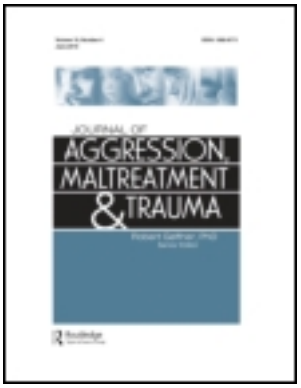

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Unrecognized Posttraumatic Stress Disorder as a Treatment Barrier for a Gang-Involved Juvenile Offender

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CASE STUDY

Unrecognized Posttraumatic Stress Disorder as a Treatment Barrier for a Gang-Involved Juvenile Offender

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This study examines the case of GH, an 18-year-old Latino male participating in an employment-based delinquency intervention for gang-affiliated youth. Although postintervention measures revealed that GH showed gains on key outcomes (i.e., delinquency, employment), he experienced sporadic treatment setbacks (e.g., work absenteeism, fighting) that disrupted his progress. A comprehensive psychological assessment suggested that his aggressive, illegal behavior and difficulty maintaining employment could have been influenced by previously undiagnosed posttraumatic stress disorder (PTSD). Excerpts from counseling sessions illustrated how reactive aggression, hypervigilance, sleep disruptions, and emotional numbing could have interfered with treatment gains and ultimately contributed to GH's re-arrest. Implications for early,

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accurate identification of PTSD in delinquency interventions for gang youth are discussed.

KEYWORDS abuse, assessment, delinquency, PTSD, violence exposure

The association between juvenile delinquency and trauma-related symptoms is well established (Bertram & Dartt, 2009; Snyder & Sickmund, 1999; Wood, Foy, Layne, Pynoos, & James, 2002), with approximately 12% of incarcerated youth meeting criteria for posttraumatic stress disorder (PTSD; Abram, Teplin, McClelland, & Dulcan, 2003). Adjudicated delinquent youth can experience numerous traumas before incarceration and sometimes even within correctional settings (Wolf & Shi, 2010). Unfortunately, clinicians often misinterpret trauma-related symptoms in juvenile offenders as indicators of conduct disorder (CD; Bertram & Dartt, 2009; Ovaert, Cashel, & Sewell, 2003), which limits the breadth and scope of treatment. Thus, despite the high prevalence of trauma-related symptoms in delinquent populations and the link between PTSD symptoms and violence perpetration, many delinquency interventions do not expressly focus on treating underlying PTSD symptoms (Ovaert et al., 2003). The following case study illustrates how an unrecognized case of PTSD, marked by hypervigilance, erroneous threat detection, emotional outbursts, and reactive aggression, might have interfered with the treatment gains of an adolescent male participating in an employment-based delinquency intervention.

IDENTIFYING INFORMATION AND TREATMENT SYNOPSIS

GH is an 18-year-old, gang-involved, bilingual, Latino, male high school graduate who participated in a pilot trial of the Behavioral Employment Program (BEP; Walter & Mills, 1980), an employment-based intervention for youth offenders (Huey, McDaniel, & Smith, 2012). Prior to beginning BEP, GH evidenced an extensive history of maladaptive behaviors, including aggression, delinquent behavior and illegal drug use beginning in the fifth grade, participation in court-mandated anger management treatment at age 14, school failure in the ninth and tenth grades, and joining a gang at age 16. Notwithstanding his eight prior juvenile arrests for offenses including vandalism, armed robbery, and weapons possession and his substantial history of gang involvement, GH was enthusiastic about participating in BEP and quickly engaged in treatment. He expressed commitment to the program, attended 36 sessions (slightly higher than the average of 30 sessions across other participants), and immediately found a job working for his father in the family business. In addition, he involved his parents

TABLE 1 GH's Treatment-Interfering Behaviors over the Course of the Behavioral Employment Program

Incident type	Number of incidents
Fights	4
Arrests	1
Quitting work	2
Missing work or almost missing work	3
Drinking alcohol	31
Using marijuana	18

and girlfriend in sessions when counselors thought it would be helpful. Although GH attended sessions regularly and completed most counselor-assigned homework, sporadic setbacks interfered with his progress in BEP. Specifically, GH periodically exhibited aggressive and impulsive behaviors, including fighting, missing work, and driving while intoxicated (see Table 1) that interfered with his treatment goals of maintaining regular employment and reducing risk for re-arrest.

