Screening and assessment of traumatic stress and its psychosocial after-effects play an important role in a trauma-informed juvenile justice system. Trauma exposure and its negative consequences are highly prevalent among justice-involved youth. For example, a frequently replicated finding is that over 80 percent of detained youth report exposure to at least one potentially traumatic event and the majority of youth report multiple forms of victimization (e.g., Abram et al., 2004; Dierkhising et al., 2013; Ford et al., 2008; Kerig et al., 2011, 2012; Wood et al., 2002). Longitudinal research also demonstrates that childhood trauma is predictive of adolescent delinquency (Ford, Elhai, Connor, & Frueh, 2010) and that, once youth are on a delinquent course, trauma is associated with the severity of youths' offenses and their likelihood of recidivism (see Kerig & Becker, 2014 for a review). Further, while youth are in detention, exposure to traumatic stressors is associated with problem behaviors which can endanger youths as well as staff (DeLisi et al., 2010). Consequently, trauma-informed screening and assessment have value in helping to align youth with the most appropriate interventions and services, directing scarce resources to those most in need, and increasing the physical and emotional safety of both youth and staff.

Thorough assessment of trauma also is a prerequisite to preventing the potentially severe problems in biological, psychological, and social functioning that can occur when PTSD and/or associated behavioral health disorders go undetected and untreated (Nader, 2008). Although, like adults, most youth who experience a single traumatic stressor do not develop PTSD (Nader & Fletcher, 2014), many youth in the juvenile justice system have experienced the kinds of multiple, chronic, and pervasive interpersonal traumas that are most likely to result in serious symptoms (Ford, Grasso, Hawke, & Chapman, 2013; Kerig et al., 2012). Unresolved posttraumatic stress in turn can lead to serious long-term consequences into adulthood (Briere, 1997), such as problems with interpersonal relationships; cognitive functioning; mental health disorders, including PTSD; substance abuse; anxiety; disordered eating; depression; self-injury; conduct problems—all of which can increase the likelihood of involvement in the justice system (Ford, 2009; Friedman, Keane, & Resick, 2014; Kerig & Becker, 2014).

Types of Trauma Exposure Among Justice-Involved Youth

The majority of youth in the juvenile justice system report experiencing multiple types of trauma, termed polyvictimization (Finkelhor et al., 2011; Ford, Grasso, Hawke, & Chapman, 2013). Girls are especially likely to endorse having experienced interpersonal traumas, particularly sexual abuse and assault (Cauffman et al., 1998; Kerig et al., 2009, 2011; 2012; Martin et al., 2008; Wood et al., 2002). For example, Dierkhising and colleagues (2013) found that, among the 658 youth in the NCTSN Core Data Set who became involved with the juvenile justice system, the average number of traumatic events endorsed was 4.9. Among these youth, 61 percent reported experiencing traumatic loss or bereavement, 51.7 had an impaired caregiver, 51.6 percent had been subject to domestic

violence, 49.4 percent had undergone emotional abuse, 38.6 percent had been physically abused, and 34% had been exposed to community violence. For more than half of the youth, the onset of their first traumatic experience was within the first five years of life. Further, girls were twice as likely as boys to report sexual abuse (31.8 percent versus 15.5 percent) and girls were over four times more likely than boys to have experienced sexual assault (38.7 percent versus 8.8 percent).

Prevalence of Posttraumatic Stress Disorder Among Justice-Involved Youth

Estimates of the prevalence of posttraumatic stress disorder (PTSD) in the juvenile justice population are more variable, due to differences in the way that PTSD is assessed from study to study. Methods of assessment vary as a function of the type of instrument (e.g., a structured clinical interview versus self-report); the way the questions are presented (e.g., via an in-person interview versus a computer-administered questionnaire); the trauma(s) to which symptoms are indexed (e.g., the youth's one worst traumatic experience as opposed to the entire history of trauma exposure); the informant (e.g., the youth versus a caregiver); the time frame assessed (i.e., symptoms during the current month, past year, or lifetime); and the strictness with which PTSD is defined (e.g., whether partial as well as full PTSD is considered). These variables may affect youths' willingness to acknowledge traumatic experiences as well as yielding different kinds of data. Consequently, estimates of the prevalence of PTSD in samples of juvenile justice-involved youth range widely, between 5 percent and 52 percent for girls and between 2 percent and 32 percent for boys, with an overall prevalence rate of about 30 percent (Kerig & Becker, 2012). These rates are up to eight times higher than those seen in community samples of same-age peers (Wood et al., 2002).

