



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

Introduction

Screening and assessment of exposure to traumatic stressors and its psychosocial after-effects play an important role in a trauma-informed juvenile justice system. Trauma exposure and its negative consequences are significantly more prevalent among justice-involved youth than the adolescents in the larger community (Ariga et al., 2008). For example, a frequently replicated finding is that over 80% of detained youth report exposure to at least one potentially traumatic event and most youth report multiple forms of victimization (e.g., Abram et al., 2004; Charak et al., 2019; Dierkhising et al., 2013; Ford et al., 2008, 2013a; Kerig et al., 2011, 2012; Wood et al., 2002).

Longitudinal research also demonstrates that childhood exposure to psychological trauma is predictive of adolescent involvement in delinquency (Ford, Elhai, Connor, & Frueh, 2010). Once youth are on that trajectory further exposure to traumatic stressors is associated with more severe offenses and recidivism (see Kerig & Becker, 2014). Further, while youth are in detention, exposure to further traumatic stressors is associated with problem behaviors which can endanger youth as well as staff (DeLisi et al., 2010; Dierkhising et al. 2014; Mendel, 2011). Consequently, trauma-informed screening and assessment have value in helping to provide 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 (Ford, Kerig, Desai, & Feierman, 2016).

Thorough assessment of traumatic stress is also 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. Although, like adults, most youth who experience a single traumatic stressor do not develop PTSD (Fairbank et al., 2015; Kerig, 2017). 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 (Charak et al., 2019; Kerig et al., 2009; Ford, Grasso, Hawke, & Chapman, 2013). Unresolved posttraumatic stress, in turn, can lead to serious long-term consequences into adulthood, 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, 2020; Ford et al., 2012; 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 (Charak et al., 2019; Finkelhor et al., 2011; Ford et al., 2013a). Girls are especially likely to endorse having experienced interpersonal traumas, particularly sexual abuse and assault (Cauffman et al., 1998;

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Chaplo et al., 2017; Kerig et al., 2009; Martin et al., 2008). For example, Dierkhising and colleagues (2013) found that trauma-exposed youth in the NCTSN Core Data Set who were recently involved with the juvenile justice system reported rates of trauma exposure significantly greater than trauma-exposed peers who were not justice-involved. The justice involved youth reported an average of 4.9 different types of traumatic events: over 60% reported experiencing traumatic loss or bereavement, 51.7% had an impaired caregiver, 51.6% had been subject to domestic violence, 49.4% had undergone emotional abuse, 38.6% 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 versus 15.5%) and girls were over four times more likely than boys to have experienced sexual assault (38.7 versus 8.8%). When polyvictimization begins in early childhood and continues through the school years and adolescence, as is often the case for justice-involved youth, this cumulative trauma exposure is associated with severe emotional, behavioral, social, learning, and posttraumatic stress problems (Dierkhising et al., 2019). Additionally, when polyvictimization begins in early childhood it leaves an adverse legacy of emotional, behavioral, social, and learning problems even if the youth is not exposed to victimization after those crucial first years of life. When polyvictimization occurs in adolescence – including because of justice involvement—even youth who had been relatively free from trauma exposure earlier in their lives can develop serious emotional problems (Dierkhising et al., 2019).

It also is important to note that the over-representation of youth of color and LGBTQ+ youth in the juvenile justice system means that many justice-involved youth have experienced – or are continuing to experience (Auguste et al., 2021; Charak et al., 2023) – chronic traumatic stressors that are due to racism (Allwood et al., 2021a, b) and homophobia and transphobia (Charak et al., 2023). The discrimination and stigma resulting from these identity, and culturally, based biases leads many justice-involved youth to have experienced profound violence and other life-altering losses, adversities, and disparities in their communities and schools. Also, in the course of contacts with law enforcement and then in the courts and downstream juvenile justice system (Dierkhising et al., 2014).

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 youth's 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% and 52% for girls and between 2% and 32% for boys, with an overall prevalence rate of about 30% (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).

