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Summary Report

Effects of Child Maltreatment, Cumulative Victimization Experiences, and Proximal Life Stress on Adult Crime and Antisocial Behavior

NIJ Grant Number: 2012-IJ-CX-0023

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Abstract

This study sought to replicate and extend research findings on subtypes of child maltreatment, childhood exposure to domestic violence, subsequent forms of victimization, and stress in relation to antisocial behavior, crime, and adulthood IPV perpetration and victimization. The study also investigated protective factors for maltreated children and predictors of self-reported crime desistence among maltreated and multiply victimized children. Data are from the Lehigh Longitudinal Study, an ongoing prospective investigation of children and families that began in the 1970s. The original sample was comprised of 457 children. Over 80% of the children, now adults, were assessed in 2008-2010 at an average of 36 years. Data on child maltreatment and related risk and protective factors were collected much earlier, beginning when participants were preschoolers, 18 months to 6 years of age.

Findings of seven publications, the products of this secondary data analysis project, provide further evidence of the relationship between child maltreatment and adult antisocial behavior and crime. They also point to instances in which this relationship is influenced by other variables, including those pertaining to the socialization of peers and partners. Findings raise the possibility that physical, emotional, and sexual abuse relate differently to self-reported crime and that predictors and pathways differ at times on the basis of gender. Further, several analyses highlight the risk-lowering effects of education variables (e.g., educational engagement, academic achievement, high school graduation), suggesting that attention should be given to incorporating perspectives on schooling and education in prevention and criminal justice policy.

Purpose of the project

This was a secondary data analysis project that sought to replicate and extend published findings on the adverse effects of child maltreatment and processes of resilience and protection. Primary outcomes include adult self-reported antisocial behavior and crime, as well as intimate

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partner violence (IPV). In these analyses, we were particularly interested in the combined and unique effects of different subtypes of abuse, subsequent forms of victimization, and household and environmental stresses.

Specific aims of the project were as follows: Aim 1. To prospectively examine the effects of child maltreatment and childhood exposure to domestic violence on antisocial behavior, crime, and adulthood IPV perpetration and victimization; Aim 2. To prospectively examine the influence of cumulative victimization experiences on these outcomes in adulthood; Aim 3. To examine the extent to which proximally and earlier measured household and environmental stresses predict and help explain the effects of early forms of victimization on the proposed outcomes; Aim 4. To examine resilience in maltreated and multiply victimized children using a dynamic, life course model; and Aim 5: To comprehensively examine where and how gender moderates the relation between predictors and outcomes of the proposed aims (Aims 1-4).

Design of the project

The original design of the study called for a comparison of children from child welfare agencies and those recruited from other group settings (e.g., day cares, Head Start, nursery schools) located within a two-county area of Pennsylvania. The goal was to select children from these setting who were comparable in gender and age to those in child welfare, and to include families from different income and socioeconomic status categories. The full sample (N=457) contained 248 (54%) male and 209 female children. Of these, a majority (80.7%, n = 369) were White; 5.3% (n = 24) were Black or African American; 1.3% (n = 6) were American Indian/Alaska Native; 0.2% (n = 1) were Native Hawaiian or Other Pacific Islander; 11.2% (n = 51) were more than one race; and 1.3% (n = 6) had an unknown race and ethnicity. Eighty-six percent of children were from two-parent households. About 61% of families were in poverty, according to the income-to-needs ratio in 1976.

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The first “preschool” wave of the study was completed in 1976-1977 when children were 18 months to 6 years of age. A second “school-age” assessment was completed in 1980-1982 when children were between 8 and 11 years of age. A third “adolescent” assessment was completed in 1990-1992. When they were assessed in adolescence, participants were 18 years of age on average (range: 14-23). A fourth “adult” wave of the study was completed in 2008-2010 when participants were, on average, 36 years of age (range: 31-41 years). Approximately 80% of the original study sample (N=357) was reassessed and the sample remained gender balanced: 171 (47.9%) females and 186 (52.1%) males. Although fewer members of the original child welfare abuse group completed the adult assessment, analyses showed that those who were retained did not differ from those lost to attrition on gender, age, childhood SES, or parent-reported neglect or physical discipline.

Data analysis

Data analysis methods consisted of basic descriptive models, regression analyses, structural equation models, and latent class analysis. Methods were chosen for consistency with the hypothesis under investigation and the distributional properties of the variables. Missing data were handled using techniques to obtain unbiased estimates of parameters and their standard errors. These include full-information maximum likelihood estimation (Arbuckle, 1995; Muthén & Muthén, 1998-2012) available in the Mplus structural equation modeling program (Muthén & Muthén, 2004).

Variables

Variables used in analyses are described below. Descriptive statistics for the measures listed in this report can be found in the relevant publications or provided upon request.

Child maltreatment

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Officially recorded child maltreatment was measured using a dichotomous variable that distinguished individuals originally recruited to the study from child welfare caseloads for abuse or neglect from those who were recruited from other group settings. This variable was included in analyses as both a predictor of adult crime and also as a covariate (*Publication #'s 1, 2, 3, 4, 5, 6, 7*).

Physical and emotional abuse was based on parent reports of their (and others') use of physically and emotionally abusive disciplining strategies.. Data on physical abuse from the preschool wave of the study pertain to (a) the last 3 months and (b) prior to that last 3 months. Data on emotional abuse pertain to disciplining in the last 3 months only. At the school-age wave of the study, parents reported on their physically and emotionally abusive discipline for the past year. Various coding strategies were used to derive variables for specific analyses. Analyses include dichotomous measures of abuse/no abuse occurrence; abuse counts indicating the number of abusive disciplining strategies used; and a latent variable scaling. Analyses also include measures of abuse chronicity, which reflect the consistency in abusive disciplining over consecutive waves of the study (*Publication #'s 2, 3, 4, 5, 6, 7*).

A measure of sexual abuse was based primarily on participants' retrospective reports of having been sexually abused in childhood (prior to age 18 years) from the adolescent and adult waves of the study. Data were also compiled from other sources, including interview notes and child welfare case records (*Publication #'s 4, 5, 6*).

Neglect was measured at the preschool wave of the study using observations of the parent-child interactions and a family's living environment. Indicators were aligned with the "child level of living" scale developed and validated by Polansky and colleagues (Polansky, Borgman, & De Saix, 1972; Polansky, Cabral, Magura, & Phillips, 1983; Polansky, Chalmers, Buttenwieser, & Williams, 1978) and correspond with its four subscales—neglectful home

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environment (e.g., dirty dishes, food scraps on floor, dirt, house smells of urine and/or spoiled food, broken glass and/or rusty cans, and garbage), physical neglect (evidence of poor dental and/or medical care of children and physical injuries), inadequate supervision (e.g., poor judgment about leaving a child alone or with an older sibling unable to care for the child), and emotional neglect. A composite measure of neglect was based on a sum of the four subscales (*Publication #5*).

Childhood exposure to intimate partner violence (IPV) was dichotomously measured in the preschool wave using parent self-reports to reflect the frequency with which parents threatened to physically harm the other; hit, pushed, or kicked; or destroyed something of value to the other (*Publication #6*).

Self-reported crime and offending

Adult and adolescent crime and offending: Measures of self-reported adult crime were scaled from 29 survey items on lifetime and past-year offenses included in the adult and adolescent waves of the study. These measures are based on Elliott, Dunford, and Huizinga's (1987) Self-Reported Delinquency Scale and reflect crimes against property (e.g., knowingly bought, sold, or held stolen goods; stole money, goods, or property; used or tried to use credit cards without owner's permission.); crimes against persons (e.g., had or tried to have sexual relations with someone against their will; was involved in a gang fight; hit or threatened to hit your supervisor or other employee); and crimes against society (e.g., was paid for having sexual relations with someone; paid someone for having sexual relations; carried a hidden weapon; sold drugs). Overall lifetime and past-year crime measures were also included (*Publication #'s 1, 2, 3, 4, 5*). A measure of adolescent offending based on the same 29 items was used in one publication (*Publication #5*).

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Lifetime arrests, convictions, and incarceration are single-item measures, which indicate whether a participant had ever been arrested, convicted, or incarcerated. Measures of an individual's overall number of arrests and convictions were also included (*Publication #1*).

Intimate partner violence (IPV)

Measures of adult IPV include perpetration and victimization of physical, psychological, sexual violence, and injuries from violent interactions. In the adult wave of the study, participants self-reported on their experiences with IPV using items from the Revised Conflict Tactics Scale. These were dichotomously scaled to reflect the presence and absence of each for or type IPV exposure (*Publication #'s 6, 7*)

A measure of perceived intimidation and control was derived from the Women's Experiences with Battering Scale (Smith, Earp, & DeVellis, 1994; Smith, Smith, & Earp, 1999). Summed scores were recoded to a binary indicator of intimidation and control (*Publication #6*).

Adolescent violence victimization

In the adolescent wave of the study, youth participants reported on their past-year physical and sexual victimization. Responses indicated whether youth had been victimized, and by whom (e.g., boyfriend or girlfriend). Experiences that involved a boyfriend or girlfriend were taken as evidence of dating violence victimization. Responses that identified the perpetrator as someone other than a boyfriend or girlfriend were coded as general victimization. Responses that indicated a youth had been victimized by a boyfriend or girlfriend *and* another person were taken as evidence of both forms of victimization (*Publication #7*).

Partners

Partner's risk-taking behavior was based on five binary items, which pertain to the presence or absence of partners' involvement in delinquent behavior, including substance use, violence, and criminal involvement. Example questions include, "During past year did partner

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regularly drink alcohol heavily?", "During past year did partner regularly physically beat or seriously hurt people?", and "During past year did partner regularly commit serious crimes?" Items were summed to form a composite measure of partners' involvement in risk-taking behavior (*Publication #4*).

Partner's warmth was based on six items assessing participant's perceived emotional support from their partner and their assessment of the quality of the relationship. Example questions include, "On average, about how often do you receive informal emotional support from your partner?", "How much warmth and affection have you received from your spouse/partner or boyfriend/girlfriend?", and "How much support and encouragement have your received from your spouse or partner/boyfriend or girlfriend?" Items were standardized and then averaged to form a single composite measure *(Publication #4*).

Peers

Antisocial peers in adulthood was based on 10 items assessing participant's perception of their peers' endorsement of antisocial behaviors. Example questions include, "How would close friends react to you if you sold hard drugs?", "How would close friends react to you if you hit/threatened to hit someone without reason?", and "How would close friends react to you if you damaged/destroyed property not belonging to you?" Items were standardized and then averaged into a single composite measure (*Publication #4*).

Peer approval of violence was measured in the adolescent wave of the study using questions about how an individual's friends would react if they "deliberately injured their spouse/boyfriend/girlfriend, e.g., hit, choked, or cut him/her" (peer approval for dating violence) or "hit or threatened to hit someone without any reason" (peer approval for general violence).

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Each question was dichotomously coded to reflect approval (or disapproval) of the behavior in question (*Publication #7*).

Pro-violence attitudes was measured in the adolescent wave of the study to reflect attitudes toward violence generally and toward dating violence in particular. Youth respondents indicated how wrong they think it is "for someone to deliberately hit and injure their spouse/boyfriend/girlfriend" (indicative of favorable attitudes toward dating violence); or to "hit or threaten to hit someone without any reason" (indicative of favorable attitudes toward general violence). Each question was coded 1 (pro-violence attitude) or 0 (*Publication #7*).

Childhood and adolescent behavior problems and antisocial behavior

Childhood and adolescent externalizing and internalizing behavioral problems were assessed using the parent-report Child Behavior Checklist (CBCL) (Achenbach, 1978, 1988) and the Achenbach Youth Self-Report (YSR) form (Achenbach, 1997: YSR). Externalizing behaviors consist of aggression and nonaggressive, rule-breaking, or antisocial (delinquent) behaviors. Items include 'lie or cheat,' 'argue a lot,' 'get in many fights,' and 'use alcohol or drugs for nonmedical purposes.' Items were summed to form a composite measure of externalizing behaviors in the school-age and adolescent eaves of the study (*Publication #'s 2, 3, 4*). Internalizing behaviors consist of withdrawal, depression, anxiety, and somatic problems. Items include 'be secretive and keep things to myself,' 'cry a lot,' 'feel overtired,' 'feel worthless or inferior,' 'think/talk about killing self.' Items were summed to derive a single score of the externalizing behaviors for each assessment period (*Publication #3*).

Adolescent antisocial behavior was based on 39 lifetime antisocial behaviors including acts such as stealing, breaking and entering, and property damage, which were reported by youth during the adolescent wave of the study. Items were summed to form a single composite

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measure, for consistency with earlier publications (Moylan et al., 2010) and with the scaling strategy used in the National Youth Survey (Elliott et al., 1987) (*Publication #4*).

Education

Education attainment was assessed in the adult wave of the study and was coded to reflect an education of 1= eighth grade or less; 2 = some high school; 3 = high school grad or GED; 4 = some college; 5 = 2-year college grad; 6 = 4-year college grad; 7 = some post graduate; 8 = post college/professional degree (*Publication #5*).

Educational engagement was measured using the Youth Self-Report (YSR) form of the CBCL (Achenbach, 1997) to reflect participants' aspirations and expectations for education; importance of their schoolwork; past educational experiences; satisfaction with their education; and hours spent studying or doing schoolwork weekly outside of school. A composite measure of educational engagement was formed by averaging the standardized scores of these seven indicators (*Publication #5*).

Academic performance was measured using items from the YSR (Achenbach, 1997). These items pertain to school grades in four subject areas: English or language arts, history or social studies, arithmetic or math, and science. Another set of the same four items was provided by parent interviews. A single additional item pertains to the grades that best describe the adolescents' performance during the most recent grading period (1 = Mostly Fs to 5 = Mostly As). A composite measure of academic performance was formed by averaging the standardized scores of these items (*Publication #5*).

Suspensions was dichotomously measured using a single, youth self-report item that pertains to whether an individual had ever been suspended from school in Grades 7 – 9 (*Publication #5*).

Covariates

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Gender was included in analyses as a binary indicator for males and females (males coded 1 and females coded 0; *Publication #'s 1, 2, 3, 4, 5, 6, 7*). A measure of childhood socioeconomic status (SES) was also included. SES is a standardized composite measure of parents' occupational status, educational level, and family income (*Publication #'s 1, 2, 3, 4, 5, 6, 7*). Minority race was a binary indicator for 'White' versus 'other' (*Publication #'s 1, 2, 3*). Education level was included as a binary indicator for 'high school graduate or GED equivalent' versus 'no high school degree' (*Publication #1*). Marital status was a binary variable for 'married' and 'not married (single, divorced, separated, and widowed)' (*Publication #1*). Age was continuous, and separately coded for adolescence (*Publication #7*) and adulthood (*Publication #'s 1 ,3*). A measure of IQ was based on scores from the Wechsler Intelligence Scale for Children-Revised (WISC-R; Wechsler, 1974), which was administered in the school-age wave of the study (*Publication #5*).

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Publications and Findings

Publications are listed in the table below, along with key findings under each study aim. Articles are available upon request.

	Aim 1. To prospectively examine the effects of child maltreatment and childhood exposure to domestic violence on antisocial behavior, crime, and adulthood IPV perpetration and victimization.	**Aim 2. To prospectively examine the influence of cumulative victimization experiences on these outcomes in adulthood.**	**Aim 3. To examine the extent to which proximally and earlier measured household and environmental stresses predict and help explain the effects of early forms of victimization on the proposed outcomes.**	**Aim 4. To examine resilience in maltreated and multiply victimized children using a dynamic, life course model.**	**Aim 5: To comprehensively examine where and how gender moderates the relation between predictors and outcomes of the proposed aims (Aims 1-4).**
1. *Jung, H., Herrenkohl, T. I., Klika, J. B., Lee, J. O., & Brown, E. C. (2015). Does child maltreatment predict adult crime? Reexamining the question in a prospective study of gender differences, education, and marital status. Journal of Interpersonal Violence, 30, 2238-2257. (PMC4436036)*	Bivariate analyses showed a significant association between officially recorded child maltreatment and later crime and more lifetime self-reported arrests, convictions, and incarcerations. Analyses of crimes by category—property, person, and society—provided further evidence of this link in bivariate models. In multivariate models that controlled for childhood SES, minority racial status, marital status, and education level, the significant association between child maltreatment and crime outcomes were mostly reduced to non-significance.			Having graduated from high school and being married predicted less crime in adulthood.	Tests of gender differences showed that crime is more prevalent among maltreated and non-maltreated males, although maltreated females were also at risk for crime.

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2. *Jung, H., Herrenkohl, T. I., Lee, J. O., & Klika, J. B. (2015). Effects of physical and emotional child abuse and its chronicity on antisocial behaviors into adulthood. Violence & Victims, 30, 1004-1018. (PMC4991621)*	Parent reports of emotional abuse predicted later self-reports of crime both directly and indirectly through childhood externalizing, while physical abuse predicted crime only indirectly.	In subgroup analyses, chronicity of physical abuse was indirectly related to later crime among those who had been physically abused; chronicity of emotional abuse was neither directly nor indirectly related to crime among those who had been emotionally abused.			
3. *Jung, H., Herrenkohl, T. I., Lee, J. O., Hemphill, S. A., Heerde, J. A., & Skinner, M. L. (2015). Gendered pathways from child abuse to adult crime through internalizing and externalizing behaviors in childhood and adolescence. Journal of Interpersonal Violence, Advance online publication. doi: 10.1177/0886260515596146. (PMC4991959)*	In a study of developmental pathways to adult crime, physical and emotional child abuse was associated with internalizing and externalizing behaviors in the elementary school years for males and females. Gender differences in pathways from internalizing and externalizing behaviors to later crime were observed.			Internalizing behaviors in childhood among males predicted a lower risk of adult crime.	Internalizing behaviors in childhood increased the risk of adult crime for females only. Externalizing behaviors increased the risk of adult crime for males only.
4. *Lee, J. O., Herrenkohl, T. I., Jung, H., Skinner, M. L., & Klika, J. B. (2015). Longitudinal examination of peer and partner influences on gender-specific pathways from child abuse to adult crime. Child Abuse and Neglect, 47, 83-93. (PMC4567933)*	For both genders, physical and emotional child abuse predicted adult crime indirectly through child and adolescent antisocial behavior/crime, as well as adult partner and antisocial peer influences. Sexual abuse also predicted adolescent antisocial behavior, but only for males.		Risk influences from partners and peers help to explain the link between child abuse and later crime.	For males, partner warmth reduced the risk of adult antisocial peer involvement, a predictor of adult crime.	For females, having an antisocial partner predicted an affiliation with antisocial peers, and that in turn predicted adult crime. For males, having an antisocial partner was associated with less partner warmth, which in turn predicted an affiliation with antisocial peers, itself a proximal predictor of adult crime.

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5. *Jung, H., Herrenkohl, T. I., & Skinner, M. L. (2016, under review). Does educational success mitigate the effect of child maltreatment on later offending patterns? Journal of Interpersonal Violence.*	Latent class analysis revealed patterns of chronic offending, adolescent offending (desistence), and stable low offending. Physical-emotional and sexual abuse predicted a higher likelihood of chronic offending relative to patterns of desistence and low-level offending. No significant interactions of child abuse and education variables were detected.			Although no significant interactions of child abuse and education variables were identified, educational engagement and academic achievement predicted a higher likelihood of stable low offending compared to adolescent or chronic offending. Educational attainment predicted a higher likelihood of desistence relative to chronic offending.	There was no evidence that the inclusion of gender in the model changed the nature of the offender classes.
6. *Jung, H., Herrenkohl, T. I., Skinner, M. L., Lee, J. O., & Klika, J. B. (2016, under review). Gender differences in intimate partner violence (IPV): A predictive analysis of IPV by child abuse and domestic violence exposure during early childhood. Violence Against Women.*	Five latent classes of IPV victimization and perpetration were generated from adult self-reports. There were no statistically significant main effects of child abuse and child exposure to IPV on later adult IPV class membership. However, significant gender interactions were found for physical-emotional child abuse and childhood exposure to IPV as well as sexual abuse.	Analyses examined the association between child abuse victimization and adult IPV victimization and perpetration.			Physical-emotional child abuse and childhood domestic violence exposure was more strongly associated with multi-type violence and intimidation class membership for males. Sexual abuse was associated with a higher likelihood of multi-type violence and intimidation for females.

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7. *Herrenkohl, T. I. & Jung, H. (2016, in press). Effects of child abuse, adolescent violence, peer sanctions, and pro-violence attitudes on intimate partner violence in adulthood. Criminal Behaviour and Mental Health.*	In multivariate models, officially recorded child maltreatment predicted IPV perpetration in adulthood.	Dating violence victimization and peer approval of dating violence in adolescence predicted IPV victimization and perpetration in adulthood.		Parent-reported physical and emotional child abuse was not predictive of IPV outcomes after accounting for other variables in the analysis, including dating violence victimization.	Male gender predicted adult sexual IPV victimization and physical IPV perpetration, such that males were at lower risk of each predicted outcome.

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Limitations

While this study has a number of important strengths, including its longitudinal design, gender balanced sample, examination of various subtypes of abuse, and focus on resilience and protective factors, it also has limitations. These include a relatively homogenous sample with respect to race and ethnicity and a reliance on self-reports of crime and antisocial behavior. The composition of the sample limits the extent to which findings can be readily generalized to other populations. Replication of these findings in other longitudinal studies with diverse samples will provide further evidence of the relationships under investigation.

Implications for criminal justice policy and practice

Findings provide further evidence of the relationship between child maltreatment and adult antisocial behavior and crime, but also point to instances in which that relationship is influenced by other variables. Analyses raise the possibility that physical, emotional, and sexual abuse relate differently to self-reported crime and that predictors and pathways differ at times on the basis of gender. These are important findings for theory, practice, and policy in that they suggest the need to pay greater attention to gender in the development and tailoring of crime prevention strategies (Chesney-Lind & Belknap, 2004). Further, there is some evidence from this project that the associations between child maltreatment and later forms of victimization are influenced by the socialization of peers and partners to antisocial behavior, although factors implicated in this process are not all the same for males and females. In that several analyses highlight the risk-lowering effects of education variables (e.g., educational engagement, academic achievement, high school graduation), attention should also be given to incorporating perspectives on schooling and education in prevention and criminal justice policy (Fagan & Catalano, 2013). Programs focused on strengthening the educational experiences of

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vulnerable and at-risk youth, and keeping these youth connected and engaged in school through high school, are important goals for prevention (Monahan, Oesterle, & Hawkins, 2010), which emphasizes the need to identify and intervene early and sometimes over consecutive years in order to reduce risk factors and enhance protective factors to lessen crime (e.g., Fagan & Catalano, 2013; Hawkins & Herrenkohl, 2003; Herrenkohl, Chung, & Catalano, 2004; Jenson, Powell, & Forrest-Bank, 2011; Wilson & Lipsey, 2007).

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TRAUMA AND DELINQUENCY:

A QUALITATIVE STUDY OF THE RELATIONSHIP BETWEEN

SEXUAL TRAUMA AND JUVENILE DELINQUENCY

FOR AFRICAN AMERICAN AND LATINA GIRLS

by

Gena Castro Rodriguez

A Dissertation Submitted to the Faculty

of the California Institute of Integral Studies

in Partial Fulfillment of the Requirements for the Degree

Doctor of Psychology in Clinical Psychology

California Institute of Integral Studies

San Francisco, CA

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Dear Dr. Covington:

I am completing a doctoral dissertation at the California Institute of Integral Studies in San Francisco entitled “Trauma and Delinquency: A Qualitative Study of the Relationship Between Sexual Trauma and Juvenile Delinquency for African American and Latina Girls.” I would like your permission to reprint the “Process of Trauma” chart in my dissertation (appendix).

