
Trauma-Informed Assessment and Intervention

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Trauma-informed assessment involves evaluating the ways in which a youth's functioning might have been affected by the experience of trauma. There are three dimensions of trauma on which such an assessment might focus: a) whether a youth has been **exposed** to potentially traumatizing events; b) whether a youth displays **symptoms** associated with posttraumatic stress; and c) whether a youth meets the criteria for a formal **diagnosis** of Posttraumatic Stress Disorder (PTSD) as per the DSM-IV or ICD-10 diagnostic manuals. Although often equated (e.g., the presumption that a youth who has been exposed to adverse events must therefore necessarily have PTSD), these three targets involve assessing for different aspects of trauma, and may thus arrive at different conclusions that in turn might lead to different intervention plans. In addition, although *assessment* is a term generally reserved for an evaluation that is performed by a trained mental health practitioner, we can also include *screening* under this heading, a procedure that can be carried out by anyone involved in the juvenile justice system (e.g., judges, probation officers, detention staff), with no specialized training required. Screening is appropriate for an evaluation of the extent to which a youth has been exposed to traumatic events or displays symptoms of posttraumatic stress, and thus warrants referral for a more in-depth assessment. In contrast, a qualified mental health professional is needed to determine a youth's diagnostic status as well as to cast a wider net in assessing not only for trauma exposure and PTSD but for the related disorders to which trauma increases youths' vulnerability. Screening generally takes place through the administration of a brief questionnaire, either through youth self-report or interview, whereas the "gold standard" for diagnosis is the administration of a structured diagnostic interview protocol. Particularly when we include screening in the equation, trauma-informed assessment is relevant for the practice of every aspect of the juvenile justice system (e.g., diversion, probation, court, detention).

Trauma-informed intervention most centrally involves providing youth and families with evidence-based interventions that are proven to be effective in ameliorating the negative effects of exposure to trauma. In addition, there are trauma-informed interventions that have been designed to increase the awareness, sensitivity, and responsiveness of larger systems involved with juvenile justice, such as the *Think Trauma Curriculum* (Marrow et al., 2012) for detention staff, and the elements of *TARGET-A* (Ford & Hawke, 2012) that address training staff and changing the overall milieu of juvenile justice facilities in order to make them more trauma-informed and effective in intervening with traumatized youth.

Trauma-informed assessment and intervention are key elements of a trauma-informed juvenile justice system

The extremely high rates at which youth involved in the juvenile justice system evidence trauma exposure and symptoms of PTSD make it evident that trauma-informed assessment and intervention are critical to the development of a trauma-informed juvenile justice system. Another way in which trauma-informed assessment is crucial is that it helps to identify those youth most in need of services in order to allow the system to wisely allocate its limited resources. Once these youth are identified, trauma-informed intervention is essential for uncoupling the links between trauma and the underlying disruptions in interpersonal, cognitive, emotional, and physiological functioning that contribute to youth delinquency.

At present, neither assessment for exposure to trauma nor for symptoms of PTSD are routine components of the standard mental health screening process implemented in most juvenile justice systems, despite the robust evidence that they should be, given the high rates of trauma exposure and posttraumatic stress among justice-involved youth. Similarly, trauma-informed treatments are not routinely on the “menu” of services that are offered to youth and families identified as in need of treatment. It is imperative that a trauma-informed juvenile justice system provide these services to the youth in the system in order to promote improved outcomes for youth and their families.

Trauma is directly relevant to understanding the driving factors underlying a youth’s delinquent behaviors and the driving factors that are likely to contribute to desistance or recidivism. For example, Judge Michael Howard and Robin Tener (2008) provide an excellent description of how an inquiry about trauma allowed the Stark County, Ohio Family Court to better discern how PTSD interferes with a youth’s social, cognitive, behavioral, and academic functioning, and how entire families are often impacted by these traumas in ways that interfere with their ability to provide a supportive and structured environment for their child’s development. Their experience also points to an important fact that we have learned in our own work especially, but not only, with youth in the juvenile justice system: ***if you don’t ask, they won’t tell***. Consequently, trauma assessment is essential to inform our understanding and our disposition in planning for youth in the juvenile justice system. By the same token, trauma-focused treatment is essential for fostering resilience and intervening in the trauma-related disruptions in functioning that interfere with the youth’s ability to return to a more prosocial developmental course.

How to integrate trauma-informed assessment and intervention in juvenile justice systems

Ideally, trauma-informed assessment and access to trauma-informed intervention would be diffused throughout the juvenile justice system. There are multiple gateways through which youth in the system pass, each of which might provide access to trauma-informed care, rather than serving as the kind of yawning “gap” that youth too often fall through.