BEP clients met with counselors in their homes and other community settings to learn job skills, problem-solving strategies, and behavioral regulation skills necessary to meet program goals. Progress was measured by assessing weekly and quarterly changes in self-reported delinquency (Elliott, Huizinga, & Morse, 1986) and hours employed during the previous week (Staff & Uggen, 2003). Although limitations of self-reported delinquency include impression management and memory biases, self-report measures have several advantages of high relevance to assessing BEP treatment outcomes, including greater sensitivity to less serious delinquent behavior and moderate correlation to official arrest records (Krohn, Thornberry, Gibson, & Baldwin, 2010). GH missed two quarterly assessments (the 6-month assessment, while incarcerated, and the 12-month assessment, when he stated he was too busy working), but he did complete an additional assessment one year after treatment ended (24 months postenrollment).

A review of GH's quarterly progress (Figures 1 and 2) showed linear trends suggesting clinically meaningful changes in employment and delinquency over time. However, weekly measures indicated a less favorable, nonlinear pattern, characterized by extreme fluctuations in employment and delinquent behavior (Figures 3 and 4). Additionally, a number of treatment setbacks occurred during the course of the intervention, suggesting significant functional impairment (see Table 1). Among these, a felony arrest, aggressive behavior, and repeated job-quitting were most concerning.

GH's setbacks perplexed him and his counselors. GH often asked his counselors for help, explaining that he did not understand his own behavior and thought something was wrong with him. Although he willingly engaged in functional analyses of treatment-interfering behaviors, GH and his counselors were unable to identify clear antecedent triggers

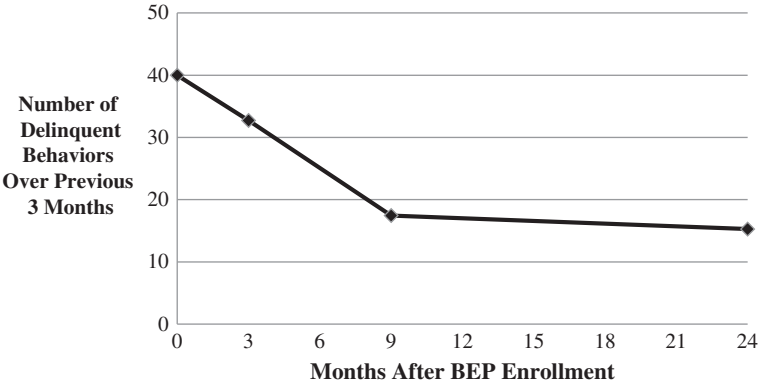

FIGURE 1 Delinquency reduction over 24 months.

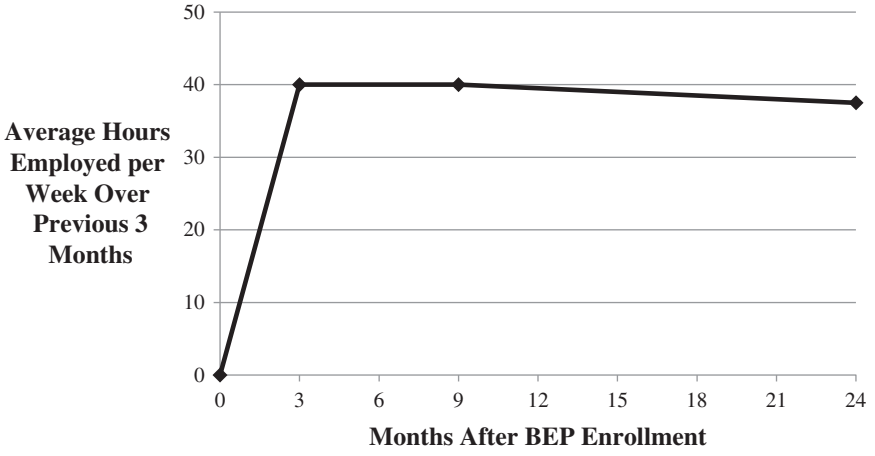

FIGURE 2 Maintained employment over 24 months.

for his aggressive and impulsive behaviors. Given that GH effectively used problem-solving and refusal skills throughout treatment, counselors concluded that GH's sporadic setbacks could not be easily explained in terms of skills deficits. Counselors began to suspect GH might meet criteria for a psychiatric disorder.