The requested permission extends to any future revisions and editions of my dissertation including nonexclusive world rights in all languages, and to the prospective publication of my dissertation by UMI. These rights will in no way restrict republication of the material in any other form by you or by others authorized by you. Your signing of this letter will also confirm that you own the copyright to the above-described material.

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Sincerely,

Gena Castro Rodriguez, M.A., LMFT
Doctoral Candidate
California Institute of Integral Studies
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____
Stephanie S. Covington, Ph.D, L.C.S.W

____3/6/14_____
Date

Gena Castro Rodriguez
California Institute of Integral Studies, 2014
Benjamin R. Tong, Ph.D., Committee Chair

TRAUMA AND DELINQUENCY:
A QUALITATIVE STUDY OF THE RELATIONSHIP BETWEEN
SEXUAL TRAUMA AND JUVENILE DELINQUENCY FOR
AFRICAN AMERICAN AND LATINA GIRLS

Abstract

This study explores the relationship between sexual trauma and juvenile delinquency for adolescent African American and Latina girls. The purpose of the study is to gain a greater understanding of ways in which sexual trauma contributes to delinquent behaviors. Moreover, it seeks to contribute to the direction for future research on the causation, treatment, and prevention of delinquency for girls. Participants were recruited through community-based service agencies working with girls and young women who have histories of trauma and criminal justice system involvement. This study used the semi structured interview qualitative method of research. Findings include risk factors for delinquency, pathways from trauma to delinquency, and elements that contribute a change in girls' sense of self due to sexual trauma leading to increased risk-taking behaviors and delinquency.

DEDICATION

To the strong, smart, and beautiful women in my life—past, present and future.

Past: My Nana, Angie Covarruvias, who to taught me about compassion, empathy and taking care of others.

Present: My Mother, Ginger Castro, who taught me about love, strength and taking care of my self.

Future: Tèa Ysabel Castro Rodriguez, who taught me about unconditional love, joy and pride and how to help someone grow and become their own amazing person.

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This project has been a profound journey for me, made possible by many people who love, support and have faith in my work and passion for girls and young women.

To Dr. Benjamin Tong, who has been a fearless, tireless and invaluable ally in my journey with both this project and my graduate program. His understanding and compassion have carried me though my challenges, struggles and success and I am eternally grateful to know him and honored to have worked with him.

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To the brave and strong young women who shared their stories, pain and hope with me to help us better understand how to help girls and women. I am grateful for your trust in the process and faith in sharing your stories.

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To my love and inspiration Tèa Ysabel. Your love, humor, curiosity and creativity kept me going when I was tired and when this was tough. I am inspired by your capacity, potential and strength. You are far smarter, braver and kinder than me, and you inspire me to do well and continue to make the world a safer, gentler and better place for girls like you.

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CHAPTER 1: INTRODUCTION

> "You may not control all the events that happen to you, but you can decide not to be reduced by them."
>
> — Maya Angelou (2009, p. xii)

Background of the Problem

Over a hundred years ago, the first attempts at juvenile justice for girls started with training schools for female immigrants who were thought to be immoral and wayward. These institutions were created to prepare them for marriage, motherhood, and taking care of the home. Part of the lager Progressive movement, their sexuality and sexual expression was of paramount concern, and this began the development of a system with the primary goal of "protecting" their chastity (Sherman, 2012). In the mid- to late 20th century, an exceedingly large number of girls, particularly immigrant and girls of color were incarcerated for status offenses, [1] probation violations and running away to prevent "straying from the path of sexual purity" (Pasko, 2010, p. 1100).

In 1974, the De-institution of Status Offender (DOS) mandate was added to the Juvenile Justice Delinquency Prevention Act (JJPA) to address the problem of incarceration of large numbers of girls in the name of protection. Unfortunately, in 1980, Congress yielded to state pressure and passed an amendment to the DSO mandate that allowed confinement of status offenses if they violated a court order (Sherman, 2012). This change

[1] A *status offender* is a juvenile charged with or adjudicated for conduct that would not, under the law of the jurisdiction in which the offense was committed, be a crime if committed by an adult. Act 4 Juvenile Justice Working Group (2007).

allowed states to continue to over incarcerate girls for low-level offenses in order to "protect" them.

In the 1992 amendments to the JJPA, Congress advised states to consider their provisions of gender-specific services to female offenders and plan for implementation of both treatment and prevention services, but they did not make it a core requirement for funding as they had done before with other special categories like disproportionate minority confinement (Sherman, 2012). Most states continued to incarcerate females for low-level offenses, overused detention, and failed to integrate gender-responsive strategies into their systems.

Today girls are the fastest growing segment of the juvenile justice system (Miazad, 2003). Between 19080 and 2000, arrest rates for girls soared 35% while rates for boys declined (Taylor-Thompson, 2006, p.1137). By 2008, the number of girls referred to juvenile court had increased by 48%, almost 30% of the total delinquency court referrals (Sherman, 2012 p.1587). Even though arrest numbers remained higher for boys than girls during that period, arrest rates for girls increased while rates for boys decreased.

Crimes

Girls are less likely to be charged with a violent offense and are primarily arrested for drug, property, and status offenses. In California, felony referrals and petitions for burglary, theft, and auto theft represent 47% of the felony referrals and 46% of the felony petitions filed on girls (SERIES, J.J.P.B., 2010, p. 4). Felony assault and misdemeanor assault and battery accounted for

approximately one third of girls' petitioned offenses (SERIES, J.J.P.B., 2010, p. 4). Girls' arrests for simple assaults increased 24% between 1996 and 2005 (Sherman, 2012, p. 1602). Some explanations include changes in laws and law enforcement practices concerning domestic violence, including mandatory arrest policies that came out of 1994 Violence Against Women Act (VAWA) (Sherman 2012). Girls are more likely to fight at home and their crimes are more likely to be considered domestic violence than boys. Girls make up 35% of domestic violence assaults and 60% of those offenses are against a parent with just 46% of the same type of arrests for boys (Sherman, 2012, p. 1603).

Child Welfare System Involvement

Families of girls involved in juvenile justice have higher rates of intrafamily conflict and involvement in the foster care system (Taylor-Thompson, 2006). Abuse and neglect in childhood increases the likelihood of arrest as a juvenile by 59% (Widom & Maxfield, 2001, p.1). Girls then tend to stay chronically involved in delinquency once engaged, entering the system for low level offenses and "corkscrewing" through the system with recidivism rates as high as 81%, and approximately 32% served time in an adult jail or prison (Coleman, Kim, Mitchell-Herrzfeld, & Shady, 2009, p. 11).

Gender Roles

Girls in the criminal justice system experience heavier shame for their delinquency than males, as society stigmatizes "girls gone wild" (Covington, 2007a). Many families reinforce traditional female social roles and concepts

of femininity, leading them to give up on girls who don't conform (Taylor-Thompson, 2006). Some parents refuse to attend court with the girls, cooperate with probation terms, and sometimes even refuse to take the girl back into their homes. Boys are given more latitude, employing a "boys will be boys" attitude, but parents and juvenile authorities overpathologize girls' behavior and they are then are more likely to be sent to detention-oriented placement (Taylor-Thompson, 2006). This process leads to deeper system involvement as they violate conditions of probation and are remanded to custody for these acts.

System Response

The system continues to try and "protect" girls with incarceration. Girls are often detained for offenses that boys are not detained for because of paternalism. Paternalist practices include using the justice system and juvenile detention to provide services for high-needs girls, prevent teen pregnancy, regulate girls' sexuality, protect them from sexual victimization, and punish girls who are not compliant. Recent studies have revealed that besides policing girls' voluntary sexuality, the juvenile justice system also continues to punish girls for their sexual victimization (Sherman, 2012). A recent case in Sacramento, CA involved the detention of a young girl who had been raped by an adult male; she was held in detention for two weeks in order to ensure her "safety" and testimony against the perpetrator (Thompson, 2012). This archaic practice is not only traumatizing and

dehumanizing for girls, but it is ineffective and often leads to deeper and chronic criminal justice system involvement for girls.

A 2010 study of 100 girls involved in the San Francisco juvenile justice system found that on average girls were charged with a range of 1 to 22 offenses, with an average of 5.98 charged, but by the point of disposition, the range of charges had decreased to 0-7, with an average of 2.17 (Brown, Castro Rodriguez & Smith, 2010, p. 3). On average, the difference between the original charges alleged and those sustained was 3.7 (p. 3). This creates a "win–win" situation for the defense attorney who reduces the charges, and for the prosecution who sustains some charges, but a "lose" for the girl as she is detained longer, her placement options including going home decrease, and her disposition or sentencing is more complex and restrictive.
Liberal uses of this strategy result in a large population of girls in detention and placement facilities who pose little risk to the community (Sherman, 2012).

Characteristics

Girls involved in the juvenile justice system share many of the same characteristics. Most enter the system at early adolescence (Taylor-Thompson, 2006), come from under-resourced urban environments, and have been raised by single mothers, or have been in foster care placements. Many parents who were, or are themselves involved in criminal justice, have substance abuse problems, histories of trauma, and are under- or un-employed. These young women share common histories of victimization,

especially physical, sexual and emotional abuse; unstable family life including displacement and absent caregivers; school failure, truancy, and drop out; unhealthy attachment with caregivers linked to later dependent and abuse relationships; and undiagnosed or untreated mental health issues including Post-Traumatic Stress Disorder (PTSD), depression, anxiety, and substance abuse. Most experience violence, trauma, and abuse in the home and delinquency typically begins with running away from the abuse (Chesney-Lind, 2001; Dohrn, 2004; Goodkind, Ng, & Sarri, 2006).

Relational Motivation and Violence

Researchers have found that girls' involvement in delinquency is often relationally motivated; girls primarily commit crimes with, for, or because of other people. When they do participate in violent crimes, it is usually directed against the people they are closest to and who have hurt them, especially family members and significant others (Herrera & McCloskey, 2003).

More recently, researchers like Hillary Potter (2008) and Nikki Jones (2010) have written about the intersection of race, class, gender and violence, emphasizing how girls' and young women's experiences with victimization. Potter discusses how images and expectation of the "strong black woman" shape how women make sense of abuse in their lives, and explains "dynamic resistance" as the propensity for women to verbally and physically retaliate against their abusers. Nikki Jones' research focuses on the social meaning of violence and victimization for African American girls. She

found that girls who grow up in neighborhoods that are poor, violent, and unpredictable are preoccupied with survival. This preoccupation leads them to learn to engage in violence to manage their safety. Given all of this, their risk to society is usually low, and they are far greater risk to themselves as victims than to others (Covington & Bloom, 2006).

Overrepresentation of Girls of Color

Finally, poor girls of color are grossly over-represented in the delinquency system (National Council on Crime and Delinquency [NCCD], 2009) and negative stereotypes and misperceptions of their behavior lead to increased and deeper system involvement (Nanda, 2012). A 2009 report from the National Council on Crime and Delinquency (NCCD) Center for Girls and Young Women showed girls of color are disadvantaged all along the juvenile justice continuum from arrests to detention, judicial handling, and commitment and placement. Arrest rates for girls of color have also increased at dramatically disproportionate rates (Dohrn, 2004). After Native American boys, African American girls and Latina girls were most likely to be adjudicated (Freiburger & Burke, 2011). According to the San Francisco Juvenile Probation Department 2012 Annual Report, 71% of the girls in custody were African American and 16% were Latina (Perla, 2012, p. 8). African American girls only represent approximately 7% of San Francisco's population and Latina approximately 22% (San Francisco Commission and Department on the Status of Women, 2012, p. 10). These girls come from primarily from four neighborhoods in the city: (a) Bayview/Hunters Point,

(b) Visitation Valley, and the (c) Inner and (d) Outer Mission. A remarkable 34% of girls are from other counties, with the highest concentration from Alameda County (Perla, 2012, p. 9). These areas represent the most economically challenged districts in San Francisco and the Bay Area.

African American girls are detained almost six times as often and committed over four times as often for violent offenses. Latina girls are detained almost twice as often for violent, public order, and technical violations (National Girls Center Fact Sheet, 2009, p. 7). African American girls also make up nearly half of all those in secure detention nationally, and 70% of those in Northern California (Morris, Bush-Baskette, & Crenshaw, 2012, p. 1) and Latinas constitute 13% of girls in Northern California. Although Caucasian girls make up 65% of the population of at-risk girls, they account for only 34% of girls in secure detention (Bloom & Covington, 2001, p. 7). Seven of every 10 cases involving Caucasian girls are dismissed, compared with 3 of every 10 cases for African American girls (Bloom & Covington, 2001, p.7).

Racial and gender perceptions of girls of color contribute to their over-representation (Nanda, 2012). The Coalition for Juvenile Justice (n.d.) refers to this as structural racism and implicit bias. *Structural racism* is defined as any set of laws, policies, or practices with the intent or effect of treating girls of color more harshly than whites, or denying people of color access to the same opportunities as whites. Because structural racism is actually embedded in the system, it can be hard to identify and address.

Implicit bias is the subtle and often more pervasive value held by people that reflects deep-rooted, automatic, and even unconscious to those who hold them. The greatest challenge of implicit bias is that if people don't recognize or acknowledge it, they fail to see the unique experience of girls of color that contribute to both their strengths and challenges. Derald Sue (Sue et al., 2007) refers to this as "color blindness" and cautions that it is particularly dangerous because it contributes to and perpetuates disparities in our society. For girls of color in the juvenile justice system this means increased incarceration and fewer opportunities for treatment and rehabilitation.

For instance, there are two systems of justice: one private and one public. The private system operates for girls whose families have resources and delinquent behavior is handled in the schools, with private therapy, boarding schools or other means. Over the past two decades, Caucasian girls are disappearing from the second system, the public juvenile justice system. The public institutions that incarcerate girls (detention centers, training schools, correctional institutions, and reformatories) are filling up with girls of color (African American and Latina), primarily confined for nonviolent offenses (Dohrn, 2004). Racial, ethnic, gender, and economic discrimination may contribute to female delinquency through bias and profiling and lead to decreased opportunity, disparities in treatment, gender bias, and lack of program parity in rehabilitation and treatment (Bloom & Covington, 2001).

Summary

There is a growing desire and need to understand how and why girls of color are the fastest growing population in juvenile justice. The juvenile criminal justice system is an expensive and often ineffective intervention for female delinquency (Mendel, 2011) and, as many jurisdictions face local and state budget cuts, it is important to focus and improve strategies for addressing delinquency prevention and intervention for girls. It is imperative that girls who are committing nonviolent offenses, related to their poverty and trauma, be directed to treatment rather than incarceration in a system that deepens their criminal behavior and decreases their likelihood of eventual health and independence.

Statement of Problem

A particularly important gender-specific factor for girls in delinquency is sexual abuse and maltreatment. It has been estimated that over 75% of delinquent girls have a history of sexual abuse (Bloom, Owen& Covington, 2003). Victimization may be an important etiological factor for various behaviors, such as running away, drug abuse, prostitution, and even violence that can lead to criminal involvement (Siegel & Williams, 2003). Many studies of special populations suggest that the incidence of sexual abuse is more pervasive among girls who engage in antisocial behavior, particularly those who engage in violent behavior, than among their male counterparts (Goodkind, 2008). Several researchers have identified a relationship between sexual abuse, maltreatment, and delinquency for girls

(Bloom et al., 2003; Seigel & Williams, 2003), but none have found why this relationship exists. Our juvenile justice system has focused on punishing the behavior, but little on the factors that contribute to behavior. We rarely even ask the question "How did you get into this system, or what is going in your life?" Risk-taking and delinquent behaviors are not "natural," they don't help or serve girls well, and they often cause far more harm to the girl through continued violence, victimization and harm. As other researchers have pointed out, there is a need to understand both the experience of girls who get involved in delinquency and the deep-rooted system assumptions that feed the treatment of girls to begin to make effective change (Taylor-Thompson, 2006). This research examines the pathways and relationship between sexual trauma and delinquency in an attempt to find more effective strategies for prevention, intervention, and treatment and inform policy for girls who begin as victims and are then treated as perpetrators.

Purpose of Study

The purpose of my dissertation is to understand the relationships between sexual trauma and delinquency for adolescent Latina and African American girls, and why sexual abuse is so highly correlated with delinquency. This subjects important because these girls start out as victims of abuse, survivors of traumatic, horrible experiences that they were not protected from. Even those who entered systems like foster care and child welfare were not protected and often further abused (Courtney et al., 2001). These girls were forced to employ important self-protective coping strategies

including running away or fighting back, or more self-destructive strategies like substance use or unhealthy relationships. When one focuses on the risk behaviors (running away, substance use) and the crimes, we miss the etiology of the behavior. Girls are forced to develop adaptation to survive a dangerous, abusive, non-protective world. Second, since we unfortunately miss opportunities for early prevention (childhood) or intervention (pre-delinquency) involvement, we need to better utilize the juvenile justice system as an assessment and treatment option for the many girls that land there with the experience of trauma prior to their delinquency. This research can be used to develop intervention and treatment strategies for girls who have been victimized before they enter the juvenile justice system and to develop better policies for standard trauma assessment and treatment for girls who cross over to the system.

Through qualitative research and interviews with 10 young women aged 18-25 who have exited the juvenile delinquency system, I have identified factors that help society better understand what impact sexual abuse has had on girls and why it puts them at such high risk for delinquency. This research is novel, in that there is much written about the correlations between sexual trauma and delinquency, but little about pathways that develop between sexual trauma and delinquency for girls. This research is extremely relevant and useful to develop prevention, intervention, and treatment models for girls who have experienced sexual trauma to prevent

delinquency, and to improve child welfare, juvenile justice, and social service systems.

Research Question

My specific research question is "How do African American and Latina girls understand the pathways that led from their sexual trauma to the juvenile delinquency system?" I spoke with 10 young women and asked them to discuss their early family relationships, experiences with sexual trauma and abuse, trajectory in the juvenile justice system, and reflections on the relationship between their trauma and subsequent delinquency.

Conceptual Hypothesis

Based on the literature, I hypothesized and confirmed with my research that common pathways such as internalized shame, decreased feelings of self worth, ineffective self-protection strategies, and chronic victimization and traumatization would emerge in the interviews with girls who have both experienced sexual trauma and been involved in the delinquency system. Complex and chronic symptoms of trauma are contributing factors to (a) a fragmentation of developing self, (b) negative characterological development, and (c) development of pathological beliefs, all of which contribute to risk-taking, self-harm, and delinquent behaviors.

CHAPTER 2: REVIEW OF LITERATURE

The literature review consists of four sections. The first provides an overview of female delinquency including the trajectory and pathways that move a young woman toward delinquency. The second section addresses mental health issues and diagnosis common for girls involved in juvenile justice and discusses the prevalence of those issues for girls. The fourth section tackles and defining and understanding trauma, including a review of major trauma theories. And finally, the fourth section trauma discusses gender responsive theory, a structure for understanding the needs and strengths of girls and young women.

Female Delinquency: Trajectory and Pathways

Literature suggests that girls and boys do not have the same trajectory into the juvenile justice system (Chamberlain & Moore, 2002). Males who exhibit antisocial delinquent behaviors in adolescence often exhibited these behaviors in childhood, but females rarely exhibit antisocial behavior until their entrance into delinquency (Chamberlain & Moore, 2002). This means that delinquency and the evolution of antisocial behaviors may be more predictive for boys than girls. In contrast, girls' delinquent behavior appears to be more related to abuse, sexual exploitation, or trauma at home (Miazad, 2003).

Belknap and Hoslinger (1998) discuss the idea of a "pathway framework" in which a sequence of events beginning with victimization for girls then leads to offending, as a way in which girls are actually protecting

themselves from the victimization. For example, a young woman who is experiencing abuse at home runs away to escape abuse, but is then committing a status offense of running away, and is at risk for committing criminal offenses in order to survive, such as theft, drug sales, and prostitution (Belknap & Holsinger, 1998). Although males and females may have some similar histories prior to delinquency, those experiences can be different and unique. I now discuss some of those female pathways in more detail.

Aggression

Developmental Pathways theory posits that gender differences exist not only in the typical progression of delinquency behavior, but also in the development of aggression (Cauffman, 2008). These differences begin as early as preschool, and by adolescence girls are more likely to direct aggression toward their family members, romantic partners, and female friends. In *A Rallying Cry for Change* (Patino, Raviora, & Wolf, 2006) the authors write that more than half of the aggravated assault charges for girls in a Florida study were involved domestic violence (p. 25).

Aggression is a common predecessor to delinquency for both males and females, but aggression is different for each gender. Girls tend to exhibit more "relational aggression" in childhood and adolescence like exclusion, gossip, and collusion directed at relational bonds between friends (Chamberlain & Moore, 2002). This unique type of relational and social

aggression appears to contribute to girls' continued experiences as both victim and perpetrator, and serves as a mechanism for delinquent behaviors.

Family Dysfunction

Girls are also more affected by family dysfunction than males, and self-worth is often affected by this dysfunction (Chamberlain & Moore, 2002). Research findings suggest that family disturbances alone may not predict delinquency, but that the development of psychological difficulties from the dysfunction might contribute to delinquency system involvement (Wood, Foy, Gouguen, Pynoos, & James, 2002b). Abuse has been found to be a stronger predictor of offending behavior for females than for males (Makarios, 2007) and family issues such as ineffective parental supervision, frequent parent–child conflict, and history of family problems are overwhelmingly linked with girls' delinquency.

Academic Failure

Academic failure appears to be one of the most significant risk factors for early delinquency for girls including poor academic performance, truancy, and dropping out. A disproportionate number of girls in delinquency have learning disabilities, and by the time they enter the system they are at least one grade level behind their peers (McCord, Widom, Bamba, & Crowell, 2000). Girls often begin missing school because they have trouble learning the information, then fall behind in classes, and finally, out of frustration, stop going to school.

Another reason girls become truant and or drop out of school is because of bullying, violence, and behavior problems. In a summary of academic risk factors for youth involved in delinquency (McCord et al., 2000) researchers found negative peer relationships to be influential on poor academic outcomes. Peer rejections and grouping of negative peers, for example, are potentially more detrimental to girls than boys, as they are relationally oriented and heavily impacted by their peer associations. A girl who cannot negotiate relational problems with peers in a healthy manner avoids conflict or problems by discontinuing school or moving schools. In this situation, the girl gets further behind academically and makes it more challenging and less likely that she will catch up and keep up at grade level.

In addition to these interpersonal challenges, zero tolerance policies that mandate school arrest and expulsion can export girls directly to juvenile detention for offenses that would have been handled by the school or parents in the past. African American girls are particularly affected by this "pipeline to prison" with exclusionary discipline informed by stereotype-driven fears and harsh treatment due to nonconformity with gender stereotypes, where their behavior is interpreted more harshly (Morris, 2012). School can be a protective place for girls who have experienced trauma and abuse, so when they are suspended and expelled, it increases their likelihood of risk-taking and delinquent behaviors (Morris et al., 2012).

Child Welfare System Involvement

Girls who have been abused or neglected and enter the foster care system are at far greater risk of entering the juvenile justice system. They are referred to as "crossover youth," "dual-jurisdiction," or "dually involved" youth by the court system. A girl becomes a crossover through one of three avenues: (a) she has experienced sustained allegations of abuse or neglect and then commits an offense and enters the delinquency system while under the care and custody of child protective services; (b) she has a prior but not current, child welfare case, and commits an offense and enters delinquency; or (c) she has no prior child welfare system contact when she enters the delinquency system, but probation refers her to child protective services to investigate an allegation of abuse or neglect (Herz & Ryan, 2008). A high proportion of crossover youth are girls, particularly African American girls, and approximately half are not regularly attending school or experienced suspension or expulsion prior to entering delinquency (Herz & Ryan, 2008). Many were in the dependency system for long periods of time, have parents who have been absent for many years, and are struggling with their own criminal justice, substance abuse, and mental health issues. Approximately one third of the arrests of these youth occurred while they were residing in group homes (Herz & Ryan, 2008). Finally, the majority of these crossover youth have mental health or substance abuse problems and risk factors such as history of running away and prior arrests and detention (Herz & Ryan, 2008). A study of girls in San Francisco found that 33% of the girls in the

sample were part of the child welfare system at the time of entering delinquency, and 40% had mention of child protective services cases or child welfare in their history according to court records (Brown et al., 2010, p. 2). Girls with child protection system histories in Chicago (Cook County) were four times more likely than the general population to have a delinquency petition filed against them, compared to twice as likely for males (Dohrn, 2004, p. 308).

