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Childhood trauma and risk for suicidal distress in justice-involved children

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ABSTRACT

Justice-involved children (JIC) have higher rates of trauma exposure and suicidality than the general population. The Childhood Trauma Model predicts that children can accumulate multiple traumatic experiences that can be more harmful than a single traumatic event. The purpose of this study is to investigate the individual and cumulative effects of childhood trauma on suicidal distress among JIC. The study employs logistic regression to analyze panel data on 2367 12–16 year-olds from the Florida Department of Juvenile Justice (FLDJJ). The study shows that 9 types of individual traumatic experiences increased risk for suicidal ideation from 22 to 180%. For one unit increase in the trauma score, the risk for suicidal distress increased 25%, so that JIC who experienced 5 types of traumas were 2.4 times more likely to experience suicidal distress as JIC who experienced a single trauma. These findings illustrate the need to invest mental health services and suicide prevention resources in populations in the juvenile justice system. Intervention must be tailored to serve children who suffered specific traumatic events, as well as those who experience multiple types of trauma. Further, policies that manage JIC as kid criminals rather than as traumatized children may exacerbate their suicidality and problematic behavior.

Suicidal ideation, attempts, and fatality are tragic public health concerns that cost an estimated $51 billion in combined medical and work loss costs (Berman, Jobes, & Silverman, 2006). Suicide is the second-leading cause of death for adolescents and young adults, ages 12 to 24, according to the U.S. Center for Disease Control and Prevention (CDC, 2013). More teenagers and young adults die from suicide than the 4th through 10th leading causes of death combined. This is a critical issue for all adolescents, and is especially an issue for children in the juvenile justice system, also called justice-involved children (JIC).

Suicidal distress refers to a cluster of experiences including suicidal ideation, suicidal attempts, or non-suicidal self-injury. JIC have exceptionally high rates of contemplating, attempting, and committing suicide (Penn, Esposito, Schaeffer, Fritz, & Spirito, 2003; Scott, Underwood, & Lamis, 2015). According to a review by the National Action Alliance for Suicide Prevention (Alliance, 2013), up to one-third of JIC reported suicidal distress in the past year and nearly 40% attempted suicide at some point in their life. Some studies found that suicidal thoughts and behavior in this population are two to four times higher (Gallagher & Dobrin, 2006) and more violent than the general population (Penn et al., 2003), and risk increases with longer involvement in the justice system (Stokes, McCoy, Abram, Byck, & Teplin, 2015). In a national report, Hockenberry, Sickmund, and Sladky (2015) found that more than a third of the deaths among juveniles in confinement were due to suicide.

The Childhood Trauma Model (Johnson, 2017) argues that early trauma exposure predicts suicidality and other symptoms of distress. Childhood trauma is a well-documented precursor of suicidal ideation and behavior (Dube et al., 2001; Miller, Esposito-Smythers, Weismoore, & Renshaw, 2013; Stokes et al., 2015), and the children in the criminal justice system represent some of the most traumatized children in America (Abram et al., 2013; Baglivio et al., 2014; King et al., 2011; Slate & Johnson, 2008; Stokes et al., 2015).

Their social positions create circumstances that disproportionately expose them to both deeply disturbing experiences throughout their childhood and negative police contact. Many of the significant risks and resources that can attenuate or exacerbate negative manifestations of their distress are socially allocated in ways that reduce their access to resources and increases their exposure to risks. For example, trauma effects are often worse for minorities, women and younger children (Alliance, 2013). Though childhood trauma is often the defining characteristic of JIC, they are commonly stigmatized as criminals and re-traumatized by the criminal justice system (Alexander, 2010; Gallagher & Dobrin, 2006). In this unfortunate social scenario, children in distress may be on a pathway to prison and/or early death.

1. Childhood trauma and suicidal distress

The Childhood Trauma Model (CTM) emphasizes children and their

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upbringings in understanding health and health-related disparities (Johnson, 2017). It has two main components: trauma and distress. It submits that individuals who are on the lower rungs of society are subject to more traumatic circumstances and less protective resources in their childhoods, which obstruct healthy development, causing a chain reaction of pathology that may endure for generations. Depending on the toxicity of the traumatic condition and the presence of risks and/or resources, trauma can produce diverse symptoms of distress. Distress refers to a state of extreme anxiety, sorrow, and/or pain.

1.1. Distress

JIC are perceived and managed as kid criminals (Slate & Johnson, 2008), but are commonly crying out for help. Less than 9% of the youth arrested are serious or violent offenders, and 94% have been exposed to trauma (Baglivio et al., 2014). Suicidal ideation rates in juvenile justice populations range from 14% to 51% (Bhatta, Jefferis, Kavadas, Alemagno, & Shaffer-King, 2014; Esposito & Clum, 2002; Scott et al., 2015; Wasserman & McReynolds, 2006). In a study of Chicago detainees, Abram et al. (2008) found that more than one third of juveniles and nearly half of females had felt hopeless or thought about death in the 6 months before detention. Among a juvenile justice population in Nevada, 18% attempted suicide with intent to die (Buttar, Clements-Nolle, Haas, & Reese, 2013).