Screening vs. Assessment

A useful distinction can be made between screening and assessment. Screening refers to a very brief form of evaluation designed to identify youth who may be in need of a closer look. Screening typically is implemented universally and at an early point of contact, such as to all youth when they enter a detention facility. Because screening does not involve establishing a diagnosis, it can be conducted by any staff member with only minimal training, and is highly cost-effective. However, although screening can be effectively conducted by staff members who are not mental health professionals, it is nonetheless important that training be provided to assist these staff to respond in helpful ways to youth disclosures and to provide them with skills to cope with vicarious traumatization that may follow from hearing about distressing events that have occurred to youth

In contrast, assessment refers to a more comprehensive clinical evaluation that is designed to establish whether a youth meets criteria for a diagnosis or is in need of mental health services—as well as to guide treatment planning and monitoring of progress in (as well as adverse reactions to) treatment. Therefore, assessment requires formal clinical training, and assessment for trauma and PTSD involves additional specialized clinical knowledge.

Trauma Screening	Trauma Assessment
Universal	Targeted
Cost-effective	Comprehensive
Descriptive	Diagnostic
Can be conducted by non-clinicians	Requires a trained mental health professional
Can be implemented at initial system contact	Involves referral for psychological assessment
Used to determine whether referral for assessment is indicated	Used to formulate a case conceptualization and treatment plan, monitor progress, evaluate outcomes, and detect/prevent adverse reactions
Can guide trauma-informed and trauma-responsive programming and procedures	

Screening can be used to serve a number of purposes, and consideration of these may help to guide agencies and facilities regarding what screening device would be most useful and most easily accommodate with their available capacities, procedures, and needs. For example, a screening procedure designed to document a youth's trauma history may look different from one whose purpose is to help staff to develop a trauma-informed safety plan to prevent a youth from endangering him- or herself or others while in care. Institutional readiness and capacity to conduct universal screening, as well as to implement follow-through to use this information to refer youth to trauma-informed services, also requires consideration.

Questions to Consider When Planning to Implement Trauma Screening
What is the goal of screening youth involved in or at risk for involvement in juvenile justice? • Document youths' trauma history? • Provide information requested from courts, protection workers, attorneys, or others? • Inform adjudication or disposition decisions? • Identify youth in need of referral for trauma-specific mental health assessment or treatment? • Identify youth at risk for adverse reactions to detention, probation, or court procedures? • Inform a trauma-informed safety plan to reduce harm to self or others while youth are in care? • Increase staff's ability to work effectively with youth?
What is the institution's readiness to implement screening? • Are staff and resources available to conduct screening? • Are effective measures available? • Is there training available to equip staff to respond sensitively and effectively to youth disclosures and to protect staff from vicarious traumatization?
Who will see the screening findings, and how will they be utilized? • What is the youth's state of mind and understanding of the purpose of trauma screening, and how might this affect her/his ability and willingness to respond accurately and completely? • How will disclosures be handled in keeping with mandated reporting laws? • Will youths' privacy and rights to avoid self-incrimination be protected?
What capacities are available to implement follow-though after screening? • Are resources available to refer youth in need to trauma-informed behavioral health assessments? • Are trauma-informed behavioral health services available and accessible to the youth and family? • How will the institution's and staff's practices be adapted in ways that are trauma-informed?

Screening for Traumatic Stress History

A common strategy for psychological trauma screening is to inquire about a youth's history of exposure to potentially traumatizing events. Screening tools for history of exposure to psychological trauma vary widely in their length and comprehensiveness. For example:

- the Adverse Childhood Experiences (ACE) Scale (available at http://acestudy.org/yahoo_site_admin/assets/docs/ACE_Calculator-English.127143712.pdf) asks questions about 10 kinds of adversity including maltreatment, assault, and family/parental mental health and substance use problems
- The Rapid Assessment of Pediatric Psychological Trauma (RAPPT) (available from jsugar@usc.edu) asks about maltreatment, witnessing or experiencing violent assault (including due to bullying or to punishment by adults), traumatic deaths, and life-threatening accidents, disasters, or illnesses, as well as emotional abuse, physical neglect, and a resilience item (relationships providing security/safety). Separate versions are provided for youth self-report and parent informants
- The UCLA PTSD-Reaction Index for Children/Adolescents–*DSM*-5 (information about costs and ordering copies available from ASteinberg@mednet.ucla.edu) asks about 13 types of

potentially traumatic events including maltreatment, family, school, and community violence, traumatic deaths, war, disasters, and life-threatening accidents or medical care. Separate versions are provided for youth self-report and parent informants