Running Away and Sexual Exploitation

Child sexual assault, running away, and drugs are correlated with adolescent prostitution, and create a setting with potential further violence and abuse. Girls who have been sexually abused frequently run away from home or from placements and social agencies where they have been sent to escape that abuse. Widom and Kuhns examined the extent to which childhood abuse and neglect increases the risk of promiscuity, prostitution, and pregnancy among traumatized teens. In analyzing results from 1,196 subjects (676 abused or neglected and 520 controls) they found that childhood abuse and neglect is a significant predictor of prostitution for females (Widom & Kuhns, 1996, p. 1611).

When girls run away from home, it not only puts them in the pathway of delinquency (Dohrn, 2004), it puts them in a world of danger as homeless youth. Homelessness can be a symptom of underlying problems, such as lack of financial support, mental illness, or family conflict and instability. Being homeless places a young woman at risk for further abuse, particularly sexual

assault, or prostitution in the community, as she must do whatever it takes to survive (Kipke, Simon, Montgomery, Unger, & Iversen, 1997, as cited in Goodkind et al., 2006).

The trafficking of girls for prostitution has become another revenue stream for drug dealers who have found it too risky or dangerous to sell illegal drugs. Many young victims of exploitation are further negatively impacted when the courts charge the girls with prostitution or detain them for their own protection or to ensure they will testify against their pimps. They need treatment for the abuse and trauma that propelled their involvement in the first place, and support to help them leave exploitative relationships. These young women bond with their exploiters in response to their psychological exploitation and often refer to these pimps as boyfriends, protecting and even taking charges and sentences for them (Morris et al., 2012).

Intersectionality: Race, Class and Gender

Intersectionality is an important framework to understanding the juvenile justice system's over-representation of African American and Latina girls. *Intersectionality* means that women have multilayered identities and can be faced with multiple complex issues as a result, and helps us understand why we cannot look at this issue without considering all of levels of impact. These young women and girls have been affected by racism, classism, and sexism in a system that does not acknowledge the complexity of issues or their perpetuation of the policies that contribute to and maintain

high rates of delinquency for girls of color. In 1993, Kimberle Crenshaw wrote a foundational article on intersectionality, titled "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color," in which she describes the theoretical framework that recognizes multiple intersecting inequalities facing poor women of color. More contemporary examinations of this idea have been expanded to include age, nationality, religion, physical ability, and other locations of inequality as they are related to criminal justice and informed by multicultural feminism (Burgess-Proctor, 2006). The praxis of intersectionality becomes important when examining the realities of girls involved in child welfare and delinquency because it begs the inclusion of issues of power, privilege, and oppression ingrained in the system.

Mental Health

The incidence of mental health issues is more prevalent for girls than boys in the delinquency system. One study estimates mental disorder for incarcerated boys at 27%, compared to 84% for incarcerated girls (Timmons-Mitchell et al., 1997, as cited in Alemagno, Shaffer-Kin, & Hammel, 2006). Another study by Teplin, Abram, McClelland, Dulcan, and Mericle in 2002 found 74% of girls, compared with 66% of boys, met the full criteria for a mental health disorder (p. 1140). The majority of girls in juvenile justice have at least one mental disorder (Cauffman, 2008; Cauffman, Feldman, Waterman, & Steiner, 1998; Dixon, Howie & Starling, 2004). Delinquent girls with serious mental health problems are significantly disadvantaged in the

juvenile justice system because if they are not properly diagnosed and treated, mental health can actually decline with system involvement. Isolation, extended confinement, and restrictions on relationships are all counterproductive to positive mental health for girls. Girls are also often medicated in detention facilities in order to control their behavior, which is not a suitable strategy when administered alone, in the absence of therapy. Below I discuss some common diagnoses associated with juvenile justice-involved girls.

Conduct Disorder and Oppositional Defiant Disorder

Common diagnoses for girls in the delinquency system are conduct disorder and oppositional defiant disorder. According to Simkin and Katz (2002), girls who are victims of extreme abuse often act out in ways that cause them to be arrested, and subsequently they are criminalized and labeled or diagnosed by the juvenile system. In a recent study, 40% of girls met criteria for disruptive behaviors like conduct disorder or oppositional defiant disorder (Veysay, 2003, p. 2). Girls who are diagnosed with conduct disorder have a higher risk than their male counterparts of developing more severe psychopathology later as adults (Veysay, 2003). Ford's (2002) review of the research on the development of oppositional defiant disorder and conduct disorder indicates that victimization and PTSD are prevalent among girls with these disorders and these diagnoses may be inaccurate (NCTSN, 2004).

Affective Disorders

Affective disorders are especially high for girls, with more than 25% meeting criteria for a major depressive episode (Dorn, 2004, p. 307), with some studies reporting as high as 55% (Dixon, Starling, 2004). Researchers have found that nearly three quarters of the girls detained at the Juvenile Temporary Detention Center in Chicago met diagnostic criteria for one or more psychiatric disorders; almost 20% of detained girls met the criteria for a major depressive episode (Dohrn, 2004, p. 307). Depression is common but rarely diagnosed; sadness, isolation, and the sense of loss that comes from childhood trauma are internalized. Evidence suggests that girls with depression are at greater risk of antisocial behavior (Obeidallah & Earls, 1999). There are three ways depressive feelings might underlie a girls' antisocial behavior: (a) depressive feelings could feed indifference toward safety and increase likelihood of risk and delinquent behaviors; (b) depressed girls may be withdrawn and isolated, leading to rejection by prosocial peers and leading to interaction with deviant peers; and (c) poor concentration and lack of interest in former activities may lead to lack of attachment with pro-social activities like school and sports, and an increasing likelihood for antisocial behaviors (Obeidallah & Earls, 1999).

Anxiety is another significantly correlated disorder for juvenile justice involved girls, as high as 41% (Teplin, et al., in Cauffman, 2008, p.3). Girls' focus and attention on the importance of interpersonal relationships may explain the disproportionate level of anxiety for girls compared to boys, as

they are more likely to suffer when there are interpersonal conflicts. This issue makes detention and out-of-home placement particularly hard for girls, as they are kept away from their important relations with family, peers, and romantic partners.

Substance Use

Between 15% and 50% of girls have been found to have a substance use disorder (Cauffman, Lexcen, Goldweber, Shulman, & Grisso, 2007, p. 310). Young women who have been sexually abused are likely to use substances in an effort to self-medicate and cope with their anxiety and depression resulting from the trauma (Acoca, 1998; McCartan & Gunnison, 2009; Tyler, 2002). This link holds firm even when controlled for other factors like biology and environment (Goodkind et al., 2006; McCartan & Gunnison, 2009). Alcohol and other drugs can provide an escape from the emotional pain experienced by survivors of abuse, and substance use can quickly lead to problems at school and involvement with delinquent peers (Cauffman et al., 2007).

Suicide and Self-Harm

Unfortunately, it is all too common for girls who are suffering with mental health symptoms to turn inward and engage in self-harming behaviors like cutting, suicidal ideation, or suicide attempts. In a study by Timmons and Mitchell (1997, as cited in Alegmagno et al., 2006), 37.3% of girls reported suicidal thoughts and 26.4% had attempted suicide (p. 47). These internalizations of trauma are more common for girls than boys,

contributing to the high incidences of depression and anxiety for girls in this population.

Trauma

History.

Judith Herman explains the history of our understanding of sexual trauma for girls and women in her foundational 1997 book *Trauma and Recovery*. The first documented "study" of traumatic sexual experiences was the early work of Pierre Janet, Joseph Breuer, and Sigmund Freud about "hysteria," then described as a disease for women originating in utero. They concluded that the cause of hysteria was psychological trauma that produced an altered state of consciousness. In 1846, Freud wrote "A etiology of Hysteria" which discussed the effects of childhood sexual trauma and later adult distressing symptoms characterized as hysteria. The book was highly controversial as it exposed the dark and dirty secrets of an epidemic of sexual abuse perpetrated at the time by elite and ruling classes of Austria against women and children. The work was shunned and Freud dropped his pursuit of the relationship between sexual abuse and pathology due to public and political pressure.

The next major period in the history that has fed our understanding of trauma came following the major World Wars and the Vietnam War. What was first understood as "combat neurosis" or "fatigue" during the first two World Wars, and then further observed from returning veterans of the Vietnam War, finally informed new diagnosis and treatment for trauma in the

1970s. The Veterans Administration acknowledged the disorder and offered treatment. It was at this time that feminists began to advocate for the acknowledgement of the pervasive sexual and domestic violence perpetrated against women, which mirrored many of the symptoms observed from those in combat, and push for the redefinition of rapes as a crime of violence. The first rape crisis centers were established in 1971, and in 1972 Ann Burgess and Lynda Holmstrom completed a groundbreaking study of women and children who had experienced trauma in Boston. They developed the term "rape trauma" to include the symptoms of experiencing a life-threatening event, with fear of death or mutilation and in the aftermath, experiencing symptoms of insomnia, nausea, startle response, nightmares, and dissociation or numbing (Herman, 1997).

In 1980, PTSD was included in the *Diagnostic and Statistical Manual of Mental Disorders*, *Third Edition* (*DSM-III*; American Psychiatric Association, 1980) and symptoms for victims of rape, domestic violence, and child abuse were recognized along with those of combat victims, with the newly defined disorder. In the early 1990s a task force was formed to look into expanding the definition of trauma to include the experience of childhood interpersonal abuse as a distinct disorder, taking into account the additional issues associated with early trauma. These symptoms included self-destructive behavior, risk taking, interpersonal problems, somatic concerns and hopelessness/despair. The task force was not successful in including the diagnosis in the *DSM-IV* or *V*.

The most recent event that has had a profound impact on the way we think about trauma is 9/11. As a result of the unimaginable events associated with and following the hijacking and plane crash into the World Trade Center and destruction of the towers themselves, we now have a new understanding of not just the direct, but the indirect impact of psychological trauma. *Secondary* or *vicarious trauma* is defined as exposure to trauma of others as experienced by providers, family members, or friends in close contact with the event. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-V*) is reported to expand the definition of trauma to include this idea of trauma as not only an intense subjective experience, but also will include the repeated and extreme exposure to aversive details of events (first responders) and includes negative alterations in cognition and mood.

Correlation Between Trauma and Female Delinquency

Trauma history is not only a correlate of delinquency, but actually drives girls into the juvenile justice system. Research data consistently points to a strong link between victimization, trauma, and girls' delinquency (American Correctional Association, 1990; Bloom et al., 2002; Sheldon & Chesney-Lind, 1992) and girls who have been abused and neglected are nearly twice as likely to be arrested as juveniles as those who have not (Veysay, 2003). In 2002, a comprehensive study about trauma for African American and Latina girls studied 100 girls (46 African American, 54 Latina) in Los Angeles County probation camp and juvenile halls, examining three domains: violence exposure, psychological distress, and family dysfunction

(Wood, Foy, Gouge, Pyros, & James, 2002a). When comparing findings of these girls to a sample of 100 boys, researchers found females reported significantly higher levels of physical punishment and sexual abuse exposure. High rates of sexual trauma and dating violence was found for girls: 36% reported being kicked or hit by boyfriends, 24% reported being beaten up at least once, and 21% reported threatened with a knife or gun (p. 118). Twelve percent reported forced sex with a boyfriend and 22% reported forced sex with someone in the past few years (p. 119). Reporting on experiences before age 14, 18% of girls reported forced sex by an adult, and an adult touched 31% of girls in an unwanted sexual manner (p. 119). Many also experienced other types of violence, with 58% reporting that someone had held a gun to their head, 10% had been tortured or physically mutilated (burns, etc.), and 31% hit with an object such as a bat, club, or tire iron (p. 119).

Experience with community violence was also high for the girls in this study: 65% witnessed homicide of a close friend or relative, and16% had a close friend or relative who committed suicide (Wood et al., 2002a, p. 117). When screened for PTSD using the LASC-R, females reported significantly higher levels of overall psychological distress and scores on all three PTSD subscales of re-experiencing, arousal, and avoidance. Fifty-two percent of females met full criteria for PTSD, in contrast to 28% of males (p. 120). Fifty-two percent of females in the study carried a gun prior to arrest, and females involved with guns described higher levels of family risk, lower perceived

social support from family, and higher levels of physical punishment in comparison with males (p. 120).

Additionally, girls described higher levels of multiple forms of victimization within their families, in their relationships with boyfriends, and in the community. The study concluded female delinquents had more disturbed families, and that females in this study who had experienced physical punishment were more likely to carry and use guns associated with the delinquency. Carrying a gun could be an adaptation to the pervasive sense of threat and vulnerability experienced by trauma, which would be consistent with idea that abused kids see the world as dangerous and requiring vigilance and survival (Wood et al., 2002a).

Finally, the depth of this victimization is staggering. For example, chronically delinquent girls studied by the Oregon Social Learning Center reported their first sexual encounters at an average age of 6.75 years old (Sherman, 2005, p. 12). An overwhelming 92% of girls interviewed in four California counties in 1998 had suffered some form of abuse; 88% suffered emotional abuse, 81% reported physical abuse, and 56% reported one or more forms of sexual abuse (40% reported at least one incident of forced sex and 17% reported more than five incidents) (p. 21). Trauma appears to be more central to the histories of girls in the system than it does for boys (Sherman, 2012).

Sexual Trauma

The high rate of sexual trauma for girls is particularly critical to understand because it a distinguishing variable for girls in delinquency. There is growing understanding of the correlation between sexual trauma and delinquency (Belknap, 2007; Chesney-Lind & Pasco, 2004; Goodkind et al., 2006; McCartan & Gunnison, 2009; Siegel & Willians, 2003), but researchers have not yet found sexual trauma to be a strong predictor of female offending (McCArtan & Gunnison, 2009). Adolescence is a particularly risky time for girls, and 14 is the age at which they are at greatest risk (Covington, 2008). We know that sexual trauma leads to many of the internal and external symptoms discussed in this paper—depression, anxiety, substance abuse, and criminality—and that it can have a cumulative impact on these issues for adult women (McCartan & Gunnison, 2009). Adult women who experience sexual trauma are also at risk for ongoing adult abusive relationships (McCartan & Gunnison, 2009) and are at greater risk for divorce and dissatisfying sex life (Finkelhor et al., 1998, as cited in McCartan & Gunnison, 2009). McCarten and Gunnison (2009) found that childhood sexual abuse was detrimental to other areas of girls' lives in adulthood including work, legal, and social aspects.

Researchers have found that sexual abuse combined with witnessing physical abuse appears to significantly predict domestic violence in later relationships, but not abuse itself (McCartan & Gunnison, 2009). It is suggested that girls who witness domestic violence in the home begin to see

the abuse a normal part of adult relationships. Also, given the correlation of sexual abuse, particularly in the home and with running away, one can see that sexual trauma can be a strong pathway to delinquency for girls who are escaping abuse and forced into a life of survival on the streets.

Girls experience sexual abuse and trauma at higher rates than their male counterparts and experience more detrimental effects. A reported 70% of girls in delinquency have a history of sexual abuse, compared to a reported incidence rate of 30% for boys (Miazad, 2003, p. 10). Sexually abused adolescents are more likely to report symptoms of mental distress or illness, especially depression, and researchers have found that girls with a history of sexual abuse scored higher on measures of anxiety and depression and lower on interpersonal sensitivity and self-esteem than did those without such a history (McCartan & Gunnison, 2009). Herrenkohl and Herrenkohl (2008) found in both bivariate and structural equation models, that sexual abuse was more strongly associated with youths' internalizing and externalizing problems than was physical abuse (T. Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008). Drawing from this research, an argument can be made that sexual abuse is the severest form of maltreatment, and thus highest on the hierarchy (Hahm, Lee, Ozonoff, & Van Wert, 2009).

Researchers have found a strong relationship between sexual abuse and mental health problems, particularly suicide attempts and negative feelings about life. Recent research demonstrates a relationship between depression and delinquency (e.g., Obeidallah & Earls, 1999), but further

research is necessary to examine whether mental health is a mediating factor between abuse and delinquency (Goodkind et al., 2006). Sexual abuse has also been correlated to school problems, substance use, risky sexual behaviors, and delinquent behaviors.

Sexual abuse and trauma can also affect physical health. Finestone and colleagues (2000) found that women with a history of childhood sexual abuse were significantly more likely to report chronic pain than were control groups of women who did not experience such abuse. Furthermore, women who experienced childhood abuse (including sexual, psychological, physical) are more frequently ill, are less likely to describe their health as good, and have a higher incidence of eating disorders, obesity, and sleep difficulties than do people who did not experience childhood abuse (Goodkind et al., 2006; Kendall-Tackett, 2002).

Finally, sexual abuse that occurs during adolescence is especially problematic because this is a crucial period of identity formation (Butler & Burton, 1990, as cited in Goodkind et al., 2006). Girls' identities are partially shaped by how they are treated by others, and their perspectives on roles are developed with cues from family members and others about appropriate behavior. According to Butler and Burton (1990, as cited in Goodkind et al., 2006), a girl who has been sexually abused may come to believe that her purpose is to fulfill the sexual desires of others. She may be afraid to tell adults about the abuse because she fears punishment, denigration, or

stigmatization and she may also feel forced or pressured to engage in sexual behavior by a partner who threatens her (Goodkind et al., 2006).

Post-Traumatic Stress Disorder (PTSD).

The diagnosis of PTSD is high for girls involved in juvenile justice. Among a sample of juvenile detainees, significantly more males (93.2%) than females (84%) reported a traumatic experience, but more females met criteria for PTSD: almost 18% for females and 11% for males (Abram et al., 2004 in NCTSN, 2004). PTSD rates for girls in the juvenile justice system are 8 times higher than a community sample of similar-aged peers. Among a sample of female juvenile offenders, 70% had been exposed to some form of trauma, 65.3% had experienced symptoms of PTSD sometime in their lives, and 48.9% of these incarcerated females were experiencing the symptoms of PTSD at the time of the study (Cauffman et al., 1998 in NCTSN, 2004).

Chronic and Complex Trauma

Many girls are likely over diagnosed with PTSD, but the actual phenomenon they experience might be better explained in descriptions of complex trauma, chronic trauma, or complex PTSD, none of which are diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). *Complex trauma* is described as the experience of prolonged, repeated trauma such as would be encountered as a prisoner of war or as a child in an abusive family (Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). Finally, complex PTSD transcends simple PTSD in three ways: the trauma appears to be more

complex, diffuse and tenacious; the survivors of the prolonged abuse develop characteristic personality changes including problems with relatedness or identity; and the survivor is vulnerable to repeated harm, both self-inflicted and at the hands of others (Herman, 1991).

The underlying mechanism of the cumulative classification approach is that individuals with more childhood adversity may have biological and cognitive changes that may contribute to a lower response threshold to future stressors. This lower threshold makes these individuals more reactive to adverse experiences, including increased susceptibility to depressive symptoms (Hahm et al., 2009; Post, 1992; Segal, Wiliams, Teasdale, & Gemar, 1996). Chamberlain and Moore (2002) note that stress-reactivity, developmental lags, and impairment put girls at risk for “intra and inter-relational chaos” (in NCTSN, 2004 p. 4), which can result in involvement in continued trauma. Exposure to trauma also increases the risk of illicit substance use and subsequent victimization among girls, who may wind up in the juvenile justice system (NCTSN, 2004).

Effective diagnosis and trauma treatment is important, because if trauma is not resolved, negative residual effects may result, including alcohol and drug use, violence, and development of PTSD, according to a 2000 study by Crimmins, Cleary, Browenstein, Spunt, and Warley. Crimmins et al. (in NCTSN, 2004) suggest that negative residual effects may result, including (a) alcohol and drug use, (b) involvement in violent activity, and (c) development of mental health problems such as PTSD.

Trauma Theory

Trauma literature has led to growing understanding of many aspects of the phenomenon, but important theoretical issues regarding the impact and outcomes are still in need of development.

> [There is] a lack of knowledge about and theoretical understanding of the complex forms of interactions between (1) the nature of the stressor event, (2) the personality attributes and coping processes of the person, (3) the psychobiological mechanisms affected by trauma, and (4) the cultural responses to those who are victimized. (Wilson & Raphael, 1993, as quoted in Pollard, 2001, p. 45)

Trauma theory is explained here to help shed light on some of the adverse socioemotional effects of trauma on victims (Maschi, Bradley, & Morgen, 2008). The foundations of Attachment Theory begin with Bowlby (1969) and Ainsworth (1978) and then move on to theories that explain coping, stress and strain, and traumagenic factors. Finally Schema theory addresses assumptions, character, and pathological belief development to explain the impact of trauma on self-concept.

Attachment Theory

Attachment theory lays the foundation of the understanding about how children learn foundational concepts of regulation, relationships and attunement. Bowlby (1969) first introduced the idea of Attachment Theory and Mary Ainsworth (1978) further expanded the work with mothers and infants. Their research originating in concepts from ethology, cybernetics, information processing, developmental psychology, and psychoanalysis revolutionized our understanding of the relationship between the mother and child and how disruption leads to separation, deprivation, and

bereavement (Bretherton, 1992). Some of the major tenets of attachment theory include the idea that children learn to regulate their behavior by anticipating their mother or caregiver's response to them. Because this learning occurs in the context of developing brain, neural development and social interaction are inextricably intertwined and affected, and early patterns of attachment affect the quality of information processing and attachment throughout the life span.

There are four attachment classifications: secure, dismissive, preoccupied, and disorganized. Secure attachment occurs when mothers or caregivers provide security and comfort for the child that meets his/her need for security through consistent and responsive attention. Children who were securely attached grow up able to integrate their needs, feelings, and perceptions of others in a healthy way and can have healthy, secure adult relationships. Adults who are securely attached are able to cope with stress well and don't rely excessively on defensive processes to modulate their attachment anxiety (Bain, 2006).

Insecure attachment is characterized by the experience of children who were not able to rely on their mothers or caregivers to provide physical and emotional safety (Bretherton, 1992). Because they were unable to integrate the attachment experience, memories, and affect that would have allowed for a meaningful relationship, they experience anxiety in their attachment (Bain, 2006). Adults who have experienced insecure attachment and anxiety then relies on "defensive exclusion" (Bowlby, 1969), to block

their unconscious beliefs that they are not worthy of protection and are unsafe. They do not pay attention to the experiences and memories that would provide for meaningful attachment, and therefore cannot have close and secure relationships.

Dismissive attachment happens when the mother or caregiver rejects the child's feelings of needs, fear, or anger (Bain, 2006). The child learns to "dismiss" or hold back attachment by minimizing, avoiding, or neutralizing attachment in an effort to modulate stress (George & Solomon, 1999, as cited in Bain, 2006). Dismissive attached adults under-react to distress and don't rely on attachments and relationship for support.

With preoccupied attachment, the child experienced a mother or caregiver who was inconsistent and withholding of attention. These children experienced confusion, ambivalence, uncertainty and a preoccupation with anger and sadness (George & West, 2004, as cited in Bain, 2006).