At the beginning of BEP, GH was given the Mini-International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al., 1998), a brief screening instrument, to assist with treatment planning. Results from GH's M.I.N.I. screen indicated a likely diagnosis of social anxiety disorder, but no other psychiatric disorders. These M.I.N.I. results did not sufficiently explain GH's difficulties in BEP. Given the team's difficulty understanding his treatment-interfering behaviors, GH was ultimately referred for a comprehensive psychological assessment, which suggested that PTSD might have played a role in GH's maladaptive behavior.

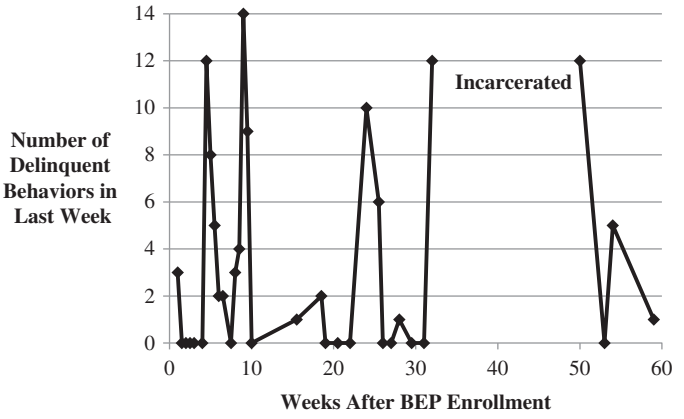

FIGURE 3 Weekly assessment of delinquency interrupted by incarceration. "Incarcerated" labels indicate periods of missing data when GH was incarcerated.

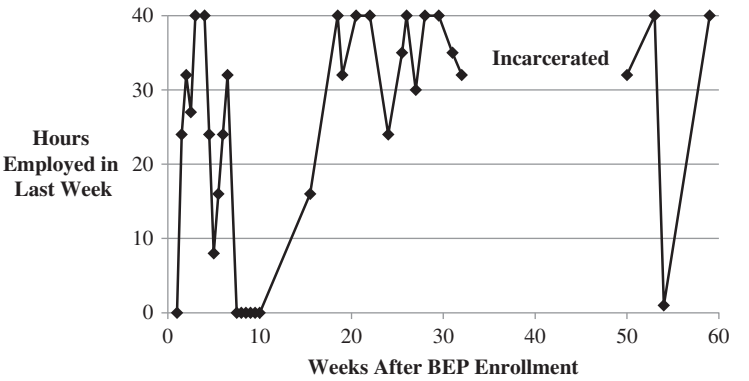

FIGURE 4 Weekly assessment of employment interrupted by incarceration. "Incarcerated" labels indicate periods of missing data when GH was incarcerated.

COMPREHENSIVE PSYCHOLOGICAL ASSESSMENT

GH was assessed in a university-based mental health clinic located in a large urban area. The comprehensive psychological assessment took place during the 11th month of counseling, which was one month prior to the planned termination date. Through careful administration of a variety of standardized instruments and clinical interviews, including the Anxiety Disorders Interview Schedule (ADIS–IV; Brown, DiNardo, & Barlow, 2004), the assessors found GH to be a motivated and cooperative young man with average cognitive ability and academic achievement (measured with the Wechsler Adult Intelligence Scale–III [Wechsler, 1997] and Wide Range Achievement Test–3 [Wilkinson, 1993]), and two psychiatric diagnoses, PTSD (chronic type) with secondary alcohol abuse, and CD (adolescent-onset type, severe). Although

GH's therapist suspected he might have attention-deficit/hyperactivity disorder (ADHD), careful interviews with GH, his mother, and his girlfriend did not indicate symptoms of inattention or hyperactivity at home, at school, or at work, and GH did not display any difficulties concentrating during the assessment tasks. Therefore, a diagnosis of ADHD was ruled out.