- The Structured Trauma-Related Experiences and Symptoms Screener (STRESS) (available from dgrasso@uchc.edu) asks about 24 types of adverse or potentially traumatic events including maltreatment, family, school, and community violence, war, traumatic deaths, and life-threatening accidents, disasters, or illnesses and medical care, as well as emotional abuse, physical and educational neglect, and homelessness. Separate versions are provided for youth self-report and parent informants
- The Traumatic Events Screening Inventory for Children (TESI-C) (available from jford@uchc.edu) and Parent Report Form (TESI-PRR) (available from Chandra.ghosh@ucsf.edu) asks about 24 types of adverse or potentially traumatic events including maltreatment, family and community violence, war, kidnapping, animal attacks, traumatic deaths, and life-threatening accidents, disasters, or illnesses and medical care, as well as emotional abuse, physical neglect, having a parent incapacitated by mental health or substance use problems, and witnessing a caregiver being arrested. Separate versions are provided for youth interviews or self-report and parent informants
- The Juvenile Victimization Questionnaire Screener Sum Version (available at http://www.unh.edu/ccrc/jvq/available_versions.html) has 32 items which cover a wide range of childhood interpersonal victimization experiences (e.g., being robbed, bullied, assaulted, maltreated, subjected to racism)
- The Childhood Trust Events Survey (available at childhoodtrust.org) includes 30 items. It is available in a child self-report and caregiver version in English and Spanish, as well as an adolescent self-report version. It is based on the TESI and the Adverse Childhood Experiences Survey, with four additional questions added to the adolescent version regarding experiences of interpersonal violence such as being shot at or stabbed

The mental health screener most widely-used in juvenile justice settings, the Massachusetts Youth Screening Inventory-2 (MAYSI-2, Grisso & Barnum, 2002), includes a Traumatic Experiences (TE) scale with 5 Items. A particular advantage to the MAYSI-2 is that it can be administered via computer with the youth listening to the items over headphones, thus allowing the measure to be comprehensible to the many youth in the juvenile justice system with poor literacy skills. Research to date suggests that the MAYSI-2 TE under-detects youths with histories of exposure to traumatic stress and has modest sensitivity and specificity for identifying traumatized youth and thus this measure is best used in conjunction with other sources of information rather than as a stand-alone tool for trauma screening (Ford, Chapman et al., 2008; Kerig et al., 2011).

One limitation to note is that the sensitivity of any trauma exposure scale will be limited to the specific events it inquires about. For example, sources of toxic stress commonly experienced by inner-city youth (e.g., being shot at; having a caregiver who is incapacitated by drugs) are not included in some trauma screens. The language used may limit youth disclosures as well. For example, many young women do not use the term “rape” for unwanted sexual experiences, especially when those were drug- and alcohol-facilitated or perpetrated by romantic partners; similarly, youth who have undergone chronic sexual, physical, or psychological maltreatment at the hands of caregivers may not label those experiences “abuse” (Kerig et al., 2011). With the exception of the MAYSI-2 (which uses the term “rape”), the screening instruments listed above do not use these types of potentially ambiguous terms, but instead describe specific actions or behaviors that the youth may have observed or experienced.

A further consideration is that, given that the overwhelming majority of justice-involved youth will report having experienced traumatic events, screening for trauma exposure alone might not meet the needs of agencies that want to use screening to help them to triage so as to distribute scarce

resources by targeting the subset of youth who are most in need. Not all youth who have undergone potentially traumatic events will have been "traumatized" sufficiently to develop persistent posttraumatic stress symptoms that impair their psychological development and their ability to engage in relationships, school, work, and other important activities. However, it also is true that youth who are highly resilient in the face of adversity may be functioning well despite coping with chronic or episodic posttraumatic stress symptoms.

Screening for Posttraumatic Stress Symptoms

In contrast to screening measures that focus on youths' past history of exposure to traumatic events, an alternative approach is to screen for the presence and frequency or severity of symptoms that are indicative of posttraumatic stress reactions in the present. This may be done as a follow-up to questions about past exposure to traumatic stressors, or in lieu of inquiring about trauma history.

