

Spotlight on Juvenile Justice: Understanding Trauma and Justice-Involved Youth

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Upon entering juvenile detention at age 16, Julian struggled to adjust. He was irritable, quick to anger with little provocation, and had difficulties sleeping and eating. He received write-ups for his behavior after involvement in fights with other residents. One of the fights led to additional charges filed for assault. Julian was evaluated for mental health symptoms and met criteria for posttraumatic stress disorder related to community violence exposure and severe cannabis use disorder. His mental health assessment revealed that Julian's neighborhood had higher rates of community violence compared to other surrounding areas. When Julian turned 16, he witnessed one of his close friends die by firearm violence. Julian began to have nightmares and constantly felt on edge. He smoked marijuana more frequently and in greater quantities to help him sleep and avoid thinking about his friend's death. He obtained a firearm from his friends and began to carry it around for protection.

Trauma is pervasive throughout the juvenile justice system. For justice-involved youth, child maltreatment is highly prevalent and vastly underrecognized. In a population of over 1,800 detained juveniles, 83% self-reported history of physical abuse; however, formal maltreatment court records existed for only 17% of youth self-reporting any abuse, 22% of youth self-reporting the most serious abuse, and 25% of youth self-reporting abuse that required medical attention.¹ Overall, adverse childhood experiences (ACE) are overrepresented within juvenile justice. In the original ACE study of a large population of insured mostly college-educated adults, 36% reported zero ACEs and 13% reported four or more ACEs; in a population of 64,329 juvenile offenders in Florida, 2.8% reported zero ACEs and 50% reported 4 or more ACEs.² More broadly, trauma is alarmingly common in juvenile justice as more than 90% of detained youth report

exposure to life-threatening trauma, over half who experience 6 or more life-threatening traumas, and over 1 in 10 juveniles who meet criteria for posttraumatic stress disorder (PTSD) (most commonly related to witnessed violence).³ Additionally, mental health problems that frequently co-occur with trauma exposure are prevalent in detained youth, such as substance use disorders, depression, anxiety,⁴ and suicidal thoughts and behaviors.⁵

Trauma exposure can profoundly affect neurodevelopment. Models of emotional development illustrate that in typically developing youth, emotional reactivity to negative stimuli declines and regulatory capacity increases with age. Current neural models implicate various regions of the brain, including the dorsolateral prefrontal cortex, amygdala, and hippocampus, in the regulation of emotional reactivity.⁶ Childhood trauma may influence the development of these regions, increasing the risk of affective disorders for these youth and resulting in dysfunctional development of fear-related neurophysiological patterns affecting emotional, behavioral, cognitive, and social functioning.^{6,7} Persistent activation of the stress response system, the hypothalamic-pituitary-adrenal axis, can lead to increased levels of adrenaline and cortisol through the body, and this overactivation may influence the changes in the structure of the brain.⁷

Retrospective surveys of adverse experiences and prospective studies of maltreatment find that children who experience trauma are at risk of poorer developmental and health outcomes because of direct harm through injury, indirect harm from insecure attachment, lack of positive stimulation and modeling behavior critical to development of the early brain, and taxing of neurobiological responses related to stress.⁷ The clinical consequences of these traumatic events may affect

children differently because of the varying stages of neural development,⁷ but many of the effects of trauma on youth can be understood as efforts to minimize threat and regulate emotional distress.⁸

However, not all children exposed to trauma develop symptoms with lasting impairment. Resilience is an individual's ability to survive and adapt through adversity despite negative circumstances; it involves the complex interplay between individual characteristics and environmental factors. Moreover, resiliency traits are malleable, and child and adolescent psychiatrists can engage in efforts to strengthen the resilience of children exposed to trauma. Research suggests that neurobiological changes associated with trauma may be affected by intervention, and early interventions may more quickly and effectively shape neuropsychological pathways.⁷

Trauma treatment for youth has grown in recognition and as an area of focus especially since the original ACE study was published in 1998. When treating trauma symptoms in children and adolescents, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is one of the most empirically supported treatment modalities for trauma symptoms in youth. TF-CBT is validated for youth 3 years old up to 17 years old.⁹ The concepts of TF-CBT were initially developed for sexually abused children but TF-CBT has been validated for youth who have experienced other types of trauma, including natural disasters, physical abuse and war.⁹ In Jensen and colleagues 18-month follow-up study, the results supported the long-term effectiveness of TF-CBT for youth with diagnoses of PTSD as well as co-occurring depression compared to treatment as usual.¹⁰

Other types of trauma-informed interventions for juvenile justice-involved youth are emerging. One such empirically-supported intervention is called Trauma Affect Regulation: Guide for Education and Therapy (TARGET). TARGET has three main components, including education about the neurobiological effects of PTSD, teaching self-regulation skills when trauma symptoms arise and an experiential exercise of the youth creating a timeline of his or her life.¹¹ Marrow *et al.* found that the juvenile

justice-involved youth who received the TARGET intervention had significantly lower rates of depression, anxiety, PTSD symptoms and an increase in perceptions of hope and optimism compared with treatment as usual.¹¹

For Julian, understanding his trauma history and mental health symptoms will help him, his providers, and the various involved care systems understand the origin of his challenges and how they have been adaptive in some certain circumstances and optimize a targeted treatment approach. In general, childhood trauma increases the risk for future victimization as well as perpetration of violence.¹² Direct and indirect exposure to violence is associated with delinquency in youth and psychological problems, including depression, anxiety, substance use, and aggressive behavior.¹³ The association between trauma and delinquency is reciprocal—trauma increases the risk for delinquency and gang involvement and involvement in delinquent behavior increases the risk for additional traumatization and exposure to violence.¹² Julian reported obtaining a firearm for protection after witnessing his friend's death by firearm. In one study on juvenile offenders, risk of gun carrying was significantly more likely after exposure to gun violence.¹⁴

Cumulative trauma, chronic exposure to violence or stress, or polyvictimization increase a youth's risk for poor health and social consequences.^{12,13} Therefore, addressing Julian's trauma-related symptoms through appropriate evidence-based treatment is critical. However, focusing on treatment to target trauma-related symptoms runs the risk of overlooking an individual's strengths and overall wellbeing, whereas the use of a strength-based approach to intervention has a basis within findings from the field of positive psychology.¹⁵ While trauma impacts people individually, we must remember that trauma is often experienced collectively, both within a whole family and often within a community, such as with Julian's case. Thinking more broadly than individual treatment for Julian, models of collective healing¹⁶ and family-based treatment can be explored. Further, minimizing recurrent trauma exposure, stabilizing Julian's current environment, and implementing

interventions that prevent revictimization are paramount to his recovery and to prevent recidivism.

Take Home Summary

Trauma is pervasive throughout the juvenile justice system. Studies show that children who experience trauma are at risk of poorer developmental and health outcomes. Clinicians should understand how justice-involved youth can be affected by a history of maltreatment. Interventions must focus on decriminalizing and treating trauma-related behaviors.

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