GH appeared to establish good rapport with the assessor. During the initial assessment, GH stated that he would only be able to stay "a couple of hours" because he needed to get back to work, despite the fact that he had originally agreed to stay for the 4 to 6 hours necessary for the scheduled tests. However, as testing progressed and GH became more comfortable, he decided to call into work to ask for the day off to complete the testing. During the intake portion of the assessment, he was talkative and provided elaborate, honest answers to all the questions he was asked, including those concerning illegal activities. Furthermore, he was compliant with all instructions and requests and displayed good effort and a high frustration tolerance on tedious and difficult tasks, particularly when given verbal encouragement. GH was also patient and helpful during the assessment; on at least two occasions, he picked up objects (a pencil and an administration manual) that had been accidentally knocked over by the examiner.

Conduct Disorder, Not Antisocial Personality Disorder or Traits

In assessing for CD, GH's juvenile court records, and his self-reported history of fighting, school truancy, school failure, and criminal behavior were considered. School records were not reviewed due to lack of availability. This information, in combination with his valid responses (Negative Impressions scale $T = 55$; Positive Impressions scale $T = 52$) and markedly elevated score on the Antisocial Behaviors scale (ANT scale; $T = 94$) of the Personality Assessment Inventory (PAI; Morey, 1991), supported the diagnosis of CD. Because a CD diagnosis in childhood makes an adult diagnosis of antisocial personality disorder (ASPD) much more likely (Lahey, Loeber, Burke, & Applegate, 2005), it was important to consider whether GH had transitioned from CD to ASPD given his gender, age, and pattern of conduct-disordered behavior before age 15 (American Psychiatric Association [APA], 2000). This assessment was pursued with caution given that ASPD diagnoses can sometimes be misapplied to individuals like GH, who are of low socioeconomic status and reside in urban areas where antisocial behaviors might represent a survival strategy (APA, 2000). Although 18-year-olds can meet *Diagnostic and Statistical Manual for Mental Disorders* (4th ed., text rev.; DSM-IV-TR) criteria for ASPD (APA, 2000) and many researchers investigate ASPD in young adults (e.g., Copeland, Shanahan, Costello, & Angold, 2009; Reinke, Eddy, Dishion, & Reid, 2012), making a personality disorder diagnosis so early in adulthood should be carefully considered. Hence, assessors focused on differentiating between antisocial personality traits and conduct-disordered behaviors.

The PAI ANT subscales, which measure various elements of antisocial behavior, including stimulation seeking, disregard for human welfare, lack of empathy, and criminal behavior, showed that GH's sensation-seeking tendencies (ANT-S, $T = 94$) contributed more to his overall ANT scale elevation than antisocial behavior (ANT-A, $T = 87$) or lack of empathy (ANT-E, $T = 75$). Although all of these scores are elevated within the clinically significant range and clearly indicate disturbances of conduct, this particular pattern of elevation is not consistent with typical patterns of elevation for individuals diagnosed with ASPD (Morey, 1991).

Moreover, GH described feeling empathy for others and some shame regarding his antisocial actions in his intake interview, which contradicts an ASPD diagnosis. For example, GH described feelings of guilt resulting from hurting or robbing "innocent people who didn't deserve it." During the interview, GH took responsibility for his delinquent behaviors, explaining that he recognized his actions were wrong, went against his goals, and upset his loved ones.

Posttraumatic Stress Disorder

GH's childhood was marked by child abuse and exposure to intimate partner and family violence. For example, he recalled many instances of watching his father verbally and physically abuse his mother. Regarding his own abuse history, GH recounted that his father would frequently beat him and his brother. In addition, GH recalled being locked in the family bathroom with his mother and brother while his enraged father stood outside, yelling, banging on the door, and threatening to kill them. He reported being afraid for the lives of his family members and himself.