Most PTSD symptom screening measures have become out-dated due to major additions to the set of symptoms that constitute PTSD in the 2013 5th Revision of the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*. In brief, the key changes in DSM-5 are:

- Clarification that for children, intrusive re-experiencing symptoms reflecting unwanted distressing memories and flashbacks may include repetitive play involving re-enacting themes, events, and/or behaviors from past traumatic events, and nightmares may take the form of frightening dreams that have vague or ambiguous content.
- Symptoms of behavioral and mental avoidance now comprise their own cluster and are separated from a new cluster of symptoms that reflect post-trauma negative changes in beliefs and emotions. These symptoms include emotional numbing (inability to recognize positive emotions, feeling detached from other people, amnesia for important parts of traumatic events, belief that one's life will be cut short), and new symptoms involving persistent negative beliefs about oneself, distorted blame of self or others for the traumatic events, and emotional distress in the form of anger, guilt, shame, horror and/or fear). PTSD thus now includes symptoms that reflect the well documented potentiation of the development of maladaptive schemas regarding the self, the world, and the future by exposure to traumatic stressors in childhood, which can lead youth down a pathway of increasing psychological risk factors related to delinquency (Ford, Chapman, Mack, & Pearson, 2006).
- The hyperarousal cluster now includes symptoms of verbal or physical aggression and reckless or self-destructive behavior, which also may contribute to delinquency (Ford et al., 2006; Kerig & Becker, 2010).
- Two symptoms of dissociation (depersonalization and derealization) have been added to identify individuals with a dissociative sub-type of PTSD.

Two PTSD symptom screening instruments for youth (and for parents to report their observations of their child's PTSD symptoms) include all of the new *DSM-5* symptoms:

- The UCLA PTSD-Reaction Index for Children/Adolescents–*DSM*-5 (information about costs and ordering copies from ASteinberg@mednet.ucla.edu) (youth self-report and parent forms)
- The Structured Trauma-Related Experiences and Symptoms Screener (STRESS) (available from dgrasso@uchc.edu) (youth self-report and parent/caregiver forms)

Even briefer trauma symptom screeners have been developed specifically for use in the juvenile justice system (e.g., Benamati, 2002; Kerig, 2014). These screeners focus on posttraumatic symptoms and avoid asking detailed questions about trauma history, which may make them useful in circumstances where there are concerns about the implications of disclosures. These screeners

also may serve clinical and practical purposes in settings in which the time required to administer, score, or interpret longer screeners is prohibitive. However due caution is needed regarding how the results of these instruments are interpreted and what use is made of them, given that to date their validity and reliability are not empirically established and scores are not indexed to DSM or other diagnostic criteria.

Complex PTSD. The World Health Organization International Classification of Diseases 11th Edition is in development (scheduled for completion in 2015 or 2016) and includes a proposed sub-type of Complex PTSD (cPTSD; Cloitre et al., 2012; Knefel & Schuster, 2013). No questionnaire or interview measures have as yet been developed and psychometrically and clinically evaluated to assess cPTSD in children or adults, but a semi-structured interview and clinician rating scale for cPTSD has been preliminarily validated with adult trauma survivors (Ford et al., in review) and an adaptation for children and adolescents is being tested clinically with juvenile justice-referred youth (information available from the NCTSN Center for Trauma Recovery and Juvenile Justice, jford@uchc.edu). The Symptoms of Trauma Scale, Child/Youth Version (SOTS-C) is a 12-item scale with behaviorally-anchored ratings for the frequency and severity of PTSD and cPTSD (emotion, somatic, interpersonal, behavioral, self, and sexual dysregulation) symptoms which can be scored to screen for the severity of *DSM*-IV or *DSM-5* PTSD (including the dissociative sub-type) or *ICD-11* cPTSD.

An adaptation of cPTSD designed to identify symptoms specific to childhood and adolescence has been formulated, Developmental Trauma Disorder (DTD; Ford et al., 2013). Simultaneously with the field testing of *ICD* PTSD and cPTSD criteria, the second phase of a field trial study is underway in the United States to validate a structured interview assessing the proposed DTD criteria, which are based on evidence of three domains of dysregulation that are consistent sequelae of exposure to both interpersonal traumatic stressors (e.g., abuse, violence) and loss or compromise of security with primary caregivers in early childhood (e.g., neglect, abandonment, out-of-home placements): emotion/somatic, attention/behavioral and self/interpersonal dysregulation (D'Andrea et al., 2012). The DTD Semi-Structured Interview will be made available through the National Child Traumatic Stress Network when the validation field trial results are complete in 2015 (information available from the NCTSN Center for Trauma Recovery and Juvenile Justice, jford@uchc.edu).