Finally, the disorganized attached child experienced an ongoing threat of abandonment and disregard resulting in feelings of helplessness (van Ecke et al., 2005, as cited in Bain, 2006). These children develop unresolved segregated systems of defense processing and are prone to the sudden emergence of segregated material when attachment systems are activated (George & West, 2001, as cited in Bain, 2006).

In a study by Allen et al. (2002), the authors examined two distinct roles of attachment organization in relation to developing social skills and delinquency during midadolescence, the role of direct predictor of changing

levels of social skills and delinquent behavior, and the role of moderator of the link between the normative development of adolescent autonomy and adolescent skill development and deviance. Secure attachment predicted increased social skills between 16 and 18 years of age, but insecure-preoccupied attachment predicted delinquency during the same period of time. Preoccupied teens that had highly autonomous mothers had the most relative decrease in skill levels and increases in delinquent activity over time. This finding suggests that the risk for deviance for preoccupied teens may increase during the normal course of autonomy in adolescence.

Effects of Trauma

The following theories address the effects of the experience of trauma for girls and young women. It is important to understand how pervasive the impact of trauma is for girls and how they begin to shape and adept their behavior in response to abuse and lack of safety.

Coping mechanisms.

Coping mechanisms theory, as described in Herrera and McClosky (2003), explains that girls who experience abuse, victimization, and violence in their homes spend more time out of their home and running away, which are their coping mechanisms, and they therefore put themselves at additional risk in those situations. As discussed earlier, these girls must engage in many dangerous activities to ensure their survival. The experience of trauma creates intolerable emotions and memories for girls, which they try to cope with through the use of substances, sexual relationships, and even engaging

in violence (Herrera & McColsky, 2003). Routine activity theory, which is a criminological theory that explains victimization as a function of who girls associate with, where they live, and where they spend their time speaks to the idea that youth experiencing similar problems in similar places will bond together and engage in healthy behaviors (Cuevas, Finkelhor, Turner, & Ormond, 2007).

Stress and Strain Theories

Stress theory suggests that trauma creates a heightened sensitivity to threat, which leads to a hostile attribution bias, impaired social competence, and increased aggressive behaviors in girls. Strain theory posits that crime and delinquency are ways of coping with adverse relationships and negative life events like victimization, or they are used as methods to prevent further victimization (Cuevas et al., 2007).

Traumagenic Factors

A landmark study by Finkelhor and Browne in 1985 attempted to explain the impact of trauma experiences in a framework that captured the victim's experience with trauma. Traumatic sexualization, betrayal, stigmatization, and powerlessness are identified as the core of the psychological injury inflicted by abuse and the authors posit that these dynamics alter children's cognitive and emotional orientation to the world and create trauma by distorting children's self-concept, worldview, and affective capacities.

Sexualization occurs through the exchange of affection, attention, privileges, and gifts for sexual behavior, so that a child learns to use sexual behavior as a strategy for manipulating others to satisfy a variety of developmentally appropriate needs. Betrayal refers to the dynamic by which children discover that someone on whom they were vitally dependent has caused them harm; stigmatization distorts a child's sense of their own value and worth; and powerlessness distorts children's sense of their ability to control their lives. As a child attempts to cope with the world through these distortions, the results may be behavioral problems that are commonly noted in victims of child sexual abuse (Finkelhor & Browne, 1985).

Finally I look at how trauma impacts developing self-concept for girls who experience trauma in childhood and adolescence. These are important theories to understand how girls that begin their experience as victims, then begin to define themselves and they're worth including risk-taking and harmful behavior.

Schema Theory

Piaget, a developmental psychologist, describes his concept of schematic processing. Paiget developed the term *schema*, which are stored bodies of knowledge, and believed that schema interact with incoming information and involve pathways of cognition, affect, and behavior (Piaget, 1952). His work is based on the idea that behavior in our external world is mediated by cognitive interpretations in our internal world (Kendall, 1993).

According to Greenberg, Rice, and Elliot (1993):

> Repeated affective experiences of a particular kind lead to the internal representation of the sequences of events involved in the experience and to the formation of a set of rules for predicting, interpreting, responding to, and controlling these experiences. This is the cognitive/affective/motivational/relational action, "emotion" scheme that governs a person's experience of self-in-the-world. (p. 70)

Emotional schemes generate people's emotionally toned experiences and feed the general sense of who they are. They produce global feelings of self-value or self-loathing from these experiences (Baer & Maschi, 2003; Greenberg, Rice, & Elliot, 1993).

Shattered Assumptions Theory

In Shattered Assumptions theory Janoff-Bulman (1992) explains that children who have been victimized by the very people they trust—and then who cannot be comforted in a secure, protective environment—will carry negative views of the self and the world into adulthood. These views become the fundamental schemas of their assumptive world, and serve as their core psychological structures (p. 87).

These basic assumptions of self and the world are different for traumatized youth. Children not traumatized in early childhood who have "good-enough" caregiving experiences can develop basic assumptions of a benevolent world and a worthy self. On the other hand, when traumatic events happen to children, as with many delinquent youth, an alternate cognitive process occurs (Janoff-Bulman, 1992). Janoff-Bulman states that this process happens because the cognitive–emotional system of the child is not firmly developed, which can be both a blessing and problem. A traumatic

event experienced by a child with necessary supports and resources from their caregivers will be able to mitigate the effects of trauma, but kids with an abusive parent will have more intense effects of the trauma. Children who have been victimized by the very people they trust, who cannot be comforted in a secure, protective environment, will carry negative views of the self and the world into adulthood and these views become the fundamental schemas of their assumptive world, their core psychological structures (Janoff-Bulman, 1992, p. 87).

Fragmentation of Developing Self

Bowen's theory of developing self (1978) states that the basic building blocks of self are inborn, but that family relationships during childhood and adolescence determine how much of the self is developed. Fragmentation of developing self theory is explained as the disruption of the child's individuation and differentiation of a separate sense of self that occurs in response to stress that overwhelms the child's limited capacities for self-regulation. Survival then becomes the focus of the child's interactions and activities and adapting to the demands of their environment takes priority in their lives. Traumatized children lose themselves in the process of coping with ongoing threats to their survival and they cannot afford to trust, relax, or fully explore their own feelings, ideas, or interests (Moroz, 2005).

Characterlogical Development

A child's character development is shaped by the their experiences in early relationships (Johnson, 1985). Children who have experienced trauma

often come to believe there is something inherently wrong with them, that they are at fault, unlovable, hateful, helpless, and unworthy of protection and love. These feelings lead to poor self-image, self-abandonment, and self-destructiveness in the child. Ultimately, these feelings may create a victim state of body mind–spirit that leaves the child or adult vulnerable to subsequent trauma and revictimization (Moroz, 2005).

Trauma Effects

Covington (Bloom & Covington, 2008) discusses the relationship between trauma, coping mechanisms and behavioral responses illustrated in the Process of Trauma chart (Figure 1).

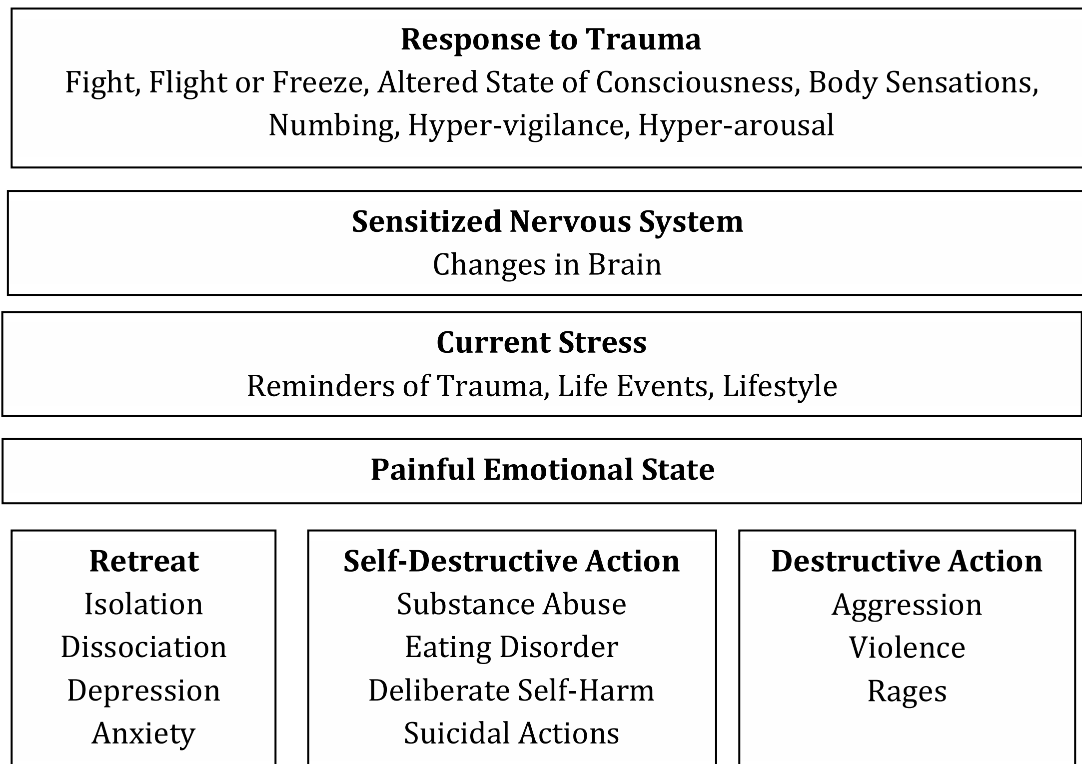

Figure 1. Process of Trauma, from “Addressing the Mental Health Needs of Women Offenders,” by B. Bloom & S. Covington, 2008, p. 12.

Trauma begins with an event or experience that overwhelms a woman's normal coping mechanisms. There are physical and psychological reactions in response to the event: these are normal reactions to an abnormal or extreme situation. This creates a painful emotional state and subsequent behavior. These behaviors can be placed into three categories: retreat, self-destructive action, and self-destructive action. Women are likely to retreat or become self destructive, while men are more likely to engage in destructive behavior (Covington, 2003).

To better explain and understand the complexity of trauma, we can put them into broad categories of biological, psychological and social responses.

Biological

A foundational study in 1998 (Felitti et al. 1998) commissioned by Kaiser Permanente and the Centers for Disease Control and Prevention found direct links between adverse childhood experiences (ACEs) and later health issues. Seventy percent of the more than 1,700 participants experienced at least one type of trauma and 87% had more than one experience (p. 250). Those with complex trauma and a score of four or more resulted in four times the risk of emphysema or chronic bronchitis; two times the risk of hepatitis; over four times the likelihood of depression; and twelve times the risk of suicide (Felitti et al., 2009, p. 245).

This research supports the work of Bessel van der Kolk (2005) that advocates for the expanded diagnosis of developmental trauma disorder. Dr.

van der Kolk argues that interpersonal trauma of sexual or physical abuse, war, and community violence in early life lead to discrete conditioned behavioral and biological responses to reminders of trauma similar to, but different than post-traumatic stress disorder. He goes on to say that it interferes with neurobiological development, and the capacity to integrate sensory, emotional, and cognitive information. Developmental trauma produces unfocussed subsequent responses to stress, leading to the need for ongoing systems (medical, correctional, social service, and mental health services) involvement. Below are some of the symptoms associated with developmental trauma disorder:

- complex disruption of affect regulation,
- disturbed attachment patterns,
- rapid behavioral regressions and shift in emotional states,
- loss of autonomous strivings,
- aggressive behavior against self and others,
- failure to achieve developmental competencies, and
- loss of bodily regulation (sleep, food, self-care) (van der Kolk, 2005).

Moroz (2005) further discusses the biological effects of trauma on the brain for children who have experienced trauma including the following profound effects:

- Increased cortisol levels in the central nervous system, which allow for action to survive at extreme levels, can cause alterations in brain development and destruction of brain cells.
- Basic regulatory processes in the brain stem, the limbic brain (emotion, memory, regulation of arousal and affect), the neocortex (perception of self and the world), as well as integrative functioning across various systems in the central nervous system, are affected.
- Fear, arousal, and dissociation associated with the original trauma may continue after the threat of danger and arousal has subsided, as traumatic experiences are stored in the child's body–mind.

Moroz (2005) goes on to explain that extreme stress triggers the "fight or flight" or "freeze" survival response, which activates the sympathetic nervous system and suppresses the parasympathetic nervous system. He says that when the brain is in a chronic state of fear-related activation, it is easily triggered into the lower functioning survival-mode track, from which the higher functioning learning track cannot be accessed. Additionally, the bodies own alarm system uses trauma triggers to detect danger, and for kids who have experienced trauma this might become overactive due to the chronicity of the traumatic experiences. Common triggers for children include unpredictability; sudden changes or transitions; loss of control; sensory overload; feeling vulnerable, rejected or lonely; confrontation; praise; intimacy; or positive attention.

Psychological

Aggression is an effect of trauma and is particularly important when discussing delinquent behavior, as it is often a part of the behavior associated with the delinquent acts. Children who are aggressive perceive and encode social cues differently than do nonaggressive children. They become hyper-vigilant, pay attention to more hostile cues, and do not use complex inferences when understanding other people's behavior. They can even begin to over perceive aggression by others and under perceive their own aggression. This pattern of distorted perception and interpretation of others contributes to their feelings of both aggression against themselves and justification of aggression against others. They also have deficiencies in problem solving strategies, with a tendency to use aggression rather than bargaining in a conflict. These distortions occur in traumatized aggressive children because their cognitive rules for predicting, interpreting, responding to, and controlling have embodied aspects of the earlier trauma (Baer & Maschi, 2003).

Emotional regulation is also an important factor in delinquency and researchers now know that the effects of trauma on emotional regulation begin as early as the womb. An infant's immature brain is in a state of rapid development and is, therefore, extremely vulnerable to early adverse experiences, including adverse social experiences (Schore, 2001). Once the infant is born the primary caregiver acts as an external psychobiological regulator of the "experience-dependent" growth of the infant's nervous

system (Schore, 1994, 1996, 1997a, and 2000c, all as cited in Schore, 2001). These early social events are imprinted into the neurobiological structures that are maturing during the brain growth spurt of the first two years of life, and therefore have far-reaching effects on the ability to regulate emotions in later life (Schore, 2001). Self and attachment difficulties are at the heart of chronic and pervasive trauma for those who experience trauma during childhood. In adulthood, these children find challenges with emotions, emotional regulation, self-worth, and the ability to form and sustain satisfying, and healthy relationships (Pearlman & Courtois, 2005).

Finally low self-control is a key indicator of delinquent behavior and important to look at here. According to Meichenbaum (1985) the acquisition of self-control is based in the use of language. Children acquire ways of perceiving the world through social interaction with parents or caregivers, especially interpersonal transactions that consist of attempts to problem-solve and control feelings (Meichenbaum, 1985). The child internalizes the thoughts that mirror these interpersonal transactions, which subsequently become internal communication and consequently modulate the child's ability to self-monitor and self-evaluate (Meichenbaum, 1985).

Data show that aggressive traumatized children have problems in affect regulation keyed to distortions in affect labeling. They are more likely to label affect as anger rather than fear or sadness. This process results in the underutilization of other responses—such as those that would be appropriate to sadness—and a narrowing in the range of problem-solving

strategies (Garrison & Stolberg, 1983; and; see also Ingram & Kendall, 1986, as cited in Baer& Maschi, 2003). A challenge for children exposed to trauma is that the development of the capacity to regulate affect may be undermined or disrupted, and children exposed to acute or chronic trauma may show symptoms of mood swings, impulsivity, emotional irritability, anger and aggression, anxiety, depression, and dissociation (Moroz, 2005).

Social

One of the greatest social effects of trauma both in adolescence and adulthood is the pervasive and invasive effect it has on interpersonal relationships. One of the explanations for this impact on relationships has to do with the development of emotional regulation in the attachment period of early childhood, which, if insecure or disorganized, prevents these children from forming or keeping healthy relationships. Additionally, I have described schema theory in which children's thinking about themselves is defined by the formation of assumptions of self and others, and then generalized to the way in which they perceive the world (Baer & Maschi, 2003). Both of these explanations produce heightened affect, hyper-vigilance, attendance to more hostile cues, and the inability to accurately read other's behavior (Baer & Maschi, 2003).

Trauma also affects the ability to self-regulate behavior. Data shows that traumatized children who are aggressive have problems with affect regulation and affect labeling (Baer & Maschi, 2003). They are more likely to read sadness or fear as anger, and act on those inaccurate readings. This is

yet another factor that makes interpersonal relationships challenging. Other common social effects of trauma, besides those discussed earlier in this paper (aggression, academics, substance use), include higher incidences of eating disorders, teen pregnancy, and lower levels of self-esteem (Miazad, 2003).

Gender Responsive Theory

Dr. Stephanie Covington, a leader in the field of gender responsive treatment, has defined gender responsive theory as "Creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of women's and girls lives and is responsive to their needs and strengths" (Bloom & Covington, 2001, p. 11). The idea of "separate but equal" has failed girls and women in the criminal justice system. Gender Responsive theory looks at fairness or equity as it is related to the level of services provided as it correlates to the girls' needs. The special and unique needs of girls have to be taken into consideration to guarantee that they receive equal opportunity for rehabilitation (Miazad, 2003).

Covington (Bloom & Covington, 2001) goes on to say that for girls and women in criminal justice, a primary motivation is to build a sense of connection with others. Carol Gilligan (1982) found that women develop through attachment to others whereas men tend to focus on interactions between one another. Foley (2008) describes the interaction within relationships as Relational Cultural theory where girls and women's

development is based on connection with others and relationships are meaningful to girls and are important factors to both delinquency and recovery.

Developmental models have traditionally approached adolescence as a time for independence and separation from parents, but if girls have an innate need to be in and develop through relationships, this can be a challenging stage to navigate. Dr. Covington (Bloom & Covington, 2001) discusses why individuation and separation are not necessary for successful development in women in work on girls and women in criminal justice.

> Theoretically, girls perceive themselves to be more similar than different to their earliest maternal caretakers, so they do not have to differentiate from their mothers in order to continue to develop their identities. This is in contrast to boys, who must develop an identity that is different from the mother's in order to continue their development. Thus, women's psychological growth and development occur through adding to rather than separating from relationships. Consequently, defining themselves as similar to others through relationships is fundamental to women's identities. (p. 12)

It has also been demonstrated that girls are affected most by those with who they are in close relationship (family, peers, romantic partners), therefore the answer to healing or change might be best found in examining those very relationships and disconnections.

> Women develop a sense of self-worth as their actions lead to relationships with others. Connection rather than separation guides women's growth. In the context of juvenile justice, therefore, one might explain the problems of these young women by examining the disconnections or violence within their family, personal, or community relationships. Disconnection leads to depression, a diminished sense of self-worth, turning away from relationships, and possibly substance abuse. (Alemagno et al., 2006, p. 51)

Although society has come to some collective knowledge that girls are socialized to be more empathic than boys, incarcerated girls have been exposed repeatedly to nonempathic, often painful relationships, and so either lack empathy for both self and others, or are highly empathic toward others, but not for themselves. In order to change this dynamic, women need to experience relationships that do not re-enact their histories of loss, neglect, and abuse, but model healthy relationships (Bloom & Covington, 2001).

Feminist pathways theory further explains that childhood traumas are precursors for risk factors of offending behavior (Foley, 2008). Childhood traumas, which occur whenever a relationship has been hurtful, disappointing, dangerous, or violating, lead to psychological problems through disconnection and violations. Traumatized individuals have trouble relating to others and this makes it difficult for others to relate to them. This problem leads to social alienation and isolation, which compounds the earlier traumatic experience as it disconnects them from important relationships and supports (Pearlman & Courtois, 2005). Trauma survivors develop major cognitive distortions about themselves, their value in relationships, and the motivations of others to be in relationship with them. These beliefs are reinforced when their future relationships reenact the dissatisfactions, abandonment, and abuses of the past (Pearlman & Courtois, 2005).

Given these foundational theories, the key elements of gender responsive strategies include developmental stages, life experiences, trauma, social expectations and motivations, roles girls play in families and

communities, safety, relationships, empowerment, and competencies (Sherman, 2012). The Office of Juvenile Justice and Delinquency Prevention (OJJDP) has recommended that the following elements be included in developing gender responsive strategies:

- assessment of needs and strengths;
- therapeutic alliance in a clinical context;
- evidence-based practices culturally adapted for girls and women;
- healthy connections with caring, healthy, appropriate adults; and
- recognition of within-group differences for differences and programming that reflects these differences (e.g., age, ethnicity, sexual/gender identity) (OJJDP Girls Study Group, 2010).

CHAPTER 3: METHODOLOGY

Definition of Terms (Operational Definitions)

For the purposes of this study *sexual trauma* will be defined as a term to include sexual maltreatment, abuse and assault as described below by the National Child Abuse and Neglect Data Systems (2000).

1. SEXUAL MALTREATMENT/ABUSE
   - i. Note: Sexual maltreatment/abuse refers to acts by an adult or older youth who is playing a caretaker role for the youth (e.g., parent, parent-substitute, babysitter, adult relative, teacher, etc.). Sexual contact/exposure by others (i.e., non-caretakers) should be classified as 'sexual assault/rape'.
   - ii. Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-inappropriate sexual material or environments (e.g., print, internet or broadcast pornography; witnessing of adult sexual activity) by an adult to a minor child
   - iii. Sexual exploitation of a minor child by an adult for the sexual gratification or financial benefit of the perpetrator (e.g., prostitution; pornography; orchestration of sexual contact between two or more minor children)
   - iv. Unwanted or coercive sexual contact or exposure between two or more minor children
2. SEXUAL ASSAULT/RAPE
   - i. Note: Sexual assault/rape should include contact/exposure by perpetrators who are NOT in a caretaking role with the youth (sexual misconduct by caregivers should be recorded as 'sexual maltreatment/abuse').
   - ii. Actual or attempted sexual contact (e.g., fondling; genital contact; penetration, etc.) and/or exposure to age-inappropriate sexual material or environments (e.g., print, internet or broadcast pornography; witnessing of adult sexual activity) by an adult to a minor child
   - iii. Sexual exploitation of a minor child by an adult for the sexual gratification or financial benefit of the perpetrator (e.g., prostitution; pornography; orchestration of sexual contact between two or more minor children)

iv. Unwanted or coercive sexual contact or exposure between two or more minors (NCANDS in NCTSN, 2012, p. 1)

Delinquency is an act committed by a juvenile (under the age of 18) that would be criminal if committed by an adult (over the age of 18). The juvenile court has jurisdiction over delinquent acts. Delinquent acts include crimes against persons, crimes against property, drug offenses, and crimes against public order (Office of Juvenile Justice Prevention, n.d.).

Type of Method

Given the research question and sample population of this study, the qualitative research approach was used as the model for this study as explained by Kazdin (2003) and Creswell (2007).

In Kazdin (2003), qualitative research is

> an approach to the subject matter of human experience and focuses on narrative accounts, descriptions, interpretation, context, and meaning. The goal is to describe, interpret, and understand the phenomena of interest. Through description and interpretation, our understanding of the phenomena can be deepened. The process of achieving this goal is to study in depth the experience of the participants—that is, those who are studied—and to convey how the experience is felt and perceived, and the meaning it has for those whose experience is being presented (p. 332)

According to Creswell (2007), qualitative research

> begins with assumptions, a worldview, and the possible use of a theoretical lens and the study of research problems inquiring into the meaning individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is inductive and establishes patterns or themes. The final written report or presentation includes the voices of the participants, the reflexivity of the researcher, and a complex description and

> interpretation of the problem, and it extends the literature or signals a call for action. (p. 37)

Both definitions speak to the goal of understanding a human problem (phenomenon) out of the experiences of the participants through the identification of patterns and themes, in a quest for meaning and deeper understanding of social and psychological phenomena that will lead to action. The objective is to draw inferences of common experience based on the collection and analysis of these themes.