As an adolescent, GH was also exposed to and perpetrated violence outside the home. When GH was about 13 years old, several family members joined the gang with which he ultimately became affiliated. GH then began to engage in dangerous, illegal behaviors with his relatives and reported being arrested and charged with assault at age 14. GH officially became a member of the gang at age 16 and reported that much of his gang activity was life threatening and included perpetrating, experiencing, or witnessing violence involving the use of firearms and other weapons. GH was incarcerated in juvenile probation camps various times throughout high school, where he reported being exposed to further violence from both inmates and staff. Medically, GH reported a history of multiple mild, closed head traumas as a result of falling down a flight of stairs while running away from "trouble" and getting hit during several fistfights. Once, during a fight, he slipped and reportedly sustained a concussion. Later, one of his teeth was "dislocated" while fighting and he had to undergo dental procedures to return it to its original position.

GH described fearing for his life many times when exposed to abuse or community violence or when perpetrating violence himself. While it might be more apparent why GH perceived a risk for death when he was abused as a child or when he was victimized by others as an adolescent, he also feared death from rival gang members or police officers on numerous occasions when he committed violent crimes. This prolonged history of violence exposure and perpetration appears to have preceded the development of PTSD. An incident when GH hid with his mother when both were afraid his father would injure or kill her was identified as the most important index trauma for GH's PTSD.

During the administration of the PTSD section of the ADIS–IV, GH readily and vividly recounted symptoms of hyperarousal, hypervigilance, extreme aggressive reactivity, flashbacks, nightmares, foreshortened sense of the future, emotional numbing, and secondary substance use. Notably, GH described these symptoms as he recounted details of events that occurred in the context of his violence exposure and perpetration, suggesting that he had some insight into the relationship between his exposure to violence and his emotions. At one point during his assessment, GH experienced and vividly described a flashback, which resulted in tearfulness and depersonalization.

GH described occasionally using substances, in particular alcohol and marijuana, to help him cope with his trauma symptoms He denied experiencing the tolerance or withdrawal symptoms necessary to diagnose a substance dependence disorder. His alcohol use, however, did meet criteria for a substance abuse disorder because of his inability to fulfill responsibilities at work after binge drinking and his decision to drive under the influence at least once (APA, 2000).

POSSIBLE PTSD-RELATED BARRIERS TO TREATMENT PROGRESS

Session transcripts were reviewed by the first two authors to retrospectively investigate the ways in which GH's PTSD symptoms might have contributed to treatment setbacks (missing work days, impulsively quitting his job, fighting). This process revealed that sleep disruption due to nightmares and flashbacks seems to have contributed to GH missing work or arriving late to work on several occasions. Likewise, his experiences of hypervigilance and hyperarousal preceded aggressive behavior at the job site and elsewhere, and episodes of emotional numbing often preceded illegal substance use. Verbatim excerpts from session transcripts illustrated the associations between these symptoms and setbacks. Retrospective examination of these transcripts highlights how counselors had several opportunities to actively address PTSD symptoms during treatment; however, because the counselors did not learn of his diagnosis until the final month of treatment, they were not able to address trauma symptomatology in BEP.

Erroneous Threat Detection and Reactive Aggression

GH described several instances of reactive aggressive behavior that were preceded by PTSD-related hypervigilance and hyperarousal. His hypervigilance might have triggered him to detect threats in safe settings (e.g., coffee shop, courtroom, job site), and his hyperarousal might have led him to respond to perceived threats impulsively and aggressively without reappraising the situation or considering the consequences of his actions. For example, during one session, GH recounted noticing a group of young men standing outside of a neighborhood coffee shop and assumed they were members of a rival gang. GH thought that these men were threats to his safety and his neighborhood, and he impulsively reacted by chasing them down the street, yelling at them, and threatening them with a baseball bat. After interrogating them, GH discovered they were "just some payasos [clowns]. Some guys who like, who can't talk English . . . but, they don't bang [engage in gang activity]." He erroneously perceived these young men as rival gang members and responded aggressively but eventually realized they were not threats at all. In another instance, GH was being arraigned in front of a judge and noticed another defendant in the courtroom "looking at him funny." GH stated he experienced this individual's glances as threatening and started a fight in the courtroom, which led GH to being temporarily incarcerated. These incidents exemplify GH's persistent pattern of behavior of mistakenly detecting threats across a wide range of situations, which might have contributed to fighting and other maladaptive behaviors counter to his treatment goals.