Assessment for the Diagnosis of Posttraumatic Stress Disorder

Structured clinical interviews are considered to be the "gold standard" for establishing the diagnosis of PTSD. A number of structured interviews for children and adolescents or their parents were being revised to conform to the criteria for the PTSD diagnosis in *DSM*-5 at the time this Fact Sheet was completed. Updates on several of these structured interviews for PTSD diagnostic assessment (e.g., the Clinician Administered PTSD Scale for Children and Adolescents, CAPS-CA) can be found at the website of the National Center for PTSD (http://www.ptsd.va.gov/professional/assessment/DSM_5_Validated_Measures.asp).

In addition to establishing whether or not the PTSD diagnosis "fits" the youth, assessors also may find it valuable to consider noting when youth meet only partial criteria for PTSD. Partial or sub-clinical PTSD has been defined as the youth having experienced a traumatic event (Criterion A) and demonstrating symptoms that either (1) meet diagnostic criteria for at least two of the remaining PTSD symptom clusters or (2) include at least one symptom from each of the PTSD symptom clusters. Many children and adolescents fail to meet all the criteria for the PTSD diagnosis while still having symptoms that are severe enough to interfere with functioning (Cohen & Scheeringa, 2009), including youth involved in delinquency or the juvenile justice system (Ford et al., 2012). Further, specific symptoms may be particularly relevant to justice-involved youth. For example, PTSD symptoms of believing that one's life will be cut short, risk-taking, and emotional numbing have all been implicated in developmental models of the origins of delinquency (Ford et al., 2006; Kerig &

Becker, 2010; Pynoos et al., 2009).

Assessment of Other Mental Health Problems Often Seen Among Traumatized Youth in the Juvenile Justice System

Although determining whether a youth meets criteria for a diagnosis of PTSD is valuable, particularly for ensuring that youth are directed to appropriate mental health services, a comprehensive assessment will go beyond only establishing the presence of this particular diagnosis. The experience of trauma in childhood acts as a "gateway" to the development of many disorders, in addition to or aside from PTSD (Kenardy, De Young, & Charlton, 2012). For example, Ford and colleagues (2008) found that, in their sample of detained youth, only 19 percent of those who had experienced traumatic stressors met criteria for a full or partial diagnosis of PTSD. Instead drug and alcohol abuse and suicidal ideation emerged as important consequences of trauma exposure.

Apart from diagnosing other specific mental health disorders, an alternative strategy, consistent with the National Institute of Mental Health's Research Domain Criteria (RDoc) initiative (http://www.nimh.nih.gov/research-priorities/rdoc/index.shtml), is to assess dysfunctions in underlying developmental processes that might be disrupted by trauma (Kerig & Becker, 2010). In particular, childhood trauma is associated with disruptions in the development of a number of constructs for which measures have been developed, including emotional, cognitive, and behavioral self-regulatory processes (e.g., Cruz-Katz, Cruise, & Quinn, 2010; Ford, 2009), fundamentally altered beliefs about self, relationships, and the future (e.g., Meiser-Stedman et al., 2009), perceived stigma (e.g., Feiring et al, 2007), alienation (e.g., Jessness, 1972), risk-taking (e.g., Pat-Horenczyk et al., 2007), and hopelessness (e.g., Kazdin et al., 1996) among others; see Ford (2011) for a review of specific measures and their psychometrics.

In addition, maltreatment, traumatic loss, and caregiving disruptions can interfere with the development of secure internal working models of attachment, thus contributing to the disturbances in the ability to connect with others in mutually satisfying and healthy ways, interpersonal dynamics for which some self-report measures have been normed specifically for justice-involved youth (e.g., Moretti, McKay, & Holland, 2000). Youth who have been removed from their families and placed out-of-home (e.g., in foster or adoptive homes, group homes, residential treatment programs) are particularly at risk, especially if they have been moved multiple times and have experienced disruptions in primary attachment relationships (Ford, Connor, & Hawke, 2009). These are so-called cross-over youth, because they literally have crossed over from the child protection system to the juvenile justice system. Cross-over youth are at high risk for further victimization, and often become deeply entangled in the juvenile justice system due to aggressive or defiant behavior that is a tragic example of post-traumatic reactive aggression, i.e., attempts to prevent further victimization that take the form of verbal or physical aggression (Ford, Chapman, Connor, & Cruise, 2012). Assessing for PTSD symptoms can be an important way to determine whether this is aggression is reactive (i.e., self-protective) as opposed to aggression that is primarily proactive or instrumental (i.e., motivated by an enjoyment of or indifference to others' injury or suffering).

