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Releasing Their Stories: A Qualitative Study of Juvenile Justice-Involved Youth with Histories of Mental Health Issues and Violence

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Too often the narratives of youth self-exploration and experience are lost in a drive to prevent, diagnose, or respond to youth-led crime. This exploratory qualitative study looks at and documents the life histories of youth concurrently involved in the juvenile justice system and in clinical treatment independent of the crimes they committed. A purposive sample of 9 male juvenile-justice-involved youth with histories of mental health issues and violence were administered a semi-structured questionnaire. A content analysis of the youths' narratives revealed 3 major themes related to trauma and responses: (a) exposure to a violent world, (b) death and loss of significant others, and (c) positive–negative responses. The implications for forensic social work practice and policy with juvenile justice youth with histories of trauma are delineated.

I'm doing good but I need to no [sic] what is wrong with me and why I am acting this way. I have to now what's wrong with my body that makes me act like I do I don't want to feel werd anymore. I am a boy and I don't want anything to go wrong with me but for me to get better. I thank I have AIDS but I just need someone to tell me are let me no what I have and when I was home I need to no what happened to me and are you going to send me to a psychatriot hospital because of the way I am acting and my social worker said that you was going to send me a away because I act werd. I am tired of this please tell me what is going on with me (A note from William to his Social Worker)

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William, an 18-year-old African American male, is just one of the many voices of juvenile-justice-involved youth who are struggling with mental health problems while in prison. More than three decades of research have documented the high prevalence of mental health problems among the juvenile justice population, ranging from psychoses, affective disorders, anxiety disorders, impulse control disorders, post-traumatic stress disorder, and substance abuse disorders (Otto, Greenstein, Johnson, & Friedman, 1992; Vermeiron, 2003). It is estimated that 20% of adjudicated youth have diagnosable mental health problems and up to 6% have a serious mental illness (Coalition for Juvenile Justice, 2000; Teplin, Abram, Mclelland, Dulcan, & Mericle, 2002).

Although the high prevalence of mental health disorders has been firmly established, our knowledge of the nature and scope of the environmental factors that have influenced these youths' lives and how such factors explain their choices and experiences is still growing (Cocozza, 1992; Martin, Sigda, & Kupersmidt, 1998; Vermeiron, 2003). Initial research has provided a glimpse into the psychosocial backgrounds of these youths beyond their *DSM* diagnoses and their offense histories. Results suggest that youth with mental health problems in the juvenile justice system have a constellation of contextual issues that range from school problems and low academic achievement; emotional lability; family instability, and disruption; histories of trauma, poverty, and homelessness; struggles with substance abuse; and ineffective child welfare, mental health, and substance abuse interventions (Abram et al., 2004; Erwin, Newman, McMackin, Morrissey, & Kaloupek, 2000; Malmgren & Meisel, 2002; Martin et al., 1998; Maschi, Morgen, Smith-Hatcher, Scotto-Rosato, & Violette, 2009; Widom, 1989).

More detailed accounts of the psychosocial histories of such youth are still being revealed, and as a result we know very little about how youth think about and describe these experiences and what impact they have had on them. Therefore, the purpose of this narrative analysis was to begin an initial exploration of the lives of youth who have both mental health problems and histories of violence and are in clinical treatment in a juvenile justice setting. The general research question was: How do juvenile offenders who have or are experiencing mental health problems and violence both identify and describe the impact of their significant life events? Gaining a better understanding of the impact of psychosocial events on juvenile-justice-involved youth can assist in the development and improvement of assessment, prevention, and intervention strategies for these youth, who present with multiple problems.

LITERATURE REVIEW

A review of the literature reveals three general areas that have direct relevance to clinical practitioners who seek to understand the complexities

of youth with histories of mental health problems, violence, and juvenile justice involvement. These three major areas are (a) the high prevalence of mental health disorders in this population, (b) the complex psychosocial stressors of juvenile offenders, and (c) theoretical explanations. Overall, the body of literature regarding juvenile-justice-involved youth with mental health problems suggests that clinical practitioners who work in a juvenile justice setting must be proficient in the diagnosis, assessment, and treatment of a wide array of mental disorders and must bring to their work a rich understanding of the complex impacts of multiple psychosocial stressors and traumas.