Sleep Impairment

Sleep impairment, often related to nightmares, flashbacks, and hyperarousal, is one of the most impairing symptoms of PTSD (Lamarche & De Koninck, 2007). Lack of sleep can contribute to the severity of PTSD by exacerbating concentration difficulties and increasing irritability (Mellman & Hipolito, 2006). Throughout the intervention, GH described nightmares and flashbacks of traumatic events that seemed to interfere with his sleep and compromise his ability to arrive at work on time or attend work at all. In the following session transcript, GH described a nightmare that kept him "frozen" or awake all night. He missed work the next day.

> GH: Hell yeah, I got, like, frozen. You know how you get so scared like that and you can't move, and can't change? That's what happened to me, and yeah. . . . That's what always happens, and I swear that always happens to me. People tell me it's 'cause I have a conscience and it ain't clean, 'cause the things I've done. A lot of the kids that were in Juvenile Hall, they were

like that. So I guess it's 'cause of the things we used to do, and, like, yeah. But it always used to happen to me ever since I was fourteen. Ever since I started kicking it with my neighborhood, I started having those dreams.

[GH describes calling in sick to work due to lack of sleep]

Counselor: So what did actually happen? [Did your supervisor] get upset or mad?

GH: No. I called 'cause I was like up all night, the whole night. It was like 5 in the morning and I was like, I should call him and let him know I'm not gonna go work because I'm, like, feeling bad. So I call him up and he said "Oh yeah, just take the day off." 'Cause I told him my head was hurting. My head was hurting, but you know, it was 'cause of that.

In addition, flashbacks periodically disrupted GH's sleep. In the following excerpt, GH described one of his flashbacks, which kept him awake all night and caused him to miss work the next morning. In this excerpt, GH began by telling his counselor that he had "done something wrong" and then transitioned into describing the flashback he had of the event. Details of GH's violent act are obscured to maintain confidentiality:

GH: Yeah. Like, there was this case that happened to me. I don't know if I want to relive it, like . . . I guess, like me, me and my homie, we kinda did something. We did something. We like . . .

Counselor: You did something you didn't want to do.

GH: Yeah, I did something I didn't wanna do. . . . I don't know, like I can't believe I did it. It was my first time I ever did something like that.

Counselor: First time you ever hurt somebody.

[Silence]

[GH describes the details of the flashback to his counselor]

GH: But I even stayed [up], 6:30 in the morning. I still tripped out. I was feeling a lot of guilt. And I don't know, I started seeing these shadows kind of squirming all over my feet. The way it was, I was just trippin' out. . . . Yeah. I was like "No, I'm trippin' out" you know, like I look to the side and I see it again and I was like getting up and I'm just saying, trippin' the fuck out. If I just start praying, and then you know, I mean, if I close my eyes, I see it too [in reference to the violent act], so I didn't really think I was crazy. I just wanted it to stop.

Counselor: Are these dreams like flashbacks of something you've done?

GH: Things like, it's just being put in a situation where . . . like in the dream, I just . . . [GH describes violent act].

Emotional Numbing and Substance Abuse

Trauma-related emotional numbing increases the risk of alcohol abuse and substance use disorders (Jakupcak et al., 2010; Macdonald, Danielson, Resnick, Saunders, & Kilpatrick, 2010). In line with this research, GH described feeling emotionally numb at times, which occasionally preceded substance use. For example, GH's use of alcohol to cope with emotional numbing might partially explain his felony arrest midway through treatment. GH stated that on the day he was arrested, he found himself thinking about people he knew who were incarcerated for violent crimes and felt like he needed to "do something" to feel alive again to alleviate his feelings of emptiness. The following excerpt illustrates how GH described his affect the day he decided to drink heavily.

GH: I don't know. I don't know what got into me. I don't know what got into me that day.
Counselor: Okay. So you weren't really thinking about those things.
GH: Nah. I don't know. I was kind of mad that day. Not mad you know, but something felt weird.
Counselor: Okay. So it sounds like something emotional . . .
GH: Yeah.
Counselor: Like there was something . . . kind of you were angry or mad . . .
GH: Yeah, I felt empty.