In the realm of assessment, screening for trauma exposure and/or posttraumatic reactions could be performed by diversion staff when a first offender is referred; by child welfare personnel, guardians ad litem, and probation officers for all youth on their caseloads; by detention staff at the youth’s point of entry into the facility; by attorneys assigned a case; and even by judges, if no one else involved in a court proceeding has as yet provided this information essential to informing their disposition of the case. Ideally, each of these entities would then have access to qualified mental health professionals to whom they could refer the youth for further evaluation and more formal assessment should screening indicate that it is needed, and to evidence-based trauma treatment when warranted. Importantly, judges, probation officers, and attorneys would be knowledgeable about the necessity to evaluate for the presence of trauma exposure and PTSD symptoms and would consequently require that all court-ordered mental health evaluations include assessments of both of these dimensions of trauma.

Judge Michael Howard (Howard & Tener, 2008) and Judge Elizabeth Trosch (2012) both provide excellent examples of how they transformed their own courts through their well-informed insistence that the local child welfare and mental health systems educate themselves about trauma and provide them with evidence-based evaluations and treatment options for the youth who came before their benches in Ohio and North Carolina. As they illustrate, the task was not always easy, and resistance to change arose at many junctures among many players in the larger system.

It may seem surprising, given the wealth of research devoted to the association between trauma and delinquency (see Kerig & Becker, 2010; Kerig, 2012), but not all mental health professionals who provide psychological evaluations to the court are themselves trauma-informed; therefore not all include trauma assessments in their evaluations, nor are all of them actually trained to do so. Therefore, a fully trauma-informed juvenile justice system would ensure that all mental health professionals who perform court-ordered evaluations are knowledgeable, skilled, and specifically trained in the assessment of trauma in adolescents.

In turn, in the realm of intervention, ideally every jurisdiction would have qualified mental health professionals trained in evidence-based interventions for trauma. In some respects, this is a very attainable goal. For example, trainings in the most well-validated intervention for the treatment of trauma among children and adolescents, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), are widely available through the developers and at many child- and trauma-oriented conferences, supported by a free online continuing education course available through the Medical University of South Carolina website: <http://tfcbt.musc.edu/>

Challenges for trauma-informed assessment

As noted above, an important challenge to making trauma-informed assessments and interventions standard practice in the juvenile justice system is the need for more trained mental health professionals who can conduct evidence-based trauma-informed assessments and interventions. However, this is not a challenge that is simple to overcome, in that this is a specialized area of knowledge that requires staying updated with a nascent but dynamic body of research. For example, the majority of existing trauma evaluation instruments that have been psychometrically well-established focus on single-event traumas (e.g., “short, sharp, shocks”) and the subsequent symptoms of “classic” PTSD (also referred to as “simple” PTSD, e.g., re-experiencing, avoidance, and arousal). In contrast, theory and research increasingly point toward a different set of developmental consequences for youth who have been exposed to chronic, pervasive, interpersonal traumas, as is true for many of the youth who become involved in the juvenile justice system. Such aftereffects of complex PTSD/developmental trauma disorder (DTD) include disruptions in interpersonal, cognitive, affective, and psychophysiological functioning that express themselves in multiple and pervasive ways. In short, although work is underway to develop and validate measures of complex trauma, there is as yet no one simple test with an established manual and norms that is considered the “gold standard” for assessing complex PTSD/DTD, and thus at present this requires specialized clinical training and expertise.

In addition, the context in which juvenile justice-involved youth are screened or assessed, and the meaning that they make of these procedures, may have a significant impact on their willingness to provide true and accurate reports about the extent of their trauma exposure and posttraumatic symptoms. At various points in their progression through the system, youth may be feeling angry or distrustful and thus be disinclined to provide this kind of sensitive personal information. Youth may also have legitimate concerns about the confidentiality of the information they provide and how it will be used, such as whether it might affect legal proceedings, justify institutionalization, or increase their sense of stigma. Particularly upon entering secure facilities, youth may feel the need to not display vulnerability and thus prefer to deny painful experiences or their effects on them. Moreover, we have consulted with juvenile justice agencies in which the staff maintained a dubious and even ridiculing attitude toward trauma assessment, and youth were certainly aware of these attitudes. Even when information for trauma screening is gathered via youths’ private reports on either computerized or paper-and-pencil instruments, having those screenings conducted in detention settings, particularly by staff members who convey negative attitudes toward them, could affect youths’ responses. This dynamic may very well account for some of the lack of correspondence we have found between rates of trauma exposure and PTSD symptoms obtained through detention staff-administered screenings via the MAYSI-2 and youth reports in a clinical interview (Kerig, Arnzen, & Becker, 2011). Therefore, an important part of the effort will be continuing psychoeducation and trauma-awareness training, particularly for detention staff and probation officers who interact frequently with youth and have a highly valuable potential role to play in identifying those in need of trauma treatment. Staff who conduct these screenings also will need training and ongoing support to ensure that they feel comfortable eliciting this kind of sensitive information and that they feel able to respond appropriately to the sometimes upsetting youth disclosures they will hear. By the same token, a framing-up for youth of the purpose of asking such questions, and the provision of an explanation of how their responses will be used to enlist resources and inform interventions on their behalf, will be essential.