Disclosures: Issues of Informed Consent, Privacy, Mandated Reporting, and Self-Incrimination

There are important legal considerations to be made before embarking on trauma screening or assessment (Feierman & Fine, 2014). It is crucial for the professional administering the measures to have clearly in mind, and to convey clearly to the youth and/or family, what the purpose is of the evaluation and who will have access to the information provided. In particular, at the outset, all parties should have a clear understanding of the extent to which youth and caregivers have the choice to provide or withhold informed consent versus whether responding to these measures is

court-ordered or compulsory. Youth and/or caregivers also should be informed whether the youth's responses will be held private versus whether they will be shared with detention staff, legal counsel, judges, probation officers, or others. Finally, it is important to be clear about whether the purpose of the evaluation is to inform adjudication decisions versus whether the purpose is to solely determine needs for services or care.

Even when screenings or assessments are not mandated by the court or facility, and youth are given the right to refuse to provide information, youth may choose to make disclosures about traumatic experiences. Such disclosures may bring in to play mandated reporting laws, with which staff administering these measures should be knowledgeable and prepared to comply (Feierman & Ford, 2015). In addition, youth may disclose information during screening or assessment that has relevance to their charges or probation status (e.g., when traumatic events have occurred during the course of youths' participation in illegal activities, probation violations, involvement with illicit substances, etc.). Some jurisdictions have statutes that protect youth's rights to avoid self-incrimination by excluding from consideration in legal proceedings any information providing during the course of mental health screening or assessment, and others restrict such information to being used only post-adjudication; however, other jurisdictions have no such protections. A helpful overview of these statutes state by state has been compiled by The National Juvenile Defender Center (2014).

Particularly when screening or assessment involves administering measures that inquire about trauma history, another important clinical consideration is the youth's state of mind regarding the purpose of the questions being asked and who will have access to the responses the youth provides (Kerig, 2013). Boys who have experienced sexual abuse, for example, may be highly sensitive to the possibility of this information being shared with others, especially with other males (Friedrich, 1997). Such concerns may lead youth to under-report their experiences with certain kinds of trauma.

In sum, because of these issues regarding privacy, mandated reporting, and self-incrimination, it is important for the professional conducting a screening or assessment to convey clearly to the youth at the outset what the purpose is of the evaluation, whether or not the caregiver and/or youth have the right to consent/assent to the process, how the information will be used and who will have access to it, and whether there are limits to confidentiality. To the extent that the assessor can factually assure youth and caregivers that the information will be used in ways that will be helpful and not inadvertently harmful to them—and that this will be the case regardless of what they disclose—their reports are likely to be more complete and accurate. Most desirable would be for the circumstance under which assessment or screening is conducted to be one that allows assessors to be able to accurately and honestly convey to youth and families that the purpose of the questions is to be helpful by connecting youth with the most appropriate resources or services.

Additional Clinical Considerations

Safety

Safety is paramount not just for the youth but also for his/her caregiver(s) and significant others (e.g., siblings). Any assessment of youth in the juvenile justice system must begin with an evaluation of the youth's current environmental and contextual risk. Safety has both an objective (e.g., determining if the youth or caregiver currently is experiencing, or is imminently at risk for, further trauma experiences) and subjective (e.g., the youth and caregiver's sense of personal safety) dimension (Newman, 2002). Both objective safety and the subjective sense of safety can take on very different forms as children and adolescents progress developmentally. If a youth is still living in a dangerous environment, the assessor must work to ensure that the youth is safe. This may require evaluating the extent of the risk, availability of supports in the home or nearby, and the

ability of the youth to seek help if needed. Assessors should be prepared to advocate for minors and involve additional resources if safety is of concern.