He began drinking alcohol and then contacted some gang-affiliated friends, who he had previously agreed to avoid. Interaction with these friends seemed to have led GH to engage in several risky behaviors including drinking 40 ounces of beer and 5 ounces of tequila in 90 minutes, which led to public intoxication and reckless driving. These behaviors resulted in a car accident and damage to public property. GH was arrested at the accident scene for driving while intoxicated. Although this risky alcohol use might also be understood as sensation-seeking related to GH's history of CD, the context he described suggests that ruminating on violence and incarceration preceded emotional numbing, which triggered the drinking.

Summary

Overall, GH showed increased employment and decreased delinquency over the course of treatment. However, he continued to sporadically fight, abuse alcohol, smoke marijuana, and miss or arrive late for work, which contributed to his unstable employment and trouble with the law. He felt confused by his own behavior, and his counselors found it difficult to understand these treatment setbacks. A comprehensive psychological evaluation

revealed that GH met criteria for CD and PTSD, but not ASPD. GH's undiagnosed PTSD appears to have contributed to his reactive aggression, sleep difficulties, and substance use, and ultimately hurt his ability to fully achieve his treatment goals of maintaining employment and reducing risk for re-arrest.

DISCUSSION

GH's case is complex. Other factors should not be discounted as important influences on his behavior, but it appears that PTSD might have played a role in GH's treatment setbacks while enrolled in BEP. Session transcripts and assessment data revealed how GH's sleep disturbance, flashbacks, reactive aggression, and emotional numbing might have contributed to his failure to make consistent treatment gains in terms of maintaining regular employment and reducing risk for re-arrest. Although this case study has constraints, including limited generalizability and reliance on self-report data, GH's experience raises possible implications for the comprehensive assessment and treatment of PTSD within the context of employment-based delinquency interventions.

Selecting Appropriate Assessment Instruments

This case study highlights the potential weaknesses of brief psychiatric screens in clinical settings with delinquent youth. Although the M.I.N.I. has advantages such as brevity, established reliability, and high correspondence with lengthier diagnostic interviews (Sheehan et al., 1998), in GH's case, this screener did not provide clinicians with sufficient information to identify PTSD. The M.I.N.I. has been described as "fully structured," which might be helpful for nonclinicians in research contexts (Black, Arndt, Hale, & Rogerson, 2004, p. 159), but the high degree of structure and limits to probing inherent within the electronic version of this instrument could have limited BEP counselors' exploration of GH's symptoms to language used in the DSM-IV-TR (APA, 2000).

Inspection of GH's first two responses on the PTSD screening portion of the M.I.N.I. revealed that he endorsed the first item ("Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else?"), but not the second ("Did you respond with intense fear, helplessness, or horror?"). Both items must be endorsed to proceed with the symptom portion of the screen. The discrepancy between the M.I.N.I.'s closed-ended questions and GH's own distress language might explain the diagnostic discrepancy between the M.I.N.I. and the ADIS–IV. The M.I.N.I. items use language that suggests vulnerability and helplessness to describe distress and fear, which was not consistent with GH's self-image as a "tough"

gang member (Vigil, 1988), nor with his tendency to stifle emotional expression during treatment. Alternatively, the ADIS–IV allowed GH to use his own language to describe his PTSD symptoms. For example, during ADIS–IV administration, GH stated that being shot at "freaked me the fuck out!" Although GH's response clearly reflected fear, it did not resemble the "fear," "helplessness," and "horror" wording of the M.I.N.I. items, which connotes both formality and weakness. The ADIS–IV, on the other hand, did not limit GH's emotional language to specific terms but rather allowed him to respond to open-ended questions, such as, "What was your emotional response while the event was occurring?" in his own words. The M.I.N.I. is a brief screener that can provide valuable information, but its usefulness in this intervention might have been limited. Embarking on a 12-month behavioral intervention based on a psychopathology screener rather than a comprehensive evaluation left clinicians without vital diagnostic information that was critical to treatment planning. The semistructured interview format of the ADIS–IV proved more useful than a screening tool for BEP counselors attempting to understand GH's psychological functioning. Best practices in treatment planning include comprehensive diagnostic assessment earlier in treatment (Anthony & Barlow, 2010). In GH's case, use of a semistructured interview such as the ADIS–IV likely would have been most effective if administered at the beginning of treatment in place of the M.I.N.I.