A further challenge is that new research and clinical evidence are shifting our views of what comprises “trauma” and how the symptoms of PTSD should be delineated. In addition to the debates noted above over the existence of a separate CPTSD/DTD disorder, those in the field continue to engage in discussion about how trauma and

PTSD should be defined in the new versions of the diagnostic manuals currently under preparation, the DSM-5 and the ICD-11. Although these are knotty issues that would go beyond the scope of the present brief, two specific examples concern ongoing discussions about the specific events that should qualify as “traumatic,” and the kind and number of symptoms that should be required for a diagnosis of PTSD among children and youth, who often show disruptions in some domains but not others, and therefore fail to meet full criteria even though they have symptoms severe enough to significantly interfere with functioning. Should the final decisions regarding the diagnostic criteria in these manuals involve significant changes from those we are basing our assessments on currently, further work will be needed to develop and validate new evidence-based instruments that will map onto these new conceptualizations of trauma and PTSD.

Challenges for trauma-informed treatment

First, one challenge that has only recently been getting due attention concerns the unique issues facing girls in the juvenile justice system, many of whom have experienced specific kinds of trauma at higher rates when compared to boys. These include traumas that are “close to home,” such as childhood maltreatment and domestic violence, as well as—especially—disproportionately high rates of sexual abuse, assault and exploitation (Kerig & Becker, 2012; Watson & Edelson, 2012). Important new work is in progress to better understand the special needs of girls within the juvenile justice system more broadly as well as specifically in regard to their experience of trauma (Watson & Edelson, 2012).

Second, returning to the theme of complex trauma, although evidence-based interventions such as TF-CBT have proven effective with a range of different kinds of traumatic experiences, some theorists and clinicians have been considering the possibility that additional strategies might be needed to effectively treat the kinds of long-standing, pervasive traumas that have been experienced by so many youth in the juvenile justice system. Furthermore, although an important effective ingredient of interventions such as TF-CBT is parental support, by the time youth have entered the juvenile justice system many of their families are characterized by high degrees of conflict, alienation, and schism. In our experience in implementing TF-CBT among juvenile justice-involved youth, we see higher rates of parental failure to participate, as well as youth refusal to allow parental involvement, than in other populations of traumatized youth. In addition, it is the case that many youth are detained in facilities far from their families, and thus parental engagement in treatment is difficult in a pragmatic sense.

To address these issues, a number of alternative treatments are being developed that target the symptoms of complex trauma among juvenile justice-involved youth, many of which are designed to be implemented with youth in care. These include TARGET-A (Ford & Russo, 2006), SPARCS (DeRosa & Pelcovitz, 2008), and TGCT-A (Layne et al., 2008). In addition, a number of promising interventions are being developed for complex trauma in children and adolescents that are not specific to delinquency, including ARC (Blaustein & Kinniburgh, 2010), ITCT (Briere & Lanktree, 2011), and Real Life Heroes (Kagan, 2007).

What is an evidence-based practice and how do you know if you’ve got one?

One of the sources of confusion those of us in the mental health community increasingly see among our clients (and here I would include not only youth and families but the probation officers, judges, and attorneys who also rely on us to inform them with our expertise) is that the term “evidence-based” is used so loosely as to refer to any procedure that is “based” on something for which there is some sort of “evidence.” When used as intended, the term “evidence-based” assessment refers to the standardized and appropriate use of an instrument that has gone through a rigorous process of validation, in which it is shown to reliably and accurately measure the construct of interest across representative samples, and for which norms and psychometric properties are provided. In the realm of interventions, “evidence-based” refers to a treatment that has gone through a rigorous process of proving that, when implemented in a standardized way with fidelity by multiple clinicians across multiple real-world settings, it leads to positive benefits that are consistent with the underlying theory of the “effective ingredients” of that intervention, and that those benefits differ in degree and kind from the positive changes that might be attributable simply to the passage of time or the provision of “non-specific” factors such as positive attention from a therapist

(Kazdin, 2008). The implementation of evidence-based treatments generally also requires a commitment from agencies and clinicians not only to undergo an initial training in the intervention, but also to allow ongoing oversight by experts in order to evaluate their continuing fidelity to the treatment manual and to correct the inevitable “drift” that develops over time.