With this method, it is important for the researcher to hold her biases and allow the phenomenon to emerge in the way it is recognized by the participants. The goal is to describe, interpret, and understand the phenomenon of interest, but do so in a way that captures the richness of the experience and meaning it has for the research participants (Kazdin, 2003). This method was appropriate for addressing the study's research goal of examining the variables of sexual trauma and delinquency by bringing the experiences to life to help move us toward a deeper understanding of the relationship between them.

Furthermore, as a goal of the study was to understand not just the correlation of the relationship between sexual trauma and delinquency, but what reactions to sexual trauma lead to delinquency. Therefore, qualitative research is an appropriate model to explore experiences about which we do not have an adequate understanding.

> We use qualitative research to develop theories when partial inadequate theories exist for certain populations and samples or existing theories exist for certain populations and samples or existing

theories do not adequately capture the complexity of the problem we are examining. (Creswell, 2007)

Participants

Ten young women who identify as African American or Latina, between the ages of 18 and 26, who had a history of sexual trauma and delinquency participated in the study. Participants were eligible to participate regardless of delinquency charge, sentence, or outcome and ethnic identity was self-identified.

Participants were recruited from nonprofit service agencies working with girls with history of trauma and delinquency by distributing Participant Information Letters (Appendix A) through email and in person. Initial screening was done by phone and participants were emailed by myself and a research assistant to ensure that participants who volunteered met the selection criteria. Young women were paid a small stipend for their participation.

Participants were initially contacted by telephone to assess interest and eligibility for participation in the study. Age, ethnicity, and trauma and delinquency history were screened and assessed using the Demographic Questionnaire (Appendix B) and participants were informed of the scope of the study including the discussion in these areas. If participants met the initial criteria, they were invited to come in for an interview.

The average age of the research participant was 22, and racial/ethnic identity is detailed in Table 1 below. Four young women identified as multi-racial.

Table 1

Participant Demographics

Participant	Age	Ethnicity
1	18	African American
2	19	Latina/Caucasian
3	24	Latina
4	23	Latina/Filipina
5	23	African American
6	24	African America
7	20	African American
8	25	Latina/Caucasian
9	25	Latina/Arab
10	19	Latina/Filipina

Note. Author's table.

Data Collection

Data for this study was collected through semistructured interviews consisting of open-ended questions informed by the literature review (Appendix C) intended to identify potential links and pathways between sexual trauma and delinquency. A total of 10 interviews were done one-on-one, privately with participants at my private office, at my private office and at the Women's Resource Center. At the beginning of each interview, the study consent form was read and signed by each participant (Appendix D). The interviews were digital-audio recorded and ranged from 30 to 85

minutes. Interviews were transcribed verbatim and coded by volunteer research assistants and me.

Each participant was told that she did not have to answer any questions that made her feel uncomfortable and that she could end the interview at any time as stated in the Participant Bill of Rights (Appendix E), but no participants exercised this privilege. Participants were informed that the interviews would be kept completely confidential as described in the Confidentiality Statement (Appendix F) and that only her demographic information and the transcript from the interview (not including identifying information) would be used. Participants were also told that the purpose of the study was to answer the interviewer's dissertation to answer the question, "What is the relationship between sexual trauma and delinquency for adolescent Latina and African American girls?" Participants were informed that the audio recordings would be deleted 3 years after collection is complete.

Interviews were transcribed and analyzed to allow dominant themes to emerge from the data. Prominent themes for the interview included issues of pathways, risks, trauma effects and delinquency.

Data Analysis

Data analysis consisted of preparing and organizing the data for analysis, then reducing the data into themes through a process of coding and condensing codes, and finally representing the data in a discussion (Creswell, 2007, p. 148). Audiotapes were checked for accuracy by listening to the tapes

while simultaneously reading the transcripts. The researcher and volunteer coders read and reread the transcripts, highlighting themes relevant to the experiences of the young women participating in the study.

Coding Process

I employed a data analysis spiral method, described by Croswell (2007) in which "the researcher engages in the process of moving in analytic circles rather than using a fixed linear approach" (p. 150). There are several steps in Cresswell's spiral analysis process. Steps to the data analysis spiral method include:

1. Data Management Researchers organized their data and convert to text units.
2. Reading and Memoing: Researchers immerse themselves in the data by reviewing the entire collection to get a sense of the data as a whole and take notes reflecting across questions to develop organizing ideas.
3. Describing, classifying and interpreting: Researchers code formation begins and is the heart of qualitative data analysis. Researchers develop themes through classification and provide interpretation through their own views and literature. Researchers develop a short list of tentative codes.
4. Representing and visualizing: researchers package what they find in text creating a visual image of the text (pp. 150–155).

This method allows me to collect, organize, describe, and represent what they see and will provide sound framework for understanding the relationship between variables of sexual trauma and delinquency in this study.

Limitations of the Study

In order to collect and analyze the complex data anticipated in the qualitative research study, the sample size for this study was kept relatively small (10 participants), and therefore the results may not be generalizable to the broader female delinquency population. Additionally, I have selected

participants who identify as African American or Latina as they are over-represented in the juvenile justice system, and findings may not be applicable to girls of other races and ethnicities. Further, as the study focuses on a defined trauma of sexual abuse, it may not be generalizable to female delinquents who have experienced other forms of abuse or trauma. Finally, participants of this study primarily reside in the urban environment of San Francisco or the greater Bay Area and findings may not be generalizable to other areas including rural settings. It is my intent though, that the interpretive phase of analysis will yield themes that lead to a greater understanding of the relationship between sexual trauma and delinquency.

CHAPTER 4: RESULTS AND DISCUSSION

This chapter presents the results of the study of 10 young women with the collective experience of sexual trauma and delinquency. These results reflect the most significant themes described in the interviews with young women as noted in Table 2. These young women were brave and generous to share their personal, traumatic, and painful experiences in order to advance our collective knowledge about the pathways between delinquency and trauma; therefore I have presented the information here in the most respectful, considerate, and protective way that I can. I share the themes of the interview in collective terms, use quotes that do not give details of a young woman's individual story, and don't discuss any information that might identify or disclose the identity of any of the young women in this study.

Interpersonal Traumas

In line with the many researchers who write about the correlation between trauma and delinquency (Belknap, 2007; Chesney-Lind & Pasko, 2004; Goodkind et al., 2006; McCartan & Gunnison, 2009; Siegel & Willians, 2003), interpersonal traumas were very high in this study. All 10 participants experienced neglect including lack of basic needs like food, shelter, clothing, and education to lack of supervision and attention. Nine out of 10 participants faced physical abuse either at the hands of their biological parents or, for three girls, at the hands of foster parents. All of the

participants experienced sexual abuse either from their biological parent (3), a close friend or relative (3), or a caregiver or entrusted adult (9).

Table 2

Participant Trauma Categories and Themes

Category and Theme	Participant										Total
	1	2	3	4	5	6	7	8	9	10	
Interpersonal trauma											
Neglect	x	x	x	x	x	x	x	x	x	x	10
Physical abuse	x	x	x		x	x	x	x	x	x	9
Sexual abuse	x	x	x	x	x	x	x	x	x	x	10
Domestic violence – witness	x	x	x	x				x	x	x	7
Domestic violence – victim	x	x	x	x					x		5
Bullying – victim	x	x	x	x			x	x		x	7
Other trauma											
Community violence			x			x	x	x		x	5
Death of loved one		x			x	x				x	4
Incarceration of family member	x	x	x		x	x	x	x		x	8
Loss of family member (nondeath)	x	x	x	x	x				x	x	7
Risk-taking/delinquent behavior											
Running away	x	x	x	x	x	x	x	x	x	x	10
Academic failure	x	x	x	x	x	x	x	x	x	x	10
Violence	x	x	x	x		x	x	x		x	8
Stealing	x		x	x	x	x	x	x	x	x	9
Substance use	x	x	x	x		x	x	x	x	x	9
Exploitation			x	x					x	x	4
Self-harm	x			x				x		x	4

Note. Author's table.

Other Traumas

Witness of or experience with other trauma was also highly reflected in the participant's responses, consistent with other research citing high incidence of multiple forms of trauma for delinquent girls (Wood et al., 2002b). Seventy percent of the girls witnessed domestic violence against their mothers in the home, and 50% reported domestic violence in their own relationships. An astonishing 70% reported bullying at school prior to delinquency, higher than other research studies has found (McCord et al., 2000). Experiencing community violence was 50%, including witness or awareness of death, violent injury, attack, or assault; most girls reported close family members or friends who had been victims of community violence. Death of a loved one was a moderate 40% of the study participants, but family incarceration (immediate family including parent or siblings) was 80%. Finally, loss of a family member, meaning that a parent was completely absent from their lives, was 70%, and none of the participants had consistent involvement from their fathers in their lives. Thirty percent had no father ever involved, 40% of fathers left early in their lives, and 30% had fathers only involved in a minor and inconsistent way.

Risk-Taking and Delinquent Behavior

Risk-taking and delinquent behaviors were very highly reported in the study, consistent with findings by other researchers (Belknap & Hoslinger, 1998; Chamberlain & Moore, 2002; Miazad, 2003). One hundred

percent of young women reported a history of running away, beginning as early as 11 years old.

> Like the first time I ran away was for six months and the second time I ran away was like for like a year and a half. I remember like I just got so into it, it was just like normal to me. (Participant 9)

Unfortunately, 30% of girls also reported being kicked out of their home or pushed out. Both factors are important risk experiences for girls (Dohrn, 2004; see also Kipke, Simon, Montgomery, Unger, & Iversen, 1997, as cited in Goodkind et al., 2006) because when they do not have a safe home to go to, they are at risk for further abuse and sexual exploitation or assault as they do whatever necessary to survive.

Academic failure was another unanimous experience for young women in the study. One hundred percent of the young women reported having problems in school including poor academic achievement, trouble maintaining/performing at grade level, or getting in trouble at school, which interfered with academics. Although all of the young women presented as smart, articulate, and capable, they had the common experience of not doing well in school. Some went on to get GEDs, graduate (4), or were in the process of completing their coursework (1), but it appears that the trauma—neglect and dysfunction in the family—contributes to instability in academics and eventual failure to succeed as described in earlier research (McCord et al., 2000). Additionally, bullying at school, which 70% of the young women in our study experienced, also appears to be related to cutting school, suspension or expulsion and eventual dropping out (McCord et al., 2000).

> When I was a kid, girls used to pick on me and pull my hair. So one time, my mom was like, “I seen them hitting you. Next time, if I see them hitting you don’t come to the house because I’m going to beat the [expletive] out of you.” So I was just like, “Wow.” So from there I started defending myself; I started being more angry, like more mad, because I’d never met my real father. (Participant 3)

Delinquent behaviors appear to closely follow the risk-taking behaviors found above. Eighty percent of girls reported being violent, 90% reported stealing, and 90% reported substance use. “I could rob the people and have no remorse to it, because of the fact that nobody cared when I was younger and they did that to me, from me” (Participant 6).

Chamberlain and Moore (2002) discussed violence and aggression as a common predecessor to delinquency, particularly relational aggression for girls. Half of the girls in this study reported violent offenses, consistent with research conducted by Patino, Raviora, and Wolf (2006) in Florida.)

Forty percent of the young women reported self-harm behaviors like cutting or suicidal gestures, all girls who reported self-harm said that they felt overwhelmed with pain and self-harm behaviors were cries for help. The girls also reported that self-harm behaviors were an effective, although dangerous mechanism for coping with intolerable emotional pain as it created a temporary distraction.

Forty percent of the young women also reported eventual involvement in sexual exploitation. Many began with relationships in which the participants believed there was friendship or love. All girls also unfortunately reported that these relationships were violent, abusive, and controlling, and they were eventually forced to have sex with others for

money against their will. Two of the four young women reported being violently raped while being exploited, and one young woman's exploitation began in her family. Participant 9 said, "He [her father] was the only person that was taking care of me. He was the only person that was like giving me any type of attention. Even though it was bad attention, it was just attention."

System Involvement

A high percentage of young women (60%) reported child welfare system involvement, but as cited above, 100% reported neglect, and physical or sexual abuse. Unfortunately this finding means that some of these young women suffered without any system response or protection. Even more disturbing though, is that three young women (30%) actually experienced abuse in foster care. The very system that was supposed to protect them from abuse in their home failed to further protect them and actually victimized them with more physical and sexual abuse. Additionally, race was a correlate in the study findings as 100% of the African American girls were in child welfare while only 33% of Latina girls had this experience.

Participants were not required to have been officially arrested to participate in the study, but 100% of the young women reported arrest in their history. Eight of them were actually detained, nine experiences resulted in probation, and half were eventually sent to out of home placement. Some experienced multiple incidences of arrest and detention, and a remarkable 80% were later arrested as adults.

Effects in Adulthood

Finally, the study found that young women's experiences with sexual trauma and delinquency unfortunately lead to ongoing problems with future system involvement, stability, and success. As discussed, 80% of participants went on to commit adult offenses and were incarcerated, resulting in 60% being placed on probation or parole. Even for those who resisted—or have so far resisted adult charges or arrests—it appears there is still marked instability in their lives. Ninety percent were homeless or had unstable housing, 90% were un- or under-employed, and 100% reported mild to moderate symptoms associated with trauma or mental health issues like depression or anxiety.

Other Prominent Themes

A few other commonly reported experiences included those associated with their relationships with their attachment and parenting, continued effects of sexual trauma, and changes to self. These themes were not prominent in the literature, but stood out as common experiences by the participants in this study, warranting some focus here in the findings.

Attachment

Attachment refers to the emotional bond between a child and her caregiver. These early bonds serve as the foundations of a girls' emotional regulation and relational approach in childhood and adulthood. This study found important implications about the challenges young women face when these attachments are disrupted or worse, traumatizing.

Mothers.

Bowlby (1969) discussed the profound effects of early disruptions in attachment in the caregiving relationship, particularly between a mother and child. All of the participants in this study reported feelings of betrayal or rejection by their mothers, leading them to feel like their mothers did not keep them safe and did not meet their basic needs. This rupture is important because it appears that the young women learned that the world is not safe through their early experiences with trauma, then went on to have the expectation that the world was unsafe and that violence and abuse were common and expected.

The betrayal and rejection in the primary caregiving relationship is especially powerful because when a child is born it is completely dependent on her caregiver for life. When that caregiver can't or won't take care of her or keep her safe, it changes her expectation of herself and others. Kendall (1993) explains this as the process by which behavior in our external world is mediated by cognitive interpretations in our internal world.

An important and dangerous result of this damaged relationship was that the participants did not or were not able to tell their mothers about their sexual trauma. For those that chose not to, the primary reason was that their mothers had their own issues (substance abuse, mental health, or relational) and the young women did not want to burden them with additional problems. For those who could not tell their mothers, they reported that they were not able to predict whether their responses would have been protective

or helpful. Unfortunately, two young women reported that when they did tell their mothers, they were either not believed or blamed for the abuse. Also worth noting is that three young women reported that their mothers themselves had been victims of childhood sexual trauma. This "generational trauma" appears to play an important role in a mother's ability to process, handle, and address her child's trauma. Participant 9 said, "I know my mom loved me, but I didn't have that love that I ever wanted."

Fathers.

Attachment with father looks different that of attachment with mother primarily because they are not usually the primary caregiver and don't usually play a major role in the dependent care of the infant, then child, but also because the need and function for them in the lives of the young woman appear to be different. All young women in this study reported nonexistent or poor relationships with their fathers, and even physical and sexual abuse at the hands of their fathers. This common shared experience appears to result in a longing to be paid attention to by, engage with, and be loved by men in their lives.

> You know, that stuff was really hard that happened and it really . . . I wanted him to be there. I wanted to have a relationship with him. I wanted and still wish that we could've been closer, but I try a lot of times to really think about me and him and how he grew up and ask more questions. I learned. . .I don't know, I don't think there's anything that he could've given me that he didn't. (Participant 8)

Although this rejection seems to have a different quality than the rejection and betrayal of the mother attachment, it nonetheless contributes to decreased sense of self-image as the young woman grapples with the

meaning of rejection or abuse by the father who is supposed to love and protect her. This is an area in great need of further exploration and research.

Continued Impact of Sexual Trauma

Janoff-Bulman (1992) explain in her "shattered assumptions" theory that young women are victimized by the very people who they trust for their care and survival, and then do not find a secure, protective environment to heal and recover, and develop negative views about themselves and the world. The young women in this study all had the common history of experiencing the world as violent, abusive, and unsafe, leading to their eventual change in view of themselves and others. When a young woman does not feel safe and taken re of in the world, she walks around in the world continuing to experience it in that way, leading to further victimization and abuse and aggression. These kids then internalize the victimization as self-blame, hatred, and identity (Janoff-Bullman, 1992). The majority of girls reporting feeling "nasty," "disgusting," "shameful," or "damaged" as a result of their abuse. Participant 7 said, "Really, it made me feel like, oh, disgusting, kind of , you know?"

Eight girls reported multiple experiences of sexual trauma, including trauma in and outside of the family. Additionally, these young women consistently reported early experiences with sex with partners, beginning as young as age 11. It was common for the young women to report these relationships as unhealthy, unsatisfying, or abusive.

> I felt I guess I still have a lot of codependent aspects and people pleasing tendencies. Definitely, I get a lot of triggers with men. . .for a

> long time, I was very afraid of people not liking me all the time like feeling like just wearing myself out to make people like me or just super hypersensitive about people and feelings and trying to control situations. (Participant 8)

In fact, unhealthy relationships were another common theme, including the fear that they might never be able to find, maintain, or enjoy a healthy relationship. Even though they expressed concern about the quality of the relationships they were in or thought they would be in, many expressed their desire to find someone to love and to feel loved by. As Johnson (1985) theorizes, children who have experienced trauma often come to believe there is something inherently wrong with them, that they are at fault, unlovable, hateful, helpless, and unworthy of protection and love. This idea leads to them feeling like they can't have and don't deserve a happy relationship. Participant 5 said, "I think it affected my relationships because I'm not open to a man just like that."

Even sadder is the belief that something is irreparably wrong with them and they will never have love. Additionally, the pairing of love and abuse in their caregiving relationships make them more likely to be in an unhealthy relationship.

> I don't trust. I can't fully trust a man and I get scared like maybe if I get married it's going to be a big problem because I'm never going to fully trust him. I am always going to wait for him to like drop the ball. He's going to. It's bound to happen. (Participant 9)

Changes to Self -Concept

Bowen's (1976) theory of developing self states that the basic building blocks of self are inborn, but that family relationships during childhood and

adolescence determine how much of the self is developed. Survival becomes the primary goal of the abused child and they make adaptations to themselves and their environments to ensure this survival. Traumatized children lose themselves in the process of coping with ongoing threats to their survival and they cannot afford to trust, relax, or fully explore their own feelings, ideas, or interests (Moroz, 2005). This perspective means that young women have to interpret what is wrong or unsafe and bare the burden of trying to make themselves safer.

An interesting example of this world view was the finding that three young women reported consciously changing their appearance to ward off unwanted sexual attention following the sexual trauma. Two young women discussed dressing or acting "tom boy" to hide physical shape, sexuality, or body and not draw male attention to them. Both reported wearing male clothing and acting less feminine as a protection strategy. Additionally, one young woman reported gaining weight to achieve the same effects as above including hiding sexuality or sexual appeal, again warding off unwanted sexual attention. In reflecting on what she felt her perpetrator took from her, Participant 5 said: "Probably my character. I think he took away my character."

Taking care of themselves can look like risk-taking or delinquent behaviors when in fact they are survival and coping skills. Anger, aggression, running away, and even substance abuse are all mechanisms to mitigate danger, pain, and abuse. When traumatized children look sad and depressed,

we understand that and read it as victimization, eliciting empathy, understanding, and hopefully assistance. But when a traumatized child looks angry, aggressive, or sexualized, we interpret, judge, and punish those behaviors, even though they stem from the same trauma and pain as the examples above. This is a common theme for girls in delinquency whose aggressive, acting-out, or delinquent behavior becomes the focus, preventing the system from focusing on the trauma that feeds the behavior.

Young women in this study consistently discussed the ways in which they were labeled, judged, and dismissed because of their behavior, while their victimization and trauma went unnoticed or unattended. This judgment further fed their ideas that they were on their own and that no one in the world cared or would protect them. Participant 2 said, "Because you can't keep getting run over. You're going to have to speak up for yourself. If they don't like it, oh well. You don't have to be around me. I speak up. "

Summary of the Results of the Study

Results of the study were consistent and confirmed research about pathway and risk-taking behaviors cited in the review of literature. Factors of neglect, running away, academic failure, substance use, arrest, and ongoing mental health symptomology were reported by 100% of the participants. Other highly reported factors include physical abuse, stealing, probation, homelessness or unstable housing, and un- or under-employment, all at 90%. Although all of the young women in the study experienced abuse or neglect, only 60% were involved in child welfare.

Among the more shocking findings was that 70% reported crossing over to the adult criminal justice system, violent delinquency, incarceration of a family member, and bullying. This final cluster of findings is scarcely mentioned in the literature review, particularly the experience of school bullying. We have recently begun to look at the psychological profile and symptomology of the perpetrator, but need further investigation into the impact of bullying on the victim, including academic failure and delinquency.

Finally, domestic violence, both as the witness of (70%) and victim of (50%), appears to have a profound impact on young women who experience trauma and delinquency. McCartan and Gunnison (2009), discussed how girls who witness domestic violence begin to see abuse as a normal part of adult relationships and they may tolerate emotional, physical, even sexual abuse as part of a relationship.

> All this domestic violence, I started losing my job, I lost my apartment because they kicked us out, I lost a baby because I was stabbed [by] him in the back. I felt like he was beating the shit out of me and one day I just stopped. I was taking it because I wanted to be in one solid relationship. I didn't want to be like my mom always having to have boyfriends.
> (Participant 4)

This study expanded on the body of information and research about the pathways and correlations between delinquency and sexual trauma to better understand what changes or happens to girls who experience sexual trauma and subsequently become involved in delinquency. Understanding the girls' life prior to delinquency is important because it addresses issues of attachment, continued impact of sexual trauma, and changes to self-concept.

Inquiry revealed that trauma and abuse in the maternal and paternal roles have profound impact on emotional regulation and sense of self and the world. Additionally, that disrupted sense of safety and self-worth appears to lead to continued trauma, abuse, and victimization. Finally, the young woman who began life as a victim of trauma, often horrendous and extreme, has to live with the consequence of that victimization through her own skewed and negative sense of self.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

This study supports the existent body of research and knowledge about the behaviors, experiences, and pathways we understand about girls who have both the experience of sexual trauma in childhood and later delinquency system involvement. Risk factors like trauma, violence, and exploitation are important because they help explain the impact that victimization has on sense of self and the world, the building blocks for how the young person will interact with and engage in the world. It is important that we as a society look at how we identify and respond to these issues so that we can help prevent further victimization and negative impact for the young woman. The pathways, including family dysfunction, academic failure, child welfare system involvement, aggression, and running way, are important because they help us understand the factors that precede delinquency and understand that if there is effective intervention, we can prevent further victimization and criminal justice system involvement. We as a society need to view these behaviors as warning signs that something is wrong in the child's life, rather than a reflection of her defective self.

This study established that it is incumbent on us as individuals, as a community, and as a society to better protect our children. The picture that emerges is that of an unsafe, violent, and traumatizing world that too many of our children—particularly girls—have to negotiate.

Finally, our child welfare and delinquency treatment systems can obviously do a better job of identifying, treating, and supporting young

women who have experienced trauma and end up in those systems. The era of focusing on the risk-taking or delinquent behavior has to end, and the era of treatment and safety should begin. Mental health treatment needs to play a primary role for children in both the child welfare and delinquency systems, in recognition of the experiences of trauma for both of these groups. Too often treatment has been secondary or an afterthought for the young women in this study, when clearly treatment was needed in all of these cases.