Mental Health Issues among Adjudicated Youth

Research has consistently shown that youth in the juvenile justice system have diagnosable mental health problems for which clinical treatment is warranted. It is clear that the rate of mental health disorders among youth in the juvenile justice population is substantially higher than youth in the general population (Atkins, Pumariega, & Rogers, 1999; Grisso, 1999; Pumariega et al., 1999; Vermeiron, 2003). *DSM-IV* diagnoses (American Psychiatric Association, 2000) may range from severe to less severe types of mental disorders and may be present either singularly or comorbidly (Wasserman, Ko, Larkin, & McReynolds, 2004). For example, psychotic disorders, such as schizophrenia and pervasive developmental disorders, such as autism, have been found to be as high as 6% among incarcerated youth (Teplin et al., 2002), compared to a general population rate of 1.1% for schizophrenia and 0.34% for autism (Department of Health and Human Services, 1999).

Additionally, high levels of affective disorders, impulse control disorders, and substance abuse disorders have also been shown to be common among adjudicated youth (Teplin et al., 2005a; Vermeiron, 2003; Wasserman et al., 2004). These findings remind us that the social work psychosocial or contextual perspective is a vital contribution to informing and providing effective intervention for youth in the juvenile justice system who may present with this wide range of psychiatric diagnoses.

Psychosocial Factors and Juvenile Offenders

Psychosocial factors that influence youth involvement in the juvenile justice system have become the subject of research interest. These studies, mostly quantitative in nature, have documented that juvenile-justice-involved youth present with a high prevalence of emotional, behavioral, and school problems; psychosocial stressors; exposure to violence; and self-destructive and/or suicidal behaviors (Government Accounting Office, 2003; Kaufman & Widom, 1999; Malmgren & Meisel, 2002). These issues can help to meet

evidentiary criteria for mental health diagnosis and can also provide a psychosocial explanation for a youth's behavioral and/or emotional presentation.

EMOTIONAL, BEHAVIORAL, AND SCHOOL PROBLEMS

Emotional and behavioral disorders and co-occurring academic problems are common among youth in the juvenile justice system. In a sample of youth drawn from schools, community health centers, and juvenile justice settings, Robertson et al. (1998) found that school attendance problems, substance use, a family history of mental illness, and running away were highly prevalent specifically among the sample of juvenile-justice-involved youth.

PSYCHOSOCIAL STRESSORS

Youth in the juvenile justice system also have been found to have a host of psychosocial stressors that have short- and long-term consequences. For example, in a sample of adolescent felons with emotional disturbances ($n = 43$) in a California prison treatment program, Eisenman (1993) found that the majority of those observed had a history of family violence which included physical, psychological, or sexual abuse; were over-representative of minority groups (African-American and Hispanic); were gang-affiliated; and had been abandoned at an early age by at least one parent. These youth were also found to lack empathy, objectify others, condone crime, and have problems with authority. The psychosocial stressors common among these youth included exposure to violence, self-destructive and suicidal behavior, and the impact of prior mental health treatment. These findings suggest that clinicians in a juvenile justice setting must conduct a thorough assessment of minor to severe psychosocial stressors that may then elucidate some of the choices, attitudes, and behaviors of these youth.

EXPOSURE TO VIOLENCE

Prior research has found that children involved in the juvenile justice system are more likely to be victims of child abuse than the general youth population (Otto et al., 1992; Smith & Thornberry, 1995; Widom, 1989). Evidence suggests that 45% of maltreated youth, as compared to 32% of non-maltreated youth, had official records of delinquency (Child Welfare League of America, 1999; Smith & Thornberry, 1995). Maltreated children also were found to be at an increased risk of other interrelated problems in adolescence including drug use, poor academic performance, teen pregnancy, and emotional and mental health disorders.