As noted above, many promising interventions for trauma, particularly complex trauma, are in the process of development, and are beginning to launch clinical trials that will in the future allow them to be labeled as evidence-based in their own right. A particularly promising example is TARGET-A, for which very positive empirical evidence is beginning to emerge from rigorous clinical studies (e.g., Ford & Hawke, 2012; Ford, Steinberg, Hawke, Levine, & Zhang, 2012; Marrow, Knudsen, Olafson, & Bucher, 2012).

In sum, challenges to making trauma-informed assessment and intervention standard practice in the juvenile justice system include: a) the need for more appropriately trained mental health professionals to conduct trauma-informed assessments and interventions; b) the need for further development of psychometrically proven assessment tools for evaluating the complex PTSD symptoms that often arises from chronic interpersonal trauma exposure among these youth; c) recognition that the diagnosis of PTSD itself is a “work in progress”; and d) the fact that interventions for complex PTSD are generally still in the early stages of development and compilation of their evidence base.

Success stories

Regarding assessment, one of our most gratifying experiences has been reaching out to juvenile court judges in our jurisdiction and seeing their immediate positive response, as well as their significant impact radiating outward throughout the system. Our local judges’ interest and awareness had already been piqued by a NCTSN presentation on trauma at a national judges’ conference, so when I attended their monthly meeting to speak on the topic they quickly moved the conversation to practical matters: “What can we be doing?” Within a week, I was receiving calls from the local mental health professionals contracted to provide psychological evaluations to the courts, requesting consultation regarding the best methods for assessing trauma exposure and PTSD, given that they were being newly mandated to provide that information by the judges who were using their reports to guide their disposition planning.

Our experiences regarding winning the system over to trauma-informed interventions have been more mixed, in that many community mental health agencies and practitioners offer “trauma treatment” and “evidence-based practices” that do not actually have an established pedigree, and therefore probation officers and judges who refer youth to these programs—and youth and families themselves—become increasingly dubious when they fail to see youth make gains and cease offending. Judge Howard (Howard & Tener, 2008) makes a similar observation, that youth and families who are “veterans” of ineffective treatments come to lose confidence in the system’s ability to help them, as well as confidence in themselves, and thus can become a “hard sell” when it comes to referrals to trauma-focused interventions. However, we have had some gratifying successes with small pilot projects we have conducted, including one in which graduate students were trained to provide TF-CBT to youth in a long-term detention program. One of our most intriguing cases was an African American youth I’ll call Devonne. Upon admission to the facility, Devonne quickly gained a reputation as a scary and unapproachable youth. He seldom talked or made eye contact, instead watching others stealthily from glowering lowered lids. One afternoon in the dayroom, he carefully tracked the movements of one of our clinicians as she interacted with staff and set up her next session with a client. Struck by the studied gaze of this normally isolative young man, the clinician decided to take the risk of greeting him and introducing herself. Devonne asked her to explain who she was and why she was there and, upon hearing her description of the TF-CBT program, announced, “That’s what I need. Can you meet with me, too?” In their sessions, Devonne shared his experience of growing up in the inner city as the child of a substance abusing mother and a violent father, both of whom abandoned him to the streets. Joining a gang in order to survive, Devonne was given the role of “enforcer,” and was required to perpetrate horrific offenses on rival gang members in the neighborhood, activities that haunted him both sleeping and awake. His trauma narratives

were harrowing and he often expressed the intention to quit, but at every juncture when he looked up and saw his therapist's continued empathy, interest, and willingness to go through those experiences along with him, he resolved to finish what he came to call his "project."

Concluding Comments

In sum, although in the best of all possible worlds the local mental health system providing assessment and treatment services to each court would already be trauma-informed, the reality is that this is not always the case. However, those involved in the juvenile justice system at every level can be knowledgeable about the need, and prepared and empowered to take leadership on this issue. For example, as Judge Howard (Howard & Tener, 2008) outlines in his description of the Stark County experience, juvenile court judges can insist that trauma screening and/or assessment be included in the evaluations of all youth who come before their bench, and that all disposition plans that include treatment for trauma involve referrals to clinicians trained in evidence-based interventions specifically designed and shown to be effective for trauma among young people and their families. The NCTSN website provides a number of helpful resources for this purpose, including descriptions of the interventions that are considered to be evidence-based and best practices in the field.

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