Regarding identification and treatment of PTSD within the context of delinquency-focused interventions, GH's case illustrates several areas in need of further investigation. First, effective pretreatment assessment of psychiatric disorders could be important and might require the use of more comprehensive, semistructured assessment tools as opposed to highly structured screening instruments. The inconsistency between GH's M.I.N.I. and ADIS–IV responses draws attention to the variety of ways in which people describe distress. Comprehensive semistructured interviews might be more helpful than screening measures for assessing trauma response in delinquent, urban youth populations, as these measures provide opportunities for youth to describe symptoms in colloquial, "street" vernacular, rather than simply endorse or deny scripted statements, which might not be consistent with the way they conceptualize their traumatic experiences. Furthermore, individuals who belong to ethnic minority groups or who are bilingual could be assessed more accurately with semistructured interviews, because they might be better able to communicate their symptoms using their own words. Likewise, given findings that some youth are more likely to display externalizing symptoms of PTSD (Marsee, 2008; Shields & Cicchetti, 1998), using semistructured instruments could facilitate differential or comorbid diagnosis between PTSD and CD symptoms, as being able to ask detailed, follow-up questions allows the clinician to determine the etiology of behaviors shared between CD and PTSD such as reactive aggression and impulsivity. Alternatively, screeners

like the M.I.N.I. might be more helpful if all diagnostic criteria are explored regardless of whether participants endorse the introductory items.

Treatment Adequacy

One lesson learned stems from the contrast between GH's sudden incarceration and his overall delinquency reduction and employment progress. Teaching problem-solving, behavior regulation, and job procurement skills in BEP appeared to help GH succeed at work and avoid illegal activity for significant periods of time. However, these strategies were not sufficient to prevent re-arrest. Although several factors put GH at risk for recidivism (including demographic, socioeconomic, peer, and family factors, as well as his criminal history [Cottle, Lee, & Heilbrun, 2001]), the untreated, chronic PTSD might also explain his fighting and substance use. Unfortunately, because GH was diagnosed with PTSD after he drove while intoxicated, we cannot know if treatment for PTSD would have prevented his arrest; however, future research could address this question by comparing interventions that assess and address PTSD with those that do not do so for delinquent youth.

GH did receive intervention for PTSD while participating in BEP; however, this did not occur until the 11th month of a 12-month program. Until counselors received GH's PTSD diagnosis, his treatment-interfering behaviors were addressed with a skills-based intervention targeted directly at strengthening positive behaviors and reducing his problem behaviors. Retrospectively, it is not surprising that GH did not fully respond to this type of intervention given the trauma context for GH's reactive aggression and impulsivity. If PTSD had been diagnosed during the first months of GH's participation in BEP rather than the 11th month, counselors might have addressed these symptoms by teaching GH coping skills or engaging in prolonged exposure geared toward addressing his traumatic experiences. Although no definitive conclusions can be drawn from GH's case about PTSD and treatment response, his experience provides an example of how trauma exposure and PTSD symptoms might interfere with success in a delinquency intervention. The growing evidence that the juvenile justice population is at high risk for PTSD (Bertram & Dartt, 2009; Ovaert et al., 2003; Wood et al., 2002) suggests that future delinquency programs might benefit from specifically addressing PTSD.

Conclusion

In closing, GH's case illustrates the possible need to consider underlying trauma-related symptoms to enhance outcomes for youth participating in programs like BEP. GH's undiagnosed PTSD might have contributed to his sporadic treatment setbacks, suggesting that treating his underlying PTSD might have helped him avoid re-arrest and maintain consistent employment. As such, PTSD, and perhaps other psychiatric disorders common to this

population, represents a key area to consider for future researchers designing efficacious interventions for juvenile offenders.

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