1.2. Childhood trauma

Exposure to trauma is the most commonly identified predictor of suicidal ideation and attempt among youth in the juvenile justice system (Dube et al., 2001; Esposito & Clum, 2002; Miller et al., 2013; Stokes et al., 2015). Childhood trauma is a deeply distressing or disturbing experience or condition occurring during the pre-adulthood stages of development. The most documented forms of trauma that are linked to suicidal distress include emotional abuse (Miller et al., 2013), physical abuse (Miller et al., 2013), sexual abuse (Alliance, 2013; Bhatta et al., 2014; King et al., 2011; Miller et al., 2013; Stokes et al., 2015), physical neglect (Dube et al., 2001; Miller et al., 2013), exposure to violence –as victim, observer or perpetrator (Buttar et al., 2013; Dube et al., 2001; Holsinger & Holsinger, 2005; Voisin et al., 2007; Wasserman & McReynolds, 2006), household substance use disorder (SUD), household member mental illness (Dube et al., 2001), and separation from parent or loved ones due to divorce, incarceration or death (Alliance, 2013; Dube et al., 2001). In the original Adverse Childhood Experiences Study (ACEs), Felitti, Anda, Nordenberg, and Williamson (1998) found that between 66% and 80% of all attempted suicides could be attributed to childhood trauma. In another seminal study of childhood trauma, Dube et al. (2001) found that individual trauma items increased the risk of attempted suicide two to five fold (Dube et al., 2001). Childhood trauma was linked to approximately two-thirds (64%) of suicide attempts among adults and 80% of suicide attempts during childhood and adolescence.

1.3. Accumulation toxicity

According to CTM, the toxicity of trauma refers to the relative or specific capacity for trauma to produce symptoms of distress. Accumulation toxicity is a domain of toxicity that concerns the adverse effects of experiencing multiple types of traumatic childhood experiences—also known as cumulative trauma. CTM predicts that as traumatic experiences accumulate, risk for suicidal distress increases, and multiple trauma types may be more toxic than an individual trauma. The overwhelming majority of JIC experience multiple traumas (Baglivio et al., 2014), and evidence suggests that elevated trauma exposures may predict elevated suicidal risk in JIC. In the general population, Felitti et al. (1998) found that 20% of individuals with four or more traumatic events attempted suicide. Further, there was a 1200% increase in attempted suicides when comparing those with an ACEs score of zero and those with a score of four. As trauma accumulated, attempted suicide increased by 30–51 times (Felitti et al., 1998). Dube et al. (2001) found that adults with a trauma score of seven or more were 31 times more likely to attempt suicide than individuals with a trauma score of zero, and adolescents with a trauma score of seven or more were 51 times more likely than adolescents with a trauma score of zero (Dube et al., 2001). Among JIC, Bhatta et al. (2014) found that JIC who experienced four traumatic events were 7.8 times more likely to report suicide attempts than those who experienced none.

1.4. The current research

The research on trauma among juvenile offenders is limited by small sample sizes, cross sectional designs, and homogenous populations (Stokes et al., 2015). Previous studies of Florida JIC use cross-sectional designs and none of them examined suicidal distress (Baglivio, Wolff, Piquero, & Epps, 2015; Fox, Perez, Cass, Baglivio, & Epps, 2015). Among the limited studies that examined trauma and suicidality among youth in the criminal justice system (Esposito & Clum, 2002), very few have investigated the effect of accumulating traumatic experiences on suicidal distress. Florida has the third largest juvenile justice population in the nation (Juvenile Justice Geography, Policy, Practice, and Statistics, 2017); and FLDJJ collects data on trauma exposures and several adolescent health and behavioral outcomes. Drawing on data from FLDJJ, the current study represents a longitudinal analysis of the effect of individual and cumulative childhood trauma on suicidal distress. CTM hypothesizes that JIC who report individual trauma will be associated with a higher risk of suicidal distress and attempts than those who do not experience each respective trauma; and JIC who experience multiple types of trauma will be associated with higher risk of suicidal distress and attempts than JIC who experience a single type of trauma.

2. Methods

Youth typically enter the Florida Department of Juvenile Justice (FLDJJ) system through receiving an official sanction, or arrest. During the intake process for each arrest, trained FLDJJ data collectors administer the Positive Achievement Change Tool (PACT) assessment via in-depth interviews and code the data using the FLDJJ coding software. FLDJJ typically require youth to complete a follow-up PACT assessment–procedures may vary based on the capacity of the particular entity and nature of the offense. The sample was drawn from the entire population of juveniles in FLDJJ from 2004 to 2014. FLDJJ selected all juveniles who (a) received one or more official referrals for delinquency (equivalent to an adult arrest) before the age of 16; (b) completed the (PACT) Full Assessment once in both 2007 and 2008; and (c) reached the age of 18 by year 2016. A cohort of 2687 12–16 year-old juveniles met the selection criteria. There was 12% attrition at the follow-up year, resulting in a total of 2367 juveniles. All data were self-reported by youth. All procedures were reviewed and approved by the University of Florida and FLDJJ Institutional Review Boards. A cohort of 12–16 year-old JIC were followed for two years and 2, 367 remained after attrition.

The sample comprised of roughly 371 females (16%) and 1996 males (84%). Nearly 60% of subjects were non-Latino/a Black or African American, 29% were non-Latino/a White, 10% Latino/a, and < 1% was another race. The mean age at baseline was 14.

2.1. Measures

2.1.1. Risk for suicidal distress

The term suicidal distress includes suicidal ideation, suicidal attempts, and self-injury. Risk for suicidality was measured via a dichotomous variable derived from a categorical variable reporting thoughts, threats, plans and attempts (0 = none, 1 = serious thoughts