The prevalence of youth involved in the juvenile justice system who are experiencing the much broader range of posttraumatic stress symptoms that do not qualify for a PTSD diagnosis but greatly interfere with their daily functioning, relationships, school attendance and academic performance, and ability to use good judgment in potentially illegal or dangerous situations, is even higher. Of the 80% or more youth involved in juvenile justice who have trauma histories, many do not meet criteria for PTSD but have posttraumatic stress symptoms (PTS) such as flashbacks, avoidance of trauma reminders, emotional numbing and dysregulation, negative beliefs about themselves, relationships and the future, and hyperarousal and hypervigilance. These beliefs can result in impulsive, aggressive, dissociative, or rule-breaking behavior which puts them at risk for continued and deeper involvement with law enforcement and juvenile justice (Bennett et al., 2015; Ford et al., 2006; 2013a, 2016; Kerig

et al., 2012). With the expansion of the criteria for PTSD in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5), many of these more complex posttraumatic stress reactions are now understood as part of PTSD. However, they may also occur for youth who have experienced extensive adversity and do not fully meet the criteria for a PTSD diagnosis (Charak et al., 2019; Ford et al., 2013a).

Therefore, it is important not to limit the goal of trauma-informed screening and assessment with justice involved youth to identifying only those who meet all criteria for PTSD. Trauma screening and assessment should aim to identify any justice-involved youth who need help in recovering from traumatic stress symptoms, including those not diagnosed with PTSD. The initial focus may be on the symptoms that comprise a PTSD diagnosis, but the presence of any PTSD symptom(s) that interfere with a youth's functioning and safety should be taken as the red flag indicating a need to follow up with trauma-informed services that include an assessment of related symptoms that may be trauma impacted (e.g., depression, anxiety, conduct problems, substance abuse or other addictions) rather than prematurely limiting the assessment only to the 20 symptoms comprising PTSD. Many trauma-exposed youth develop symptoms extending beyond those of PTSD. These may take the form of complex PTSD as defined by the International Classification of Diseases (Version 11) – including dysregulated emotions, detachment from relationships, and a self-image as a failure and worthless (Haselgruber et al., 2020). As well as Developmental Trauma Disorder –including dysregulated emotions, psychological and somatic dissociation, alexithymia, difficulty in completing goals, lack of concern about personal safety, self-injury and suicidality, oppositional-defiance, reactive aggression, and extreme detachment from or enmeshment in troubled relationships (Ford et al., 2021). Thus, screening and assessment should include careful consideration of the many possible self-protective survival strategies that children and youth adopt initially as adaptations when exposed to traumatic stressors and that persist into adolescence and beyond as maladaptive trauma-related symptoms.

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 need a closer look (i.e., more in-depth assessment of trauma-related symptoms). Screening typically is implemented universally and at an early point of contact, such as when they are placed on probation or enter a diversion program or a detention facility. Because screening does not involve establishing a diagnosis, it can be conducted by any staff member who has received training on the process. The staff member conducting the trauma-related screening procedures should be receiving ongoing supervision from a trauma-specialist clinician to ensure that screening is done, and screening results are used appropriately. As such, screening can be highly cost-effective. Although screening can be effectively conducted by staff members who are not mental health professionals, it is nonetheless important that training and supervision be provided by trauma specialist clinicians for the benefit of the staff as well as the youth. This includes assisting these staff to respond in helpful ways to youth's disclosures of traumatic experiences or traumatic stress symptoms, 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 needs mental health services due to symptoms that do not meet criteria for a diagnosis but are causing impairment in functioning, relationships, or other important areas of life. Assessment serves as a 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 traumatic stress reactions 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 several specific purposes. Consideration of these may help to guide agencies and facilities decide the screening device that would be most useful and most easily accommodate with their available capacities, procedures, and needs. For example, a screening procedure designed to document 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 themselves 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
<p>What is the goal of screening youth involved in or at risk for involvement in juvenile justice?</p> <ul style="list-style-type: none"> ■ Document youth’s trauma history? For what purpose, and with what follow-up when past or current exposure to traumatic stressors is identified for a youth? ■ Provide information requested from courts, protection workers, attorneys, or others? ■ Inform adjudication or disposition decisions? (This generally requires more in-depth assessment than is possible for screening, except if the question is whether the court should order a trauma/ PTSD assessment as part of the disposition of the youth’s case,) ■ 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 due to posttraumatic stress reactions that may be triggered by those 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 based on an understanding of the youth’s past or current traumatic experiences and trauma-related symptoms?

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 youth's privacy and rights to avoid self-incrimination be protected?

What capacities are available to implement follow-through 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 are institution and staff practices being adapted in ways that are trauma-informed, to ensure that results of screening are translated into effective programming?