The majority of the young women in this study felt their involvement in juvenile justice in some way saved or at least helped them. This finding means we have an unprecedented opportunity to intervene and help girls and young women. Those who are in the position to provide intervention, treatment and rehabilitation have to do it from a position of understanding their experience, treating their trauma, and supporting them to transition to successful adulthood. Focus on trauma and treatment is not just imperative for the girl, but for our community and world.

Recommendations

This research lends itself to inform policy and practice for mental health professionals, child welfare and juvenile justice system players. The Following are recommendations for mental health professionals and system stakeholders and players. These recommendations incorporate principles of trauma informed and gender responsive strategies.

Mental Health Professionals

There is a dearth of mental health professionals in the child welfare and delinquency system with specific training, experience, and understanding of trauma and delinquent girls (NCTSN, 2004). As this reports suggests, girls have a unique experience with trauma and delinquency and effective treatment requires a targeted and individual approach.

Treatment strategies that focus on the relationships between the girl and the mental health professional are paramount. A girl who experiences the betrayal and rejection of sexual trauma, especially when that trauma has occurred in her family, needs to build a relationship with a provider that is based on safety and empowerment and challenges the negative or pathological beliefs that have developed as a result of the trauma (Bowen, 1976; Finkelhor & Browne, 1985; Greenberg, Rice, & Elliot, 1993; Janoff-Bulman ,1992; Piaget, 1952; Weiss, 1993).

Additionally, our traditional treatment model needs to change. Girls who have these histories and experiences continue to be at risk for victimization and abuse and their lives continue to be unstable and chaotic. As professional providers we need to understand this trajectory as a function of their experience with trauma and respond to it with trauma-informed strategies specifically designed for this population, including the following.

- Thoroughly assess trauma including risk-taking, acting out, and self-harm behaviors. Tools should be evaluated to ensure they are

gender-responsive and trauma-informed to prevent further harm to patients.

- Consider treatment in nontraditional environments: in detention, in homes, in agencies that provide essential services to girls, and in foster homes.
- Design treatments that re-evaluate and challenge traditional roles and boundaries to include key aspects that these girls lost in attachment, including emotional regulation, self-disclosure, affection and empathy, and accountability to the patient. These young women have been hurt, let down, unprotected, and rejected by those who were supposed to love them; it is necessary for us to recreate and recover some of those experiences for them as mental health providers.
- Deliver treatment that is deep, meaningful, and long-term. These young women have been moved around, let down, and betrayed by so many adults in their lives. It is important that we not be next in the line of failed adults, and instead makes a long-term and serious commitment to their health and well-being. We need to challenge the narrow strategy of short-term, symptom-based treatments that leave girls feeling like they once again fail if they don't get better overnight, and instead get the time they deserve to work on the issues associated with abuse and victimization that happened over years of their development. We should strive to

provide treatment that is comparable to the depth of the damage the girl has endured.

System Stakeholder and Players

It is imperative that the child welfare system enforce its mission to support safety and stability for children and that the juvenile justice system address both public safety and rehabilitation for its participants. Too many young women in this study experienced further abuse after being taken from their family of origin, and this is unfortunately not an uncommon experience. The National Coalition for Child Protective Reform (2011) found that in reports from alumni of Casey Family Programs 24% of girls said they were victims of actual or attempted sexual abuse in foster care (p. 1). The juvenile justice system fairs only a little better. The National Survey of Youth in Custody by the U.S. Department of Justice (Beck, Cantor, Hartge, & Smith, 2013) found that 9.5% of adjudicated youth in state juvenile facilities and state contract facilities reported experiencing one or more incidents of sexual victimization in detention (p. 4).

These programs need to assess and evaluate their service to ensure that they reflect the unique needs, challenges, and strengths of young women including the following:

- effective gender-responsive assessment of trauma and delinquency;
- effective and ongoing training for staff at all levels on trauma, gender-responsive strategies, and effective treatment strategies;

- treatment in detention facilities and out-of-home placement as a priority, including transition services that follow her back home;
- understanding of racial inequality in the system and the additional risk for girls, youth of color, LGBT and gender nonconforming youth;
- relational elements throughout the system (police, attorneys, court, probation service providers) that focus on safety, empowerment, consistency, accountability, and relationships; and
- gender-responsive, trauma-informed programming informed by research and practice and evaluated by the girls themselves.

Future Research

This study touches on and emphasizes the need for better understanding of the short- and long-term effects of sexual trauma on girls and young women who enter the delinquency system. As discussed in the summary of findings, the impact on attachment, continued risk and victimization, and negative change in self-concept are important areas in need of future research in order to better prevent, intervene, and treat trauma and delinquency in girls.

Further, girls of color are over-represented in the Bay Area juvenile justice system and bi- and multi-racial girls are a growing group with in the subgroup. There is little research about this issue and the potential factors that contribute to the over-representation, including the intersection of racism, classism, and gender discrimination. This is a difficult, but necessary

direction needed in research for our systems to find more effective ways to address and correct the over-representation.

There was a high correlation of young women in this study who had no or inconsistent father involvement in their lives and it is an important under-researched area. Understanding this relationship and loss could feed policy recommendation at the child welfare level, including emphasis on custody or reunification with fathers.

Additionally, the impact that bullying of girls in school and its relationship to risk-taking behavior and delinquency is an important area in need of further research so that More targeted interventions can be developed for girls who are relationally structured and support them to successfully negotiate peer relationships so that bullying does not contribute to truancy or dropping out, both of which are pathways to delinquency.

Finally, there is a more than notable paucity of research on sexual and gender identity issues related to trauma and delinquency. Thirty percent of the girls in the study discussed issues related to sexual identity, same-sex relationships, and gender identity. There is not have enough specific working knowledge about the impact of trauma on this issue or the impact that delinquency has on this issue once the girl is system-involved. This information is crucial to move toward a better understanding of the spectrum of issues for girls and women in criminal justice.

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APPENDIX A: PARTICIPANT INFORMATION LETTER

This research is being conducted for a study in clinical psychology under the guidelines established by the California Institute of Integral Studied Institutional Review Board. The researcher is Gena Castro Rodriguez, a doctoral candidate at the California Institute of Integral Studies in San Francisco, CA. The purpose of the study is to explore the relationship between trauma of sexual trauma and delinquency for adolescent African American and Latina girls.

This research project will use a qualitative methodology and interviews will be used to find a common theme or experience of young women who experienced trauma of sexual abuse and were involved in juvenile delinquency. The participant will participate in a private interview with the researcher. This interview will be audio-recorded and will last approximately 2 hours. No preparation is required for the interview. Participants have the right to leave the study at any time without penalty of prejudice.

All information will be handled completely confidentially. The following safeguards will be taken to protect against the loss of confidentiality: 1) Names will not be associated with answers in a private or public report on the results. 2) Names will be kept separate from any project records, audio-recordings, transcripts, or discussion of data. 3) All identifying information will be deleted when direct quotes are used in the study. 4) All confidential materials will be coded and identified by numbers only. Interview numbers will be used instead of names on all project records, audio-recordings, transcripts, and in any discussion of data. 5) All audio recordings will be deleted after the completion of the project. Tapes will be stored in a locked safe at the residence of the researcher when not in transit on her person to and from interviews.

You are a suitable participant for this study if you 1) are female, 2) are between the ages of 18- 24 years of age, 3) identify ethnoculturally as African American or Latina, 4) have experienced sexual trauma (abuse, maltreatment, assault) as a child or adolescent (under the age of 18), and 5) were or were involved in the juvenile delinquency system prior to your 18th birthday.

Interested participants will be given a brief screening for acceptance into this study by phone. An opportunity to ask questions will be made before the screening. If you are interested in participating in this study, please contact Gena Castro Rodriguez at [withheld for privacy] or [withheld for privacy].

Please know that by participating, you will be contributing to the knowledge base about sexual trauma and delinquency for girls. Moreover, by providing

information, your are helping building an understanding about the relationship between trauma and delinquency that will lead to better interventions and treatments for girls who have experienced trauma.

If you require any therapy/mental health services please contact:

- Gena Castro Rodriguez, LMFT #49717 [withheld for privacy] 1801 Bush Street San Francisco, CA 94109
- Psychological Services Center [withheld for privacy] 1390 Market Street San Francisco, CA 94103
- San Francisco Psychotherapy Research Group Clinic [withheld for privacy]
  9 Funston, San Francisco, CA 94129

Thank you for your interest,

Gena Castro Rodriguez, M.A., LMFT Psy.D. Candidate
Professor Benjamin R. Tong, Ph.D. (Dissertation Chair)

APPENDIX B: DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

The purpose of this study is to further understand and explore the relationship between sexual trauma and delinquency.

Your participation in the project is voluntary and can be terminated at any time. In order to protect your privacy no names will appear in the dissertation and all identifying material will be kept confidential and maintained in a locked file cabinet to which only the primary researcher, Gena Castro Rodriguez, has access. All transcripts and audiotapes will be destroyed 3 years after collection.

If you have any questions, please contact me at [withheld for privacy] or [withheld for privacy].

Thank you for your time and assistance.

Name:____
Address:____
Phone:_____________________________ Email:________________________
Age:_______Ethnicity:______________Highest grade completed in school?____
Are you currently pregnant?_______ if so, how far along?_______
Do you have children? _____If so how many?_____What are their ages/gender?____
____

Are you currently attending school? ________If so where?__________________
Are you currently employed? __________If so where?__________________________

Juvenile Justice System Involvement

1. Were you ever in the Foster Care or the Child Welfare System? __________

If so when?
____
How old were you?____
Why?
____

Where/With whom did you
live?____

2. Were you ever in the Juvenile Delinquency System?_______________________

If so at what age did you first have
contact?____
What was the charge or
arrest?____
What was the disposition or outcome of the charge or
arrest?______________________
Where you detained in juvenile hall? _____________ How
long?____________________
Where you place on formal or informal probation?
____
If so, for how long?
____
Did you successfully
complete?____
If not,
why?____

3. Please list additional contacts with Juvenile Justice System

Date	Charge	Detention Length of Stay	Outcome/Disposition

<u>Adult Criminal Justice System Involvement</u>

4. Are you now or have you ever been involved with the adult Criminal Justice System?
____

If so at what age did you first have
contact?____
What was the charge or
arrest?____

What was the disposition or outcome of the charge or arrest?________________________
Where you detained in jail or prison? ______________ How long?___________________
Where you place on probation or parole?
____
If so, for how long?
____
Did you successfully complete?____
If not, why?____
_

Date	Charge	Detention Length of Stay	Outcome/Disposition

APPENDIX C: INTERVIEW QUESTIONS

The purpose of this study is to further understand and explore the relationship and pathway between sexual abuse and delinquency. I will be asking you questions of a sensitive nature regarding your history of sexual abuse and trauma and involvement in the juvenile justice system. It is my intention to ask these questions in a manner that is sensitive and respectful of your experience and understanding of these events.

Your participation in the project is voluntary and can be terminated at any time. If you feel you cannot continue to participate in the study once we have begin, please let me know immediately so that we can conclude the interview.

Participation in this study and interview may bring up feelings or emotions associated with trauma and or delinquency and you may need or want mental health support as a result. If you would like help accessing resources for immediate or ongoing mental health support regarding these issue, please let me know so that I can help you connect with support following your participation.

In order to protect your privacy no names will appear in the dissertation and all identifying material will be kept confidential and maintained in a locked file cabinet to which only the primary researcher, Gena Castro Rodriguez, has access. All transcripts and audiotapes will be destroyed no more than 3 years after collection or after dissertation is complete, whichever comes first.

1. Who were you primarily raised by and tell me what you know/remember about your early childhood? Did you experience any abuse, neglect or violence?
2. Tell me about your earliest memories between you are your caregiver/parent?
3. When is your first memory of sexual trauma? What do you remember about it?

   How did you feel about the experience?
4. Did you ever experience sexual trauma again? Tell me more about when this happened, by whom, and what were the events surrounding this experience?
5. Did this experience inform/shape/influence the way you felt about yourself and how?
6. How do you think this impacted your life or future ? Like your relationships, school, etc? How about your own behavior or way of

being in the world? Did you engage in risk taking or harmful behaviors?

7. What are the kinds of things that first lead to your involvement in juvenile justice?
8. To the best of your recollection, how did you feel about the experience? What do you think about how you were treated in the system? What do you think about how girls are treated in the system?
9. Do you think involvement in the juvenile justice system has had an impact on your life now?
10. Do you think your experience of sexual trauma has had an impact on your life now?

APPENDIX D: CONSENT FORM

This research is being conducted for a study in clinical psychology under the guidelines established by the California Institute of Integral Studied Institutional Review Board. The researcher is Gena Castro Rodriguez, a doctoral candidate at the California Institute of Integral Studies in San Francisco, CA. The purpose of the study is to explore the relationship between trauma of sexual trauma and delinquency for adolescent African American and Latina girls.

Participants in the study meet the following criteria 1) are female, 2) are between the ages of 18- 25 years of age, 3) identify ethnoculturally as African American or Latina, 4) have experienced sexual trauma (abuse, maltreatment, assault) as a child or adolescent (under the age of 18), and 5) were involved in the juvenile delinquency system prior to your 18th birthday.

This research project will use a qualitative methodology and interviews will be used to find a common theme or experience of young women who experienced trauma of sexual abuse and were involved in juvenile delinquency. The participant will participate in a private interview with the researcher. This interview will be audio-recorded and will last approximately 2 hours and take place at the private office of Gena Castro Rodriguez, located at 1801 Bush Street, Suite 233 San Francisco, 94109. No preparation is required for the interview. Participants have the right to leave the study at any time without penalty of prejudice.

All information will be handled completely confidentially. The following safeguards will be taken to protect against the loss of confidentiality: 1) Names will not be associated with answers in a private or public report on the results. 2) Names will be kept separate from any project records, audio-recordings, transcripts, or discussion of data. 3) All identifying information will be deleted when direct quotes are used in the study. 4) All confidential materials will be coded and identified by numbers only. Interview numbers will be used instead of names on all project records, audio-recordings, transcripts, and in any discussion of data. 5) All audio recordings will be deleted after the completion of the project. Tapes will be stored in a locked file cabinet at the residence of the researcher when not in transit on her person to and from interviews.

Your privacy with respect to the information you disclose during participation in this study will be protected within the limits of the law. However, there are circumstances where a psychologist is required by law to reveal information, usually for the protection of a patient, research

participant, or others. A report to the police department or to the appropriate protective agency is required in the following cases:

1. If, in the judgment of the researcher, the research participant becomes dangerous to himself or herself or others (or their property), and revealing the information is necessary to prevent the danger;

2. If there is suspected child abuse, in other words if a child under 16 has been a victim of a crime or neglect;

3. If there is suspected elder abuse, in other words if a woman or man age 60 or older has been victim of a crime or neglect.

If a report is required, the researcher will discuss its contents and possible consequences with the patient or research participant.

I have been informed about the purpose of this study and the potential risks and benefits associated with my participation. I have been assured that all this information will be handled completely confidentially. I understand and am satisfied that the following safeguards have been taken to protect against the loss of confidentiality: 1) My name will not be associated with my answers in a private or public report on the results. 2) My name will be kept separate from any project records, audio-recordings, transcripts, or discussion of data. 3) All identifying information will be deleted when direct quotes are used in the study. 4) All confidential materials will be coded and identified by numbers only. Interview numbers will be used instead of names on all project records, audio-recordings, transcripts, and in any discussion of data. 5) All audio recordings and transcripts will be deleted after the completion of the project. Tapes will be stored in a locked safe at the residence of Gena Castro Rodriguez when not in transit on her person to and from interviews.

I know that my participation is completely voluntary and that I will not be compensated for time or any stress, which I might experience. However, I also know that I may refuse to answer any questions without risk or penalty. Gena Castro Rodriguez will be available to discuss questions or concerns that may arise.

If I have any questions or concerns about this research and my rights as a participant, or if I feel that I have been placed at risk, I know that I can contact the principal researcher Gena Castro Rodriguez, by calling [withheld for privacy], or her supervisor Benjamin Tong, Ph.D., by calling [withheld for privacy]. Furthermore, I may directly or anonymously write to The Human Research Review Committee Coordinator, Emi Kojima, California Institute of Integral Studies, 1453 Mission Street, San Francisco, CA, 94103, or by email at [withheld for privacy].

Please know that by participating, you will be contributing to the knowledge base about sexual trauma and delinquency for girls. Moreover, by providing information, your are helping building an understanding about the relationship between trauma and delinquency that will lead to better interventions and treatments for girls who have experienced trauma.

The interview questions may touch sensitive areas for some people; some discomfort may arise from discussing a situation that might have been both professionally challenging. Some questions are aimed at elucidating the possible relationship between sexual trauma and delinquency. You will be free to refuse to answer any question or to end your participation in the study at any time. Gena Castro Rodriguez will available before, during and after the interviewing process to talk about your concerns and to facilitate referral to consultants or therapists if such a need should arise. Below is contact information for her and low fee community based resources.

Gena Castro Rodriguez, LMFT #49717 [withheld for privacy] 1801 Bush Street San Francisco, CA 94109 Psychological Services Center [withheld for privacy] 1390 Market Street San Francisco, CA 94103 San Francisco Psychotherapy Research Group Clinic [withheld for privacy] 9 Funston, San Francisco, CA 94129

By signing below, I acknowledge that I have received a copy of this consent form and the Participant Bill of Rights.

I, ______________________________, consent to participate in this study of variables that contribute to delinquency for African American and Latina girls who have experience sexual trauma in childhood, conducted by Gena Castro Rodriguez of the California Institute of Integral Studies. I understand the purpose and nature of this study and am participating voluntarily. I grant permission for the audio-recorded interview data to be used in the process of completing a Psy.D. Degree. I understand that my name and other identifying information will not be used. I have received a copy of this consent form and I understand that my confidentiality will be protected with the limits of the law.

Signature Date
____

If you would like to receive a written summary of the results of the study, please provide an email address where it can be sent to you.

____
Email

APPENDIX E: PARTICIPANT BILL OF RIGHTS

As participant in psychological research, you have the right to:

- Be treated with dignity and respect;
- Be given a clear description of the purpose of the study and what is expected of you as a participant;
- Be told of any benefits or risks to you that can be expected from participating in the study;
- Know the researcher's training and experience;
- Ask any questions you may have about the study;
- Decide to participate or not without any pressure from the researcher;
- Have your privacy protected within the limits of the law;
- Refuse to answer any research question, refuse to participate in any part of the study, or withdraw from the study at any time without any negative effects;
- Be given a description of the overall of the study upon request, and
- Discuss any concerns or file a complaint about the study with the Human Research Committee, California Institute of Integral Studies, 1453 Mission Street, San Francisco, CA, 94103.

APPENDIX F. CONFIDENTIALITY STATEMENT

Your privacy with respect to the information you disclose during participation in this study will be protected within the limits of the law. However, there are circumstances where a psychologist is required by law to reveal information, usually for the protection of a patient, research participant, or others. A report to the police department or to the appropriate protective agency is required in the following cases:

1. If, in the judgment of the researcher, the research participant becomes dangerous to himself or herself or others (or their property), and revealing the information is necessary to prevent the danger;
2. If there is suspected child abuse, in other words if a child under 16 has been a victim of a crime or neglect;
3. If there is suspected elder abuse, in other words if a woman or man age 60 or older has been victim of a crime or neglect.

If a report is required, the researcher will discuss its contents and possible consequences with the patient or research participant.

NCTSN The National Child Traumatic Stress Network

Center on Children and the Law
AMERICAN BAR ASSOCIATION

TRAUMA:
What Child Welfare Attorneys Should Know

EXECUTIVE SUMMARY

Each year, over 45 million children in the United States are affected by violence, crime, abuse, or psychological trauma.[1] Trauma exposure can significantly interfere with the way children's brains assess threat, which in turn can affect how they respond to stress. The negative impact of trauma exposure is particularly relevant for children and families in the child welfare system, as the majority of child welfare-involved clients have experienced multiple traumas, including abuse, neglect, and exposure to domestic violence. By understanding the impact of trauma on youth and families, and incorporating trauma-informed skills into legal advocacy, attorneys representing children or parents in child welfare cases can improve outcomes for their clients.

This document is intended to provide you with knowledge about the impact of trauma, practice tips for incorporating trauma-informed practices into legal representation, and resources to assist in the representation of clients with histories of trauma. Its intent is to guide you in your representation of clients, with the understanding that not all suggestions will be applicable or appropriate in all cases.

Trauma-informed legal practice can strengthen legal advocacy, improve attorney-client relationships, and ensure appropriate screening, in-depth assessment, and evidence-based treatment. In addition, awareness of secondary traumatic stress can improve prevention, identification, and self-care among legal professionals.

Below is a summary of tips that may assist you in incorporating trauma-informed skills and principles into your everyday practice. More detailed information about each of these tips can be found in the document that follows.

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PRACTICE TIPS

General Tips for Representing Clients in Child Welfare Cases

- Identify known or suspected trauma the client may have experienced.
- Consider the role trauma exposure may play in a client's behaviors, including refusal to engage in treatment, missing court appearances or appointments, as well as exhibiting hostility, apathy, or defiance during court proceedings. These behaviors could be misinterpreted signs of an alarm reaction or trauma response.
- Provide structure, predictability, and opportunities for the client to exert control over decisions as appropriate.
- Provide adequate explanation to the client about his case, including your role as the attorney, a reasonable understanding of the purpose of court proceedings, and a realistic expectation of the potential outcome of court proceedings.
- Advocate for placement stability for children. When placement change is necessary, advocate for a planned transition that occurs gradually rather than abruptly.
- Advocate for visitation to begin immediately between child and parent, unless this poses a threat to the child's physical or psychological safety or the child does not want visitation.
- Support visitation that is intentional, well-planned, and held in a neutral location away from where the trauma occurred. Make every effort to prepare the child for visitation.
- Encourage continuity of treatment after transitions and collaboration among professionals providing services for the client.
- Promote client resilience by leveraging existing social supports, advocating for client involvement in services and activities that increase a sense of mastery and competence, and making referrals for trauma-informed mental health treatment when appropriate.

Trauma Screening, Assessment, and Treatment

- Advocate for universal screening of trauma exposure and related symptoms.
- Provide universal in-depth assessment for those children and parents for whom a screening identifies a history of trauma.
- Make referrals or advocate for appropriate trauma treatment for clients affected by trauma exposure. Not all mental health providers are trained to provide evidence-based trauma treatment, so it is important to identify the type of treatment offered.
- Coordinate with a client's existing therapist to ascertain information about trauma triggers, suggested steps for ameliorating trauma triggers, the treatment being provided, and any other relevant information, such as risk for self-harm.

Attorney-Client Relationship

- Consider issues of physical and psychological safety when advocating for clients and resist practices that may re-traumatize children and parents.
- Meet in a quiet space with minimal distractions and outside the presence of other parties who may contribute to the client feeling threatened.
- Provide adequate information about the attorney-client meeting, including the purpose of the meeting, expectations for the meeting, and length of the meeting.
- Provide a thorough explanation about the court process, including the purpose of each court hearing, the information that you will present in court, and potential questions that the judge or attorneys may ask of the client. Allow the client time to practice and role-play responses.
- Be alert for signs of a trauma reaction, which typically present as some variation of the fight, flight, or freeze response. These signs may include lashing out, shutting down or withdrawing, or regressive, defiant, or disrespectful behaviors.
- Try to avoid startling the client with loud noises, sudden movements, or unexpected news without adequate explanation or preparation.
- Minimize touching the client, which can trigger a reaction in individuals with histories of physical or sexual abuse.
- Avoid overpromising or telling the client that "everything will be fine." Clients may be triggered by feeling let down or misled by their attorney.