Further, a number of features of juvenile justice courts, facilities, or detention settings themselves may be experienced as unsafe for traumatized youth (Dierkhising & Marsh, 2014). Youth in detention in particular may be exposed to verbal or physical aggression from peers or staff which may exacerbate trauma symptoms that the youth is already experiencing, including hypervigilance, hyperarousal, or intrusions of traumatic images (Ford & Blaustein, 2012). Assessors should be cognizant of youths' perception of their environment and be ready to advocate for them when concerns related to safety arise.

Likewise, an assessor's ability to provide a genuinely safe setting while inquiring about emotionally painful and difficult experiences or symptoms depends upon knowledge of and sensitivity to the different ways that youth may experience a lack of safety in the juvenile justice context. Juvenile processing includes a variety of settings (e.g., police contacts, detention or incarceration sites, diversion and community-based rehabilitation programs, probation offices, courts) and legal issues (e.g., minor deviance, mandated reporting, court or probation directives) that may influence the youth or caregiver's willingness and ability to disclose information about traumatic experiences or posttraumatic symptoms. As noted above, in juvenile justice settings, safety therefore also involves explaining clearly to the youth and family, and reliably maintaining, definite boundaries and limits concerning confidentiality and sharing of clinical information (e.g., mandated reports or requests for information by courts, correctional staff, child welfare workers, or probation officers).

Multiperspective Assessment

Multiperspective assessment reduces the likelihood that unintended bias or distortion will occur due to information based on any individual informant. The perspective of the youth is important because other informants (e.g., caregiver, teacher) may over-report symptoms or only report overt symptoms (e.g., acting out behaviors) while ignoring more subtle PTSD or internalizing symptoms (e.g., anxiety, sadness, or internal distress). However, other informants are vital because youth who are traumatized may underreport symptoms that caregivers recognize as problematic. Newman (2002) recommends a "multi-modal" approach to trauma assessment (i.e., multiple informants and multiple forms of assessments, such as interviews and self-report instruments). Observations or collateral information from others who are knowledgeable about a youth's functioning at home and in the community (i.e., caregivers, teachers, peers) can provide valuable sources of ecologically valid information (Nader, 2008).

Developmental and Ethnocultural Factors

Developmental and ethnocultural factors should be taken into consideration when establishing rapport with youth and their caregivers (Nader, 2007). The optimal wording and order of questions may vary for youth of different ages, developmental levels, ethnicities, and cultural backgrounds. What constitutes a *symptom* (versus expected age-appropriate behaviors) may differ ethnoculturally. For example, the behavior of an American Indian boy who averts his eyes when speaking to an adult should not necessarily be perceived as avoidant but as consistent with Native cultural norms of respectful communication. Youth of different ages and ethnocultural backgrounds also may respond differently to interview versus questionnaire formats, as well as to assessors with different styles and backgrounds.

Apart from chronological age, cognitive and developmental delays should also be considered in the assessment process. Youth in the justice system average two years behind expected grade level (Wasserman et al., 2002) and therefore many of these have reading skills below grade level and/or have learning disabilities or developmental disabilities that may inhibit or confound their comprehension and ability to respond to written instruments. Some researchers have found that

adolescents are more comfortable reporting to a computer, rather than a person, about issues that are highly sensitive or are illegal (e.g., sexual behavior, drug use, violence) (Turner et al., 1998). Assessors need to remember that many caregivers also may be non- readers and may be intimidated by or unable to understand questionnaires.

Many screening and assessment tools for trauma and PTSD have not been translated into other languages or normed on members of diverse groups. This is particularly of concern given that youth from cultural and ethnic minority groups are overrepresented in juvenile justice settings, with the overrepresentation growing as they move deeper into the system. For example, Snyder (1996) found that while African American youth represented only 15 percent of the population, they were involved in 28 percent of all arrests and 50 percent of all violent crime arrests. Race and ethnicity also influence the probability of arrest and the severity of consequences faced by youth at every stage of the juvenile court process (Stevens & Morash, 2014). There have been many recommendations and strategies put forth for addressing overrepresentation of minorities and racial bias in the juvenile justice system (e.g., Juvenile Justice and Delinquency Prevention Act of 2002).

Source for Further Information

Reviews of a screening and assessment instruments for trauma exposure, posttraumatic symptoms, PTSD, and associated mental health problems are included in a database on the National Center for Child Traumatic Stress website (www.NCTSNet.org). Included in the review of each instrument is information about its previous use with juvenile justice populations and its availability in different languages, appropriate age ranges, comprehension levels, and administration times.

Summary and Conclusion

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

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