Screening for History of Potentially Traumatic Experiences

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 – however, note that the ACE Scale developers urge caution in using this to identify individual youth because it is not designed or validated as a screening measure (Anda, Porter & Brown, 2020).
- The Rapid Assessment of Screener for Childhood Attachment, Adversity, Trauma, Impairment and Resilience (SCAATIR) asks about maltreatment, witnessing or experiencing violent assault (including bullying and punishment by adults), traumatic deaths, and life-threatening accidents, disasters, or illnesses, as well as emotional abuse, physical neglect, race-based victimization, 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 (RI-5) (Doric et al., 2019; Kaplow et al., 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) (Grasso et al., 2015) 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) (Daviss et al., 2000) (available from <https://www.ptsd.va.gov/professional/assessment/documents/TESI-C.pdf>) and Parent Report Form (TESI-PRR) (Choi et al., 2019) asks about 24 types of adverse or potentially traumatic events. These events include maltreatment, family and community violence, war, kidnapping, animal attacks, traumatic deaths, and life-threatening accidents, disasters, or illnesses and medical care. It also includes emotional abuse, physical neglect, having a parent incapacitated by mental health or substance use problems, and witnessing a caregiver being arrested as events as well. Separate versions are provided for youth interviews or self-reports 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 youth in the juvenile justice system with poor literacy skills. Research to date suggests that the MAYSI-2 TE under-detects youth 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 traumatic experiences' 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). Apart from the MAYSI-2 (which uses the term "rape"), the screening instruments listed above do not use these types of potentially ambiguous and stigmatizing terms, but instead describe specific actions or behaviors that the youth may have observed or experienced.

A further consideration is that, given that most 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 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" such that they develop persistent posttraumatic stress symptoms that impair their psychological development and their ability to engage in relationships, school, work, and other important activities. On the other hand, screening for youth's past or current exposure to traumatic experiences could identify youth who are highly resilient in the face of adversity. It may also identify youth who are relatively asymptomatic and functioning well despite coping with chronic or

episodic posttraumatic stress symptoms—and for whom trauma-focused intervention could be beneficial as a means of preventing delayed or re-activated posttraumatic stress symptoms that could be triggered by new stressors now or in the future.

Screening for Posttraumatic Stress Symptoms

In contrast to screening measures that focus on 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.

Some older symptom screening measures have become outdated 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 themes, events, and/or behaviors related to 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 separate 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 now includes symptoms that reflect the development of maladaptive schemas regarding the self, the world, and the future following 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, 2019; Modrowski, Mendez & Kerig, 2021).
- Two symptoms of dissociation (depersonalization and derealization) have been added to identify individuals with a dissociative subtype of PTSD (Bennett et al., 2015).

Three 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 (RI-5) (Pynoos & Steinberg, 2014; includes both youth self-report and parent forms in English as well as Spanish. It is one of the most widely used and well-validated trauma screeners for youth (Doric et al., 2019; Kaplow et al., 2020; Modrowski, Munion, Kerig, & Kilshaw, 2021), and has been utilized in numerous studies of justice-involved youth (Charak et al., 2019, Modrowski, Mendez et al., 2019, 2021).
- The Structured Trauma-Related Experiences and Symptoms Screener (STRESS) (Grasso et al., 2015) includes both youth self-report and parent/ caregiver forms and can be administered in paper-and-pencil form or via an innovative computerized survey that provides a scored report. Its psychometric properties and utility have been demonstrated in several samples, including justice-involved youth (Grasso et al., 2018).

- The Child PTSD Symptom Scale for DSM-5 (CPSS-5) (Foa et al., 2018) updates this well-utilized measure to conform to DSM-5 criteria. After establishing the presence of trauma exposure, the 27-item measure provides subscale scores for intrusion, avoidance, changes in cognition and mood, and arousal; additional items assess impaired functioning. Both youth self-report and interview versions are available and there is good evidence for reliability and validity.

Ultra-brief trauma symptom screeners have also been developed and are particularly useful for settings in which only a brief time period is available, and screening is being conducted by frontline staff without specialized training in trauma assessment.