Secondary Traumatic Stress

- Maintain work environments for staff that increase resilience and acknowledge, reduce, and treat vicarious or secondary traumatic stress.
- Identify and engage in self-care on an individual and organizational basis.

TRAUMA:
What Child Welfare Attorneys Should Know

1 Defining Trauma-Informed Legal Advocacy

In 2014, more than 700,000 children in the United States were exposed to child maltreatment and more than 400,000 children were residing in foster care.[1] Children in foster care are likely to have been exposed to multiple forms of trauma, such as physical or sexual abuse, neglect, family and/or community violence, trafficking or commercial sexual exploitation, bullying, or loss of loved ones. [2] In addition to situations of abuse or neglect that lead to their removal from their homes, children in care may experience further stresses after entering the system. Separation from family, friends, and community is often referred to as system-induced trauma.

The majority of parents or caregivers involved in the child welfare system have also experienced trauma and many were maltreated or placed in foster care as children. Addressing trauma among families involved in child welfare is essential to stopping this cycle of maltreatment. Without proper intervention, the negative effects of childhood trauma may persist into adulthood, and can result in higher rates of psychiatric or medical illness, substance use, criminal offending, and early death.[3]

The Attorney General's National Task Force on Children Exposed to Violence1 recommends that all professionals serving children exposed to violence and psychological trauma learn about and provide for trauma-informed care and trauma-focused services. Similarly, the American Bar Association has called for integrating trauma knowledge into daily legal practice and integrating and sustaining trauma awareness and skills in practice and policies.[4]

Trauma-informed systems are structured with an understanding of the causes and effects of traumatic experiences, and incorporate practices that support recovery. [5] A system-wide approach requires involvement by all stakeholders working with children and their families, including caseworkers, attorneys for all parties, judges, service providers, birth parents, and caregivers such as foster parents and kinship caregivers.

By enhancing the ability to recognize the impact of trauma, respond appropriately, and avoid legal practices that may re-traumatize children or parents, trauma-informed legal representation can support recovery and enhance resilience, thus improving outcomes for children and families. Incorporating trauma-informed skills into legal practice can also improve attorney-client relationships, increase opportunities to advocate for appropriate services, and enhance prevention, recognition, and mitigation of secondary traumatic stress (STS; see Section Eight).

Trauma-informed legal representation may include:

1. Identifying all known and suspected trauma the client may have experienced
2. Understanding parent and caregiver trauma and its impact on the family
3. Considering the legal implications of routine screening for trauma exposure and related symptoms, particularly for parents and dual-system involved youth (see Glossary)
4. Making appropriate referrals for culturally sensitive, evidence-based assessment and treatment for traumatic stress and associated mental health symptoms
5. Advocating for provision of resources (e.g., psychoeducational books, victim assistance information) about trauma exposure, its impact, and treatment for children, families, and stakeholders
6. Understanding and promoting resilience and protective factors for children and their families
7. Encouraging continuity of care and collaboration across child-serving systems
8. Maintaining work environments for staff that increase staff resilience and address, reduce, and treat vicarious or secondary traumatic stress
9. Considering issues of physical and psychological safety when advocating for clients and resisting practices that may re-traumatize children and parents
10. Maintaining awareness of one's own behaviors, tone of voice, body language, and approach when engaging and questioning clients who may have a history of trauma
11. Taking steps to make clients more comfortable and to recognize when clients are having a trauma reaction
12. Engaging in continuing education about trauma to learn new and developing information that can benefit clients

These suggestions identify actions you can take to promote a trauma-informed response to your clients, *with the understanding that the confines of professional conduct, including confidentiality and ethical considerations as well as strategic case planning, may affect one's ability to act on these recommendations in individual cases*. In addition, advocates should always clearly explain their role to child clients, whether they are representing the client's expressed wishes as an attorney, best interest as *guardian ad litem*, or taking a hybrid approach.

By keeping these principles in mind, you can build more effective relationships with your clients to serve their legal interests, work to ensure necessary service needs are met, and support clients' current and future well-being.

2 The Impact of Trauma Exposure on Child Development

Approximately 80 to 90 percent of youth involved in the child welfare system have experienced at least one traumatic event.[6] Trauma may result from either direct experiences, such as being neglected or abused, or witnessed experiences including domestic violence between caregivers. Children may also be traumatized by hearing about something that happened to their parent or caregiver (e.g., serious injury, incarceration).[7]

Traumatic experiences early in life may alter how the brain assesses threat and how clients respond to stress. A fight or flight response may be "triggered" by anything that reminds a client of past traumatic events, causing a perception of immediate danger. A triggered youth or adult may engage in aggressive or avoidant behaviors in an effort to feel safe; behave defiantly or aggressively to keep others at a distance; or attempt to escape the situation. Common responses include running away from home or school; avoiding attorneys or court hearings perceived as threatening; shutting down; or "spacing out."

There are a range of potential reactions to traumatic events. Most trauma survivors, including youth in the juvenile justice system or parents accused of maltreatment, will recover from their experiences and thus should not be viewed as "damaged" or beyond help. Trauma's impact on the brain and normal child development can be reversed with appropriate treatment and other supports (see Section Six). Recovery is related to resilience; and attorneys can promote clients' resilience in a number of ways, listed below.

PRACTICE TIPS: PROMOTING CLIENT RESILIENCE

Leverage existing social supports – immediate and extended family, fictive kin (see Glossary Terms, page X), community and religious leaders, school staff, coaches, etc.

Advocate for clients' involvement in services or activities that increase their sense of mastery or competence, such as parenting classes/training for caregivers, or afterschool activities for children and youth.

Support clients in developing effective coping skills by referring them to trauma-informed treatment as indicated, and helping them cope with potentially distressing court proceedings or transitions by adequately explaining them in advance.

While many youth and adults who experience trauma are able to work through subsequent challenges without professional intervention, some will develop symptoms of Posttraumatic Stress Disorder, or PTSD (see Glossary Terms, page 6, for definition). PTSD increases the risk for negative outcomes across the lifespan, including academic challenges and peer problems in childhood and criminal justice involvement in adolescence and adulthood. (See Appendix, Section Two, for additional resources on how trauma may affect clients in different age groups.) Some clients may experience partial symptoms of PTSD or develop other disorders such as substance use, depression, or anxiety.

Many trauma survivors will not meet criteria for a PTSD diagnosis but will experience significant trauma-related impairment in daily living. Youth or adults with more chronic or pervasive exposure to traumatic events, termed complex trauma, may suffer additional challenges that are not captured by the PTSD diagnosis (see Glossary Terms). Whenever possible, clients should be screened. If a trauma screen reveals trauma exposure, a further in-depth assessment for trauma exposure and related symptoms to determine the impact of their traumatic experiences and need for appropriate treatment is warranted (see Section Five).

3 The Impact of Trauma Exposure on Child Development

Approximately 90 percent of parents or caregivers involved in the child welfare system have histories of trauma exposure, including high rates of childhood abuse and neglect, and a significant number were involved in the system as children.[8,9,10] Additionally, families may be affected by historical trauma resulting from societal racism and oppression towards ethnic minorities, particularly African-American, Native American, and immigrant communities. The impact of these traumatic experiences on both caregivers and their children can be inadvertently intensified by institutional practices within systems such as child welfare or juvenile justice.[11]

Exposure to trauma does not always determine adverse outcomes for parents and their children. However, for some parents, prior trauma exposure may negatively impact the manner in which they interact with their children, thereby placing children at higher risk for traumatic stress. This is also known as intergenerational trauma. For example, parents with histories of repeated exposure to violence may have greater difficulty recognizing the adverse effects of violence exposure for children. Untreated PTSD can also interfere with a parent's ability to use safe and effective parenting strategies and protect their children from abuse by others.[12,13] In turn, without effective intervention, children exposed to neglect or abuse are significantly more likely to perpetrate violence against dating partners, enter into abusive relationships in adolescence and adulthood, and perpetrate abuse of their own children when they become parents.[14,15,16] Consequently, addressing traumatic stress within families in the child welfare system is essential for reducing rates of child maltreatment and interrupting the intergenerational transmission of trauma. Further, recognition of these risks can position attorneys to recommend resources to clients that lessen the impact of risks and bolster clients' resiliency.

Trauma can affect a parent's approach to discipline and child-rearing.

Parents with trauma histories who abuse or neglect their children may view their parenting behavior as normal, and may not understand that there are alternative ways of interacting with their children. Additionally, a traumatized parent may be hypervigilant or overly focused on identifying potential threats to his or her child. Hypervigilant parents may react harshly to child misbehavior because they fear consequences or reactions from others if their children continue to misbehave. Parents with trauma histories may also place extreme restrictions on their children, such as requiring them to spend all free time at home to avoid potential danger. Trauma can also deplete a parent's psychological and physical energy as well as the financial and social resources necessary to accomplish parenting tasks.

After a client-centered decision-making process that includes legal counseling of the client, parent attorneys can advocate for participation in trauma-informed parenting workshops and treatment *(see Section Six)*. Since reunifi-

GLOSSARY OF TERMS

Trauma
Exposure to actual or threatened death, serious injury or violence in one of the following ways: 1) direct experience; 2) witnessing a traumatic event; 3) learning that a loved one experienced trauma; or 4) repeated or extreme exposure to aversive details of traumatic events (e.g., child welfare attorneys who develop secondary traumatic stress after repeated exposure to their clients' trauma stories).

Child Traumatic Stress
Occurs when a child experiences a traumatic event or situation that upsets and overwhelms his or her ability to cope; and the signs and symptoms interfere with the child's daily life.

The Body's Alarm System
Function of the brain that scans the environment for potential danger and prepares us to act. When triggered, the alarm system sets off a cascade of immediate physiological changes that prepare one for Fight-Flight-Freeze response in order to stay safe. This is a complex response that involves multiple areas of the brain, including the sympathetic nervous system and the amygdala.

Trigger
A reminder of a past traumatic event that sets off the body's alarm system, so that the person feels in imminent danger once again. A "trigger" can be anything connected to a traumatic event, including an event, situation, place, physical sensation, or even a person.

Posttraumatic Stress Disorder
A mental health disorder most commonly associated with trauma exposure. PTSD is characterized by problems in four areas: re-experiencing (i.e., flashbacks or nightmares of traumatic event); avoidance of thoughts or reminders of past trauma;

cation is the ultimate goal in most child welfare cases, and most children in the child welfare system reunify with their biological families[17], it is essential that parents and caregivers receive needed trauma-informed services in order to begin the healing process and improve their capacity to provide safe and stable home environments.

Trauma can affect parental reactions to court proceedings and an attorney's working relationship with the parent.

For parents or caregivers with histories of trauma, child welfare proceedings may present particular challenges that can significantly interfere with their ability to effectively manage court proceedings and relationships with court and child welfare professionals. Parents who have experienced trauma may exhibit difficult behaviors such as angry outbursts, lateness, refusal to return phone calls, and missed appointments or court appearances. One study of child welfare-involved mothers also found that those who had previous involvement with the system as children were significantly less engaged with services provided through child welfare agencies.[18] These behaviors may be interpreted as hostility or apathy, but may in fact be symptoms of traumatic stress. Traumatic stress pushes the brain into a hypervigilant mode that may cause individuals to be highly sensitive to power differentials, perceived attacks, and a perceived loss of control. This may result in a parent's distrust of, and irritability toward, those who appear more powerful and in control, such as attorneys, judges, and child welfare caseworkers.[a] In such cases, parents may need additional support to help them understand those reactions, and the impact of those reactions on the overall case. Lifelong traumas may also teach ineffective ways to assert power in the world. It is understandable for parents to exhibit distrust of a system that may have been unhelpful, even harmful, in the past, especially if they have lived in poverty and have dealt with structural racism in the very systems designed to help them. Understanding these reactions can help you develop a more effective attorney-client relationship.

[a] *Traumatic stress may decrease a parent's ability to perceive the world accurately, process information, remain organized due to executive function deficits, and increase risk of substance use. In turn, this may contribute to an increased risk of maltreating their children.*

negative changes in thought or mood (i.e., persistent negative emotions, persistent or exaggerated negative beliefs about oneself, others, or the world); and hyperarousal (angry outbursts, being constantly "on guard" against potential threats). Some people may also experience dissociation. (See Appendix Section Two for additional information).

Complex Trauma

Refers to exposure to multiple or prolonged forms of traumatic experiences in childhood and the wide-ranging, long-term impact of this exposure. Complex trauma disrupts normal child development and may lead to difficulties with attachment (i.e., ability to form trusting, meaningful relationships); managing emotions and behavior; and executive functioning (i.e., ability to focus attention, solve problems, plan or pursue long-term goals).

Kinship Foster Care

Refers to the placement of youth in foster care that is provided by grandparents, aunts, uncles, or other family members.

Fictive Kin

Individuals who play an important role in a youth's life but are not related through marriage or birth.

Dual-System Involved Youth

Refers to youth who are involved in both the child welfare and juvenile justice systems.

Psychological Safety

The belief that one is safe from emotional harm and has the ability to manage threats to safety. Psychologically safe environments encourage respect for others' feelings, even when there is disagreement. Individuals can also increase their own sense of psychological safety in stressful situations by learning and using coping skills.

Dual-System Involved Youth

Youth involved in both the child welfare and juvenile justice systems)

4 The Impact of Trauma on the Attorney-Client Relationship

Trauma can interfere with the formation of strong client-attorney relationships by impairing the client's capacity to trust others, process information, communicate, and respond to stressful situations. Understanding trauma's impact on behavior can help you modify your approach with traumatized clients, prepare clients for court proceedings in a way that reduces their likelihood of a traumatic response, and advocate for clients in a way that empowers them and helps build a sense of safety and resiliency. With adequate preparation, clients may feel empowered by the opportunity to tell their stories and receive empathy and effective support from the professionals involved.

To establish an effective working relationship with traumatized clients, you should focus on physical and psychological safety, communication, and client support.

Physical and psychological safety:

When a client is reminded, either consciously or unconsciously, of a past trauma, that trigger may cause the client to feel as if she is in imminent danger. When traumatized clients feel physically or psychologically unsafe, they may become focused on protecting themselves and avoiding the perceived danger. As a result, they may not listen to or process information accurately, may refuse to talk, or simply agree to anything in order to leave. You can assist your client and establish a safe environment by providing structure and predictability, allowing the client to make informed decisions about his or her case whenever possible.

Court hearings and other procedures in the child welfare system may inadvertently trigger or re-traumatize clients with trauma histories. For example, clients are frequently triggered by a perceived loss of control or power, such as court decisions made about placement or visitation. Therefore, you should give clients a clear voice in decisions related to their representation, elicit their views, and seek active, age-appropriate involvement.

When triggered, clients may react in ways that are misinterpreted by the court. For example, a child may withdraw emotionally or physically *(often described as freezing or shutting down)* in response to questions about desire for contact with a parent. Or, a parent with a trauma history may shut down or react defiantly during cross-examination. A child placed in foster care, particularly an adolescent, may run away or act out in response to conflict with a foster parent or group home staff member. Judges, attorneys, and other professionals may view such a client as uncooperative or disinterested rather than as someone who is having a trauma response. You can advocate for clients by explaining to the court and the other parties that the client's behavior is a reflection of underlying trauma. Decisions regarding such disclosures should be case-specific and within the bounds of attorney-client privilege and your specific attorney role.

Some suggestions for increasing physical and psychological safety include:

- Meet in a quiet space where there are minimal distractions, away from other parties who may make your client feel threatened.
- Inform the client of the purpose of that day's meeting, what to expect during the meeting, and how long the meeting will last. Several shorter meetings can build familiarity and be more productive than a single, longer meeting. Make sure to ask what questions the client may have.
- Explain the court process. Let the client know what you are going to say in court, questions you may ask the client, and questions the judge or opposing attorney may ask (particularly when you anticipate an adversarial cross-examination). Knowing what to expect can help your client feel less anxious during a hearing. Allowing the client time to practice responding and role-playing can increase a sense of control and safety.

As part of explaining the court process to child clients, it is also important to provide a realistic understanding of the potential outcomes of a court hearing. It can be empowering for child clients to know that their attorney is listening to them and will express their wishes in court, but it is also important for them to be prepared for the possibility that those wishes may or may not be granted or taken into consideration.

Additionally, when child clients are not present for court hearings, it can be triggering for them to know there was a court date but not be informed about what happened at that hearing. Children and youth should attend their own hearings whenever possible. When their presence is not possible, it is important to provide information about what happened or some type of update in an age-appropriate manner.

Communication:

Clients who have experienced trauma may experience greater difficulty forming trusting relationships with their attorneys. Many youth in the child welfare system have been hurt by a caretaker or authority figure they trusted, and many parents distrust "the system." Such clients may not believe that you will actually advocate for them. Clients also may be slow to share emotionally-charged information, or may not feel safe expressing preferences regarding their desired outcomes, such as visitation or placement. Developing an effective attorney-client relationship takes time and patience.

You can learn to recognize signs that a client may be experiencing a trauma reaction so that you do not misinterpret or exacerbate the client's response. Trauma reactions typically represent some version of fight, flight, or freeze. A client who suddenly becomes loud or combative may be going into "fight mode" in order to keep herself safe by pushing others away. Clients may go into "flight mode" and try to avoid a triggering situation by refusing to answer sensitive questions or attempting to leave a meeting or court hearing. Clients may also "freeze" by shutting down or dissociating *(a common response to trauma when a person mentally shuts down or "goes elsewhere")*. She may sit quietly but will no longer be paying attention. Do not assume that silence means the client understands or consents. *(Appendix Section Four includes information about identifying signs of trauma reactions in clients.)*

PRACTICE TIPS TO AVOID TRIGGERING CLIENTS WITH PRIOR TRAUMA

Look for signs of trauma reactions. As discussed in this section, clients may exhibit variations of the fight, flight, or freeze response.

Try not to startle the client. Loud noises *(including yelling)*, sudden movements *(jumping up from a chair)*, or unexpected news can all trigger trauma responses.

Prepare the client for what is ahead. Predictability is important to establishing a trusting relationship. Preparation can help minimize your client's hypervigilance to threats from unfamiliar or unexpected sources.

Minimize touching the client. You may intend to be supportive when you put your arm around a child or touch a parent's shoulder, but that can trigger a reaction in people who have been physically or sexually abused. By respecting your client's personal space, you can help build the client's sense of control and safety.

Do not overpromise or tell the client "everything will be fine." This includes promising clients you will always be there for them. Attorneys frequently change. Be honest in your communications because clients may be triggered by feeling let down or misled by their attorney. Remember that clients' behaviors may also be influenced by the expectation that you will inevitably disappoint them, so be honest and forthright from the start.

[b] *Child participation in the court process is considered a best practice by national organizations such as the American Bar Association, National Council of Juvenile and Family Court Judges, and National Association of Counsel for Children. A study in Nebraska found that children's anxiety levels related to court participation were low overall and even lower for children who had attended court. The children who attended court also viewed the judgments as more fair. A recent New Jersey study showed that court participation is not upsetting for youth, but can provide an opportunity for them to be heard. It also provides better information to both the youth and the court.*[19]

Client support:
Parents and children who are involved in the child welfare system may still have strong attachments to and pleasant memories of family members. In fact, a child can remain emotionally attached to a dysfunctional family and may be further traumatized by complete loss of contact with relatives. Family members can offer the best source of long-term support for a traumatized child. It is essential that a child stay connected with siblings, relatives and extended family (as defined by the client), and friends. In cases in which ongoing family contact is not feasible or is contraindicated for safety reasons, you can look for ways to involve other people trusted by your client, such as a family friend, coach, teacher, or pastor.

Finally, you should be aware that some clients may find the experience of court involvement traumatizing, whether from memories of past involvement, interactions with or observations of others in the courthouse, and especially the intensity of the courtroom environment itself. Trauma triggers might include an attorney's behaviors, tone of voice, body language or approach to questioning. You can take steps to make your clients more comfortable and to recognize when clients are having a trauma reaction.

POSSIBLE SIGNS THAT YOUR CLIENT HAS BEEN "TRIGGERED"

- Lashes out verbally or physically
- Becomes defiant, disrespectful
  (fight response meant to keep potential threats at a distance)
- Has difficulty tracking the attorney's questions
- Shuts down, stops talking
- Becomes jumpy, fidgety, starts pacing
- Has sudden, dramatic shifts in mood
- Looks spaced out, gets lost in conversation, or appears to have "gone somewhere else"
- Speech grows louder, faster
- Suddenly tries to leave situation
  (flight response)
- Adopts regressive behaviors
  (thumb sucking, rocking)

Client Resiliency:
It should be noted that despite trauma histories and traumatic stress reactions, clients are often resilient. Your actions during the course of legal proceedings can further bolster resiliency. Whether through advocacy for treatment *(Section Six: Effective Treatments for Traumatic Stress)* or facilitating a client-attorney relationship that conveys awareness of traumatic stress reactions, promoting a psychologically safe environment using the above strategies can support your clients' improved management of traumatic stress reactions.

5 Screening and Assessment

Clients involved in child welfare proceedings should be routinely screened for exposure to trauma and related mental health conditions in order to determine their need for therapy and other services. In this section we distinguish between screening, assessment, and neuropsychological evaluations.

Screening refers to a brief set of questions administered to children, parents or caregivers to identify clients who likely suffer from trauma-related impairment. Screening can be conducted by attorneys using validated assessment instruments. Any client who screens positive for likely trauma exposure or symptoms can be referred to a qualified mental health professional for a full assessment. Various trauma-informed screening instruments and questionnaires are available for use *(see NCTSN Measures Review Database)*.[20]

A ***trauma-informed mental health assessment*** refers to a comprehensive evaluation conducted by a trained mental health provider such as a social worker, psychologist, or psychiatrist. The goal is to determine if the client is suffering from traumatic stress or other mental health problems and to generate recommendations for treatment or other social services. The provider conducting the assessment gathers information on trauma experiences or symptoms along with other mental health symptoms, medical issues, academic and employment history, and family dynamics, as well as strengths exhibited by the child, parent, family, and community. A thorough assessment should include information from several sources, including clinical interviews with the child, caregivers, and collateral informants; review of client records (school, medical, and mental health treatment); and behavioral observations.

Neuropsychological evaluation *(also referred to as cognitive evaluation)* is used to assess a child's current level of intellectual and academic functioning. Such evaluations may be warranted for clients who are experiencing significant academic or vocational problems or are suspected of having undiagnosed learning disorders or developmental delays. The latter are quite common among children with prior trauma exposure. You may need to make the case that such an assessment is required by reasonable efforts and request that the court order the assessment and approve payment by the child welfare agency.

Integrating trauma screening and assessment findings into court reports is a key element of a trauma-informed child welfare court system. Including these findings will assist the court to understand the impact of trauma on the child and parent, develop plans that support their resilience, and avoid decisions that may re-traumatize the child and parent. Screenings, assessments, and evaluations may need to be court-ordered. Depending on local law, the results are generally made available to all parties or may be obtained by one party or the other for use as an advocacy tool.

PRACTICE TIPS: CONSIDERATIONS FOR TRAUMA SCREENING AND ASSESSMENT

A trauma assessment is very different from a mental health assessment conducted as part of a custody evaluation. The former is not designed to provide recommendations regarding placement and visitation within the child welfare context.

Although it is recommended that you advocate for trauma-informed assessments of clients who screen positive for trauma exposure or symptoms, this may not always be possible within the confines of your particular role. Parents' attorneys in particular may resist trauma assessments if the parent client is not amenable to an assessment or if the attorney has concern that the parent may be viewed by courts as too "damaged" to be rehabilitated. In this case, one option is to consider whether this concern is outweighed by the potential benefits. Trauma screening and assessment will help ensure that parents with traumatic stress receive appropriate services to help facilitate their healing and address mental health issues that potentially impact their legal cases. While it is ultimately the client's decision, parents' attorneys can also engage in client-centered counseling to present both the potential benefits and potential risks of a trauma-informed assessment.