- The UCLA PTSD-RI Brief Form (RI-5-BF) (Rolon-Arroyo et al., 2020) reduces the RI-5 to the 11 items that proved to be the most informative in identifying PTSD risk among clinical samples of children and adolescents. Research confirms the scale's reliability and clinical utility.
- A brief screening version of the CPSS-5 (Foa et al., 2018) also is available, which includes the 6 items most frequently endorsed and with the highest mean score among those youth who met criteria for a PTSD diagnosis. This screener shows adequate internal consistency and good test-retest reliability.
- The University of Minnesota's Traumatic Stress Screen for Children and Adolescents (TSSCA) (Donisch et al., 2015) includes one question about trauma exposure and 5 questions regarding the frequency of core PTSD symptoms, such as intrusions, avoidance, and hypervigilance. Research indicates good reliability and comparability to the RI-5.
- The Child Trauma Screen (Lang & Connell, 2017, 2018) is a 10-item measure that includes a trauma exposure scale as well as six PTSD symptom items. The screener has proven to have good psychometric properties, validity, and sensitivity and specificity in detecting PTSD among clinically referred children and adolescents. Both youth and caregiver reports are available.
- The Brief Trauma Symptom Screen (BTSSY) (Tyler et al., 2019) was developed specifically for youth in residential care and assesses 4 DSM-5 PTSD symptoms: intrusive memories, recurrent dreams, physiological reactions to reminders, avoidance, detachment, and hypervigilance. Research supports its reliability, and it shows fair correspondence with the RI-5 and psychiatrists' diagnoses of PTSD.
- The Care Process Model includes a variety of instruments for children of different ages and different levels of risk. Most relevant to justice-involved samples, the Adolescent and Pediatric Traumatic Stress Screening Tool for ages 11 and above (available at <https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529796906>) is based on an adaptation of the RI-5-BF. One question asks about exposure to trauma and 12 posttraumatic stress symptoms are rated, as well as one question about suicidality. Unique to this measure is a Roadmap of Care which provides recommendations regarding next steps for providing intervention or support, depending on the severity and types of symptoms youth endorse. The measures are available in both English and Spanish.
- A brief 14-item version of the Child Report of Posttraumatic Symptoms (CROPS) has shown predictive validity in detecting trauma exposure and posttraumatic reactions in samples of adjudicated youth (Edner et al., 2017; 2020)
- The 10-item PTSD Screening Inventory (PSI) (Kerig, 2014) was developed specifically for use in the juvenile justice system. This measure avoids asking youth detailed questions about their past trauma history and instead focuses on the presence of posttraumatic symptoms in the present. An additional question asks about current risk and safety concerns. The PSI also includes specific PTSD symptoms that are often edited out of other brief screeners, such as risky behavior, given that research has shown they implicated in the association between trauma and adolescent justice-involvement (Kerig, 2019; Modrowski & Kerig, 2019). Preliminary results show good correspondence to the UCLA PTSD-RI and predictive validity in forecasting challenging behaviors in the detention setting.

PTSD according to the ICD-11. Complicating the story further, the recently released World Health Organization International Classification of Diseases 11th Edition defines PTSD with a different set of criteria that are focused on a more limited set of core symptoms. This version of the PTSD diagnosis requires:

- Exposure to an “extremely threatening or horrific event”
- Re-experiencing of the event, such as in intrusive memories, flashbacks, or nightmares
- Avoidance of thoughts, people, or situations that are reminiscent of the event
- Persistent perceptions of being under current threat

To date, one measure has been developed to assess PTSD according to the ICD-11 criteria among youth. The International Trauma Questionnaire-Child and Adolescent Version (ITQ-CA) (Cloitre et al, 2018) includes 6 questions regarding posttraumatic symptoms as well as questions regarding whether those symptoms interfere with functioning. The measure has shown good validity and reliability with clinical samples of children and adolescents (Haselgruber et al., 2020).

Complex PTSD. The ICD-11 also includes a separate diagnosis of Complex PTSD (CPTSD) (Cloitre et al., 2013), defined as a specific set of symptoms that follow in the aftermath of longstanding interpersonal traumas, such as repeated child abuse, prolonged domestic violence, or torture. These symptoms include:

- Meeting criteria for the diagnosis of PTSD
- Problems with affect regulation
- Diminished self-esteem and feelings of shame, guilt, or failure
- Difficulties sustaining relationships of feeling close to others

The International Trauma Questionnaire-Child and Adolescent Version (ITQ-CA) (Cloitre et al, 2018) includes 6 questions regarding CPTSD symptoms as well as questions regarding whether those symptoms interfere with functioning. In addition, the Symptoms of Trauma Scale, Child/Youth Version (SOTS-C) (Ford et al., 2015) is a 12-item scale with behaviorally-anchored ratings for the frequency and severity of PTSD and CPTSD (emotional, 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 subtype) or ICD-11 CPTSD.

In addition, an adaptation of CPTSD designed to identify symptoms specific to childhood and adolescence has been formulated, termed Developmental Trauma Disorder (DTD) (van der Kolk et al., 2009). This proposed diagnosis is 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; Ford et al., 2013). The DTD Semi-Structured Interview (DTD-SI) (Ford et al., 2018, 2022; Spinazzola et al., 2018; van der Kolk et al., 2019) solicits a caregiver’s ratings on each of the symptoms of the proposed disorder and has demonstrated good reliability and validity in initial field trials (available from www.complexttrauma.org).

Assessment for the Diagnosis of Posttraumatic Stress Disorder

Structured clinical interviews are the “gold standard” for establishing the diagnosis of PTSD. Several 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); Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS) trauma-related disorders supplement) 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 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. As noted above, 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 (or is experiencing PTSD symptoms that are compromising their functioning or safety even if not diagnosed with PTSD) is valuable. Particularly it is valuable for ensuring that youth are directed to appropriate mental health services as a comprehensive assessment will go beyond only establishing the presence of this particular diagnosis. The experience of psychological trauma in childhood acts a “gateway” or contributor 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% 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 childhood psychological 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 exposure to psychological trauma is associated with disruptions in the development of a number of problems for which measures have been developed, including emotional, cognitive, and behavioral self-regulatory processes (e.g., Cruz-Katz, Cruise, & Quinn, 2010; Ford, 2020), 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, 2003), 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 (Spinazzola, van der Kolk, & Ford, 2018) that place them at risk for the development of many internalizing (e.g., anxiety, depressive, psychotic) and externalizing (e.g., attention deficit, oppositional defiant, and conduct disorders) (van der Kolk et al., 2019). These youth and their families often become involved in several service systems in addition child protective services (such as law enforcement, juvenile justice, community mental health, and social services). It is important that the results of trauma screening and assessment are shared by providers across these systems so that each youth receives trauma-informed services in every system in which they become involved (see the NCTSN guide for trauma-informed services for youth involved in multiple systems, <https://www.nctsn.org/resources/a-trauma-informed-guide-for-working-with-youth-involved-in-multiple-systems>).

When youth become involved with law enforcement and juvenile justice after having first been in the child protective services system, they are known as “crossover youth” because they have crossed over from services designed to protect them into services designed protect the public by preventing delinquency (see the NCTSN guide to trauma informed practice with crossover youth, <https://www.nctsn.org/resources/developmental-approach-trauma-informed-practice-crossover-youth>). Crossover 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; Stimmel et al., 2013). Assessing 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, the purpose of the evaluation and who will have access to the information provided. 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 or 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 youth’s 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 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 youth are still living in a dangerous environment, the assessor must work to ensure that they are 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, several features of juvenile justice courts, facilities, or detention settings themselves may be experienced as unsafe for traumatized youth (Dierkhising & Marsh, 2014). Youth in detention 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 youth's perception of their environment and be ready to advocate for them when concerns related to safety arise.

Likewise, an assessor's ability to provide a genuinely safe setting, while inquiring about emotionally painful and difficult experiences or symptoms, depends upon knowledge of and sensitivity to the different ways 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 traumatic stress 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.

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, and with sensitivity to the compounded adversity when youth with developmental, intellectual, or learning disabilities have been exposed to traumatic adversity (Hoagwood et al., 2007). 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 have reading skills below grade level and/or have learning 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 not be able to read 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. 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 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.NCTSN.org). Included in the review of each instrument is information about its previous use with juvenile justice populations and availability in different languages, appropriate age ranges, comprehension levels, and administration times.

Summary and Conclusion

Several approaches and instruments are available for the juvenile justice professional, clinician, or researcher seeking to conduct screening or assessment of traumatic stress exposure and/or PTSD symptoms, with youth in juvenile justice settings and their caregivers. Relatively few of these instruments, however, have been evaluated with juvenile justice populations or 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 psychological 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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