You should be aware of potential legal consequences related to information shared during court-ordered assessments. For example, an accused parent may report information on trauma history that could be used against him in court proceedings. Likewise, acknowledgment of living with an abusive spouse could be used as evidence that the parent is providing an unfit home environment for the child.

Whenever possible, each child and parent involved in child welfare proceedings should be screened for traumatic events and related symptoms as long as the jurisdiction has sufficient legal protections to ensure the information will not be used in ways that will further harm the youth or family.

Not all mental health agencies routinely ask about trauma exposure or symptoms during their assessments. You should make efforts to ensure that the child welfare agency arranges for trauma-informed assessments.

6 Effective Treatments for Traumatic Stress

Even severely traumatized youth and adults can recover from trauma with the right supports, including effective mental health treatment. The terms trauma-informed or trauma-focused treatment refer to mental health interventions designed to help people recover from traumatic stress. There are evidence-based trauma-informed or -focused interventions for every age group, ranging from infants to adults *(see NCTSN Empirically Supported Treatments and Promising Practices)*.[21]

There are individual treatments for a traumatized child or parent as well as treatments designed for the parent and child to work together. Trauma-focused treatments can support client resilience by helping the client develop effective coping and problem-solving skills, build on strengths, reduce trauma-related symptoms, and improve social, academic, and developmental functioning. Trauma-informed treatment has been shown to improve mental health and behavioral outcomes among children and parents and to reduce the likelihood of future abuse or neglect.[22, 23]

Whenever a client undergoes a comprehensive assessment *(see Section Five)* and is found to suffer from trauma-related impairment, you should advocate for trauma-informed treatment. A core principle of trauma-informed practice is to provide clients with a sense of control over the process. Thus, you should ask about and advocate for client preferences about treatment modality *(e.g., individual, family, or group treatment)* and therapist gender. Regarding the latter, some youth have an aversion to or may be triggered by a clinician of the same gender as their abuser.

Not all treatments are trauma-informed, including many of the treatments commonly recommended in family courts, such as parenting groups, substance abuse treatment, or anger management. Clients with traumatic stress are less likely to benefit from such interventions and more likely to end treatment prematurely. A negative treatment outcome may be used against the client (particularly a parent) as evidence he is unwilling or too damaged to change behaviors. Therefore, you should advocate that your clients are referred to trauma-informed treatment when indicated.

Many mental health providers have not been trained in trauma-informed treatment. In order to identify trained providers, you can search through relevant online directories. You can also interview prospective treatment providers to determine whether they offer trauma-informed treatment *(see Appendix Section Six)*.

CORE ELEMENTS OF TRAUMA-INFORMED/FOCUSED TREATMENT

- Educating clients regarding trauma and its impact
- Increasing client sense of physical & psychological safety
- Identifying triggers for trauma reactions
- Developing emotional regulation skills
  (i.e., skills to help control and express strong feelings)
- Developing trauma-informed parenting skills
- Addressing grief and loss *(when appropriate)*
- Processing traumatic memories

7 Placement Decisions, Transitions, and Visitation

The child welfare court system has historically focused on physical safety. More recently, however, there has been increased attention on ensuring psychological safety for children and families. Psychological safety is the ability to feel safe within one's self as well as safe from external harm. The inability to feel safe can impact an individual's interactions with others, can lead to a variety of maladaptive coping strategies, and can result in anxiety.

Removing a child from a home where there is neglect or abuse may improve his or her physical safety, but at the same time may impair the sense of psychological safety for both the child and the parents. Research shows that frequent placement changes are associated with poor outcomes for children involved in the child welfare system.[24,25] You may not have the power to alleviate your clients' distress, but you can minimize trauma caused to families involved in the child welfare system and improve their sense of safety by becoming an advocate for them during the following critical junctures:

Placement Decisions:

In jurisdictions with client-directed representation, you should advocate for a child client's stated interests. Giving a child a voice in the proceedings will help the child feel that she has some control in a process that can otherwise be overwhelming and even traumatic. Attorneys advocating for the child's best interest should also consider the child's wishes in making the best-interest determination. You should first consider whether the child can safely remain in the home with any needed supports to minimize disruptions. When children must be removed from their homes, you should advocate that they be placed with a relative who is willing and able to provide a physically and psychologically safe home environment.

You should seek the input of your client, whether this is a child or parent, regarding relatives who may be able to provide a safe home for the child. You should also advocate for siblings to be placed together except in cases of suspected sibling abuse or other safety concerns. Research shows that youth who are initially placed in kinship foster care and with all their siblings are significantly more likely to achieve stable placement and exit the system.[26]

In cases when an out-of-home placement is unavoidable, you should consider advocating for a placement close to the child's home community. This will allow the child to maintain connections with his or her support systems including extended family, church, school, teachers, mentors, and coaches. When a child is placed outside his community, you should advocate that he remain in the same school, unless it is in his best interest to move to a new school. This can also provide the stability, continuity, and connections with adults that are needed. One positive relationship with an adult can make all the difference for a child! Having a stable, nurturing relationship with an adult can facilitate tremendous healing and develop resilience for a child who has experienced trauma.

Transitions:

You can help with transitions through thoughtful and planned decisions regarding placements, visitation, and reunification.
You can:

- Advocate for a minimal number of moves and placement changes
- Assess the appropriateness of any placement based on the child's emotional, social, developmental, and medical needs
- Advocate for allowing both the child and caregiver time to prepare for visits with a parent
- Request time to say goodbye to a foster family by planning for reunification or a placement change in advance.

Visitation:

Children involved in the child welfare system often strongly voice a desire for contact with their parent(s), even in cases when the parent was abusive or neglectful. Thus, attorneys representing children or parents should advocate for visitation to begin as soon as possible except when it threatens the physical or psychological safety of the child or the child expressly does not want visitation with a parent.

Visitation should be intentional and well planned. It should be held in a neutral location away from any environment where a child may have experienced trauma. When appropriate, encourage and facilitate positive relationships and communication between birth parents and caregivers about the child's routines, habits, triggers, and coping skills. *(See Appendix Section Seven: "Working with Parents Involved in the Child Welfare System – Visitation.")*

Visits may trigger trauma reactions, so you can prepare your client *(child or parent)* in advance. It may be beneficial to communicate with the client's therapist to understand potential reactions to visits or when considering advocating for a change in visitation. Ask child clients how they feel about visits and try to determine what might trigger them *(sights, sounds, smells, places, voices, etc.)*. You should communicate with the therapist regarding a client's reactions to visits before requesting changes in visitation. You can also encourage parent clients to use visits as an opportunity to practice certain skills and demonstrate their ability to parent safely.

8 Secondary Traumatic Stress and Attorneys

The terms vicarious trauma or secondary traumatic stress *(STS)* describe the negative physical and psychological health consequences resulting from repeated exposure to the stories and experiences of traumatized clients. Attorneys handling child welfare cases are at high risk for developing secondary traumatic stress reactions due to frequent exposure to trauma survivors and their stories of maltreatment. Furthermore, research suggests that a substantial number of attorneys, particularly attorneys practicing specialties such as criminal law and family law, will be threatened with violence at least once in their careers.[27] One study of public defenders found that 34 percent of attorneys reported symptoms of STS while 11 percent met criteria for a diagnosis of PTSD.[28,29]

STS reactions range from decreased empathy towards clients and changes in a sense of personal safety to the onset of PTSD symptoms *(see Section Two)*. STS can lead to impairment in your mental or physical health, job performance, and personal relationships.[30] Those affected by STS may engage in risky or unhealthy behaviors to cope with STS. These behaviors may include increased substance use, experiencing feelings of estrangement from loved ones, or being overly focused on protecting one's own children from danger.

Risk Factors for Secondary Traumatic Stress:

Both individual and job-related or organizational factors may increase your risk for developing STS. Individual factors include a prior history of trauma exposure, such as attorneys who were themselves abused as children, and unhealthy strategies for coping with distress.[29] Job and organizational factors that influence risk for STS include the number of trauma survivors in your caseload, level of coworker and supervisor support, and education and training about STS.[31] In a study on the incidence of STS among attorneys, participants attributed their traumatic stress reactions to a lack of education about understanding clients with trauma histories and the absence of a regular forum for discussing the stress of working with such clients.[32]

Preventing Secondary Traumatic Stress:

There are several strategies that individual attorneys and agencies can adopt to help prevent STS. Training on working with trauma survivors has been shown to increase empathy and confidence in working with this population among mental health providers.[33] Recommended areas of focus for training with attorneys include:[31]

- Understanding the impact of trauma on children and adults
- Acquiring skills for working with trauma survivors
- Recognizing the signs and risks for secondary trauma and
- Practicing stress reduction and management skills such as mindfulness techniques

Formal supervision and peer support groups can also help prevent STS by providing support and a forum for discussing the challenges of working with trauma survivors. Agencies should also offer employee assistance programs or referrals to outside mental health providers for attorneys who develop symptoms of STS.

STRATEGIES FOR SELF-CARE

- Exercise regularly and maintain a consistent sleep schedule
- Eat healthy food and reward yourself with your favorite food occasionally
- Build breaks into your schedule—even if just a few minutes
- Connect daily with others who recharge your emotional state
- Practice mindful activities that can include meditation, yoga, or spiritual practices
- Set and maintain boundaries with clients: clarify that your role as attorney differs from those of social workers, case managers, or other service providers
- Reduce your caseload or diversify your practice, if possible
- Monitor your risk for STS by periodically completing a STS self-assessment tool such as the ProQOL or the Secondary Traumatic Stress Scale (see Appendix Section Eight for links)
- Connect clients with appropriate service providers—use a team approach for clients who have experienced trauma and need a high level of support
- Create a go-to list of local resources for clients
- Access state bar legal assistance programs or confidential support services when available or seek counseling services as needed

SIGNS OF VICARIOUS OR SECONDARY TRAUMATIC STRESS

- Disruption in perceptions of safety, trust, and independence
- Sleeping difficulties or nightmares
- Exhaustion
- Alcohol or drug use to self-medicate
- Anger or cynicism towards “the system”
- Difficulty controlling emotions
- Hyper-sensitivity to danger
- Increased fear and anxiety
- Intrusive thoughts or images of client trauma stories
- Social withdrawal
- Minimizing the impact of trauma
- Illness, increase in sick days at work
- Diminished self-care and depletion of personal resources
- Reduced sense of self-efficacy

POTENTIAL IMPACT OF SECONDARY TRAUMATIC STRESS ON JOB PERFORMANCE

- Reduced empathy towards clients
- Inability to listen to, or active avoidance of, clients
- Over-identification with clients, or conversely, shutting down emotionally *(both responses interfere with effective legal representation)*
- Distancing oneself from exposure to key aspects of a client's history and ongoing trauma, thereby potentially missing events with high probative value in litigation
- Overreaction by displaying hypervigilance through angry outbursts in court, or unduly questioning the credibility of witnesses when emotional legal issues become triggers
- Excessive anger or irritability, as a result of STS, may be masked as zealous advocacy in a trial setting, but may in fact be damaging to the attorney and client.
- Compromised quality of legal service due to emotional depletion or cognitive effects of STS. Some traumatized professionals, believing they can no longer be of service to their clients, end up leaving their jobs or the serving field altogether. Several studies indicate that the development of secondary traumatic stress often predicts that a helping professional will eventually leave the field for another type of work.

9 The Importance of Collaboration

Collaboration and coordination among service providers and systems comprise a key principle of trauma-informed practice.[5] Therefore, it is important for attorneys and other providers working on a case to both collect and share information to support their clients as appropriate within legal and ethical confines. Benefits of information-sharing include:

- Preventing clients from having to repeat their trauma histories to multiple agencies or providers
- Ensuring that all involved parties understand trauma's impact on the client and tailor their services accordingly
- Increased ability to make sense of the client's behaviors or difficulties

The following section lists the roles played by professionals most often involved in child welfare cases, their scope of practice, and recommendations regarding how to work with each.

Children's Attorneys and Guardians ad Litem:

Many children do not immediately disclose traumatic events, like sexual abuse. Such children are frequently misdiagnosed, based on their behavior, with emotional disturbance, oppositional defiance, bipolar disorder, attention deficit hyperactivity disorder *(ADHD)* or other physical or developmental disabilities. Children may not understand why they engage in these behaviors, and may be afraid to tell the truth because it would require disclosure of the trauma. Collaboration with other parties is key to determining whether another assessment might be warranted. Foster parents and other caregivers often have a wealth of information that can be helpful. Has the child experienced known or suspected abuse or other trauma? If the child is engaging in conduct at home, could that conduct be caused by neurological responses to trauma? Unprovoked anger may be a manifestation of the fight response; running out of school or from home, the flight response; and tuning out, the freeze response. Sleep disturbances *(losing sleep at night, and sleeping during the day)*, inability to focus, and depression may all be caused by trauma. Are there situations that trigger these behaviors? Does the child engage in self-harm, or appear depressed? What helps the child calm down? Conducting a thorough and independent investigation by collecting information from others can help you better understand the child's situation.

Sharing information *(as allowed under ethics rules and privacy statutes)* with parent attorneys, the treating therapist, school personnel, and court staff may benefit the child as well.

Parent Attorneys:

Parents may also have information that can help. However, there are important considerations related to confidentiality and other barriers that a parent attorney must consider. When it can benefit the parent and facilitate help for the child, a parent's attorney can encourage the parent to consider sharing this information. Parent attorneys can also ask their clients about how trauma may affect their parenting ability and discuss with their client the benefits and drawbacks of sharing this information.

Child Welfare Agency Case Worker:

Child services workers are required to regularly check on the child. They see children interact with their parents, foster parents, or kinship caregivers, often in the home. Much of the information case workers discover is incorporated into case planning and reports to the court. They often have additional information that may shed light on the child's experiences.[34,35,36]

School Personnel:

Knowledge and incorporation of trauma-informed practices varies widely among different school systems. It is important that providers involved with the child's case, after obtaining the appropriate releases, inform the school about the child's special trauma needs. A child's case file will often contain information about the child's history, experiences, and family background that the school does not need in order to provide services. However, not all schools have comprehensive policies to protect children's privacy. You should ensure that only the information needed to serve the child is provided to the school, and that such information is provided only to individuals who have been trained to ensure and protect the child's confidentiality.

Many children who are experiencing neurological responses to trauma require accommodations in school to access their education. Common accommodations often provided in an Individual Education Plan *(IEP)* or 504 plan, include:

- Permitting the child to leave class early *(to avoid the hustle and bustle of busy pass times in the hall)*
- Permitting the child to leave class at any time to speak to a counselor
- Providing trigger warnings of materials in the curriculum that might trigger the student, and furnishing alternative assignments *(for example, doing an independent study in English when the class is studying a book that will likely trigger the student)*
- Adjusting the child's class schedule so the child can sleep later in the morning

The school may also have information that will help with understanding the child's needs. For this reason, ongoing dialogue with the school is essential.

Court staff:

Children's attorneys should take the lead to make sure that the child's needs are met in court and that court staff are aware of potential concerns. Important questions to consider include: Will the child or caregiver need accommodations in court? Will the client be triggered if the abuser *(i.e., abusive parent or partner)* will be in the courtroom? Do special arrangements need to be made?

Treating therapist:

With regular collaboration, the treating therapist can play a key role in making sure that a client's needs are met at school, at home, and in court. Attorneys and therapists alike must be mindful of their respective ethical duties to their clients. Treating therapists can generally opine about a client's needs and what would be helpful without violating client confidentiality. You should advise the therapist of upcoming court hearings so the therapist can help the client process the information, address potential triggers, and prepare for court. It is also helpful to obtain information from the treating therapist about a client's potential trauma triggers and strategies for preventing, addressing, or mitigating those triggers. Likewise, if a client is at risk for self-harm, you should speak to the therapist and inquire about steps or strategies that have been discussed with the client or put into place to reduce this risk.

10 Systems-Level Advocacy and Resources

The current guide was developed with two goals. The first goal is to increase the knowledge and skills of individual attorneys who work with clients who have survived trauma. The second, broader goal is to create trauma-informed child welfare and family court systems, in which all professionals, consumers, and stakeholders are educated about the impact of trauma and trauma-informed practices and policies. Creating trauma-informed service systems is a time- and resource-intensive effort that will require the involvement of a variety of stakeholders in child welfare and other service systems. In the list below, we have included specific resources that may assist attorneys and other system stakeholders in beginning to implement trauma-informed care in their local child welfare and family court systems. The Appendix to this document also includes additional resources to assist attorneys in both individual and systems-wide advocacy and practice.

Resources for educating other stakeholders on trauma-informed care

American Bar Association Center on Children and the Law's website on *Polyvictimization and Trauma-informed Legal Advocacy* http://www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health/polyvictimization.html

National Child Traumatic Stress Network and National Council of Juvenile & Family Court Judges. (2013). *Bench card for the trauma-informed judge*. Los Angeles, CA and Durham, NC: Authors. http://www.nctsn.org/products/nctsn-bench-card-trauma-informed-judge

National Child Traumatic Stress Network (2005). *Helping children in the child welfare system heal from trauma: A systems integration approach.* http://www.trauma-informed-california.org/wp-content/uploads/2012/02/A_Systems_Integration_Approach.pdf

National Council of Juvenile & Family Court Judges (2014). *Trauma court audit*. http://www.ncjfcj.org/sites/default/files/Trauma%20Audit%20-%20Snapshot.pdf

Aces too High (2014). https://acestoohigh.com/2014/09/24/trauma-informed-judges-take-gentler-approach-administer-problem-solving-justice-to-stop-cycle-of-aces/

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APPENDIX

Section One: Defining Trauma-Informed Legal Advocacy

American Bar Association's Policy on Trauma-Informed Advocacy for Children and Youth (2014) http://www.americanbar.org/content/dam/aba/administrative/child_law/ABA%20Policy%20on%20Trauma-Informed%20Advocacy.authcheckdam.pdf

National Council of Juvenile & Family Court Judges (NCJFCJ) site on Trauma-Informed Systems of Care http://www.ncjfcj.org/our-work/trauma-informed-system-care

Section Two: The Impact of Trauma Exposure on Child Development

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Section Three: The Impact of Trauma Exposure on Parents

NCTSN Fact Sheet: *Birth Parents with Trauma Histories and the Child Welfare System*
This factsheet series from the Birth Parent Subcommittee of the Child Welfare Committee highlights the importance of understanding the serious consequences that trauma histories can have for birth parents and the subsequent potential impact on their parenting.

- For Parents (2012)
- For Child Welfare Staff (2011)
- For Judges and Attorneys (2011)
- For Mental Health Professionals (2012)
- For Resource Parents (2011)
- For Court-Based Child Advocates and Guardians ad Litem (2013)

Section Four: The Impact of Trauma on the Attorney-Client Relationship

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Section Five: Screening and Assessment

Vandervort, F. E. (2015). Using screening and assessment evidence of trauma in child welfare cases. *Child Law Practice, 34.* Available from http://www.americanbar.org/publications/child_law_practice/vol-34/may-2015/using-screening-and-assessment-evidence-of-trauma-in-child-welfa.html

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Section Six: Effective Treatments for Traumatic Stress

Finding Effective Trauma-Informed Treatment for Children, Teens, & Families
http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
The National Child Traumatic Stress Network's website includes a comprehensive list of the most effective and widely used trauma-informed treatments for children, adolescents, and families. This site includes a description of the core components of trauma-informed treatments and a list of trauma-informed interventions for children, adolescents, and families, with fact sheets summarizing the key components of each treatment and the research evidence that shows its effectiveness.

Finding a Trauma-Informed Therapist or Expert in Your Area
http://www.nctsn.org/about-us/network-members
The National Child Traumatic Stress Network is comprised of more than 100 federally-funded and affiliated academic and treatment centers around the US that provide trauma-informed mental health services and training/consultation on child traumatic stress. To find a trauma expert in your area, search the NCTSN's list of network members by state

http://www.istss.org/find-a-clinician.aspx
The International Society for Traumatic Stress Studies offers a searchable online database of mental health professionals that offer trauma-informed treatment across the globe.

http://www.nctsn.org/resources/get-help-now
The NCTSN's *Get Help Now* site offers information on finding help for children who have experienced abuse or neglect.

NCTSN Fact Sheet: *List of Questions to Ask Mental Health Professionals*

1. Does the individual/agency that provides therapy conduct a comprehensive trauma assessment?
   If so: What specific standardized measures are given? What did your assessment show? What were some of the major strengths and/or areas of concern?
2. Is the clinician/agency familiar with evidenced-based treatment models?
3. Have clinicians had specific training in an evidenced-based model *(when, where, by whom, how much)*?
4. Does the individual/agency provide ongoing clinical supervision and consultation to its staff, including how model fidelity is monitored?
5. Which approach(es) does the clinician/agency use with children and families?
6. How are parent support, conjoint therapy, parent training, and/or psychoeducation offered?
7. Which techniques are used for assisting with the following: Building a strong therapeutic relationship; affect expression and regulation skills; anxiety management; relaxation skills; cognitive processing/reframing; construction of a coherent trauma narrative; strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience; personal safety/empowerment activities; resiliency and closure
8. How are cultural competency and special needs issues addressed?
9. Is the clinician or agency willing to participate in the multidisciplinary team *(MDT)* meetings and in the court process, as appropriate?

Section Seven: Placement Decisions, Transitions, and Visitation

ReMoved – video about the experience of children in foster care system http://vimeo.com/73172036

NCTSN Presentation: *Working with Parents Involved in the Child Welfare System - Visitation*
http://www.nctsn.org/nctsn_assets/anc16_new/visitation/presentation_html5.html

ACS-NYU Children's Trauma Institute. (2012). *Easing foster care placement: A practice brief.*
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Smariga, M. (2007). Visitation with infants and toddlers in foster care: What judges and attorneys need to know. Washington, DC: American Bar Association. Available from http://www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health/infants-and-young-children.html

Section Eight: Secondary Traumatic Stress and Attorneys

Rainville, C. Understanding Secondary Trauma: A Guide for Lawyers Working with Child Victims, ABA Child Law Practice, Volume 34, Number 9 (September 2015). Available from http://www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health/polyvictimization/understanding-secondary-trauma--a-guide-for-lawyers-working-with.html

Institute for Redress & Recovery, Santa Clara Law. (n.d.) *Secondary trauma and the legal process: A primer & literature review*. Santa Clara, CA: Author. Available from http://law.scu.edu/redress#5

van Dernoot Lipsky, L., & Burk, C. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others*. San Francisco, CA: Berrett-Koehler Publishers. http://traumastewardship.com/inside-the-book/

The Professional Quality of Life Scale (ProQOL) is a 30 question assessment of secondary traumatic stress, burnout, and compassion satisfaction that is intended for use by a wide range of helping professionals. To download a free copy of the ProQOL, including instructions on how to complete and score the questionnaire, visit http://www.proqol.org/ProQol_Test.html. Mental health counseling or other supports can be helpful for addressing high scores on the secondary trauma or burnout scales of the ProQOL. Refer to Section 6 of this Appendix for additional information on locating a trauma-informed therapist in your area.

Section Nine: The Importance of Collaboration

Stewart, M. (2013). Cross-system collaboration. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress. http://www.nctsn.org/sites/default/files/assets/pdfs/jj_trauma_brief_crosssystem_stewart_final.pdf

The Juvenile Law Center and Robert F. Kennedy National Resource Center for Juvenile Justice have developed the *Models for Change Information Sharing Toolkit*. Available from www.infosharetoolkit.org/

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