Additionally, a history of family and community violence has been found to be especially commonplace among youth in the juvenile justice system with clinical presentations such as depression and post-traumatic

stress disorder (Erwin et al., 2000; Martin et al., 1998). For example, Martin et al. (1998) found that the majority (75%) of the youth exhibited clinical signs of depression. Almost all of the participants (90%) were either witnesses and/or victims of neighborhood violence and 58% reported experiencing violence in the home.

Self-destructive and suicidal behavior

Suicide and other self-destructive behaviors have been found to be commonplace among youth in the juvenile justice system. According to a special report by the Surgeon General (Department of Health and Human Services, 1999), suicide is the third leading cause of death for young people between the ages of 15 and 24. In a juvenile correctional facility, suicide is the second leading cause of death and precedes homicide (Walters, 2000). Prior research has found the rate youth suicide attempts for incarcerated youth to be as high as 28% (Cairns & Rutter, 1988).

Youth with mental health problems in the juvenile justice system have a higher rate of psychiatric hospitalization, most often for suicide attempts, compared to the general population (Otto et al., 1992; Westendorp, Brink, Roberson, & Ortiz, 1986). In a comparison group study of delinquent and non-delinquent adolescents (Pumariega et al., 1999), it was found that prior to incarceration, the delinquent sample was more likely to have used out-of-home residential services and adolescent psychiatric inpatient programs than outpatient mental health services. Youth may engage in self-mutilation as a maladaptive coping mechanism while in correctional settings. Haines and Williams (1997) studied the coping and problem solving of a group of youth who self-mutilate and found that those who self-mutilate exhibited fewer cognitive resources, had lower self-worth, and engaged in more problem-avoidance coping strategies than the two comparison groups.

THEORETICAL PERSPECTIVES

Trauma theories, such as those put forth by Herman (1992), van der Kolk (1987), and Noshpitz (1994), can assist in explaining the trauma origins among youth with emotional and behavioral problems in the juvenile justice system. Traumatic events are those events that are "outside the range of usual human experience" and are "markedly distressing" (American Psychiatric Association, 2000, p. 454). According to the *DSM-IV-TR*, traumatic events can include the sudden and unexpected death of a loved one, being a victim and/or witness of physical and/or sexual abuse, and/or natural disasters. Judith Herman (1992) defined *psychological trauma* as an "affliction of the powerless" (p. 33).

Research has shown that being a victim and/or witness to traumatic events may have psychological consequences (Herman, 1992; van der Kolk et al., 1996). Several mental health theoreticians have explanations for the impact of psychosocial stressors (such as being a victim and/or witness to violence, or losing a loved one) on mental health and aggressive and self-destructive behaviors among youth (van der Kolk & Fisler, 1994; van der Kolk, McFarlane, & Weisaeth, 1996).

Bessel van der Kolk (1987) offered a biopsychosocial explanation for the impact of psychosocial stressors on mental health. He saw mental health disorders as more complex than the diagnostic label given to the client. In other words, mental health disorders are not interpreted as solely biologically or genetically driven, but in fact are understood as influenced by one's inability to cope with adverse life experiences. van der Kolk (1987) averred that traumatic experiences can deeply impact children and jade their expectations about the world, the safety and security of their lives, and their psychological, emotional, social, and behavioral functioning (van der Kolk & Fisler, 1994). More specifically, van der Kolk et al. (1996) explained that traumatic experiences can consequently impact individuals' ability to regulate affect and control impulse, manifesting in symptoms of mental health diagnoses. Similarly, Bowlby (1973) noted that exposure to negative life events can instill youth with a jaded world view, which in turn, influences the child's current and future behaviors.

Grounded in attachment theory, Noshpitz (1994) purported an additional perspective for how childhood experience influences the development of a more positive or negative world view. Noshpitz (1994) argued that disruptive attachment bonds, especially in childhood, impact a youth's world view and approach to the world. The process of infant idealization of the primary caregiver (commonly the mother) is viewed as a key component in forming attachment bonds. For example, when early childhood environment and relationships are good, the child develops a positive ideal. The infant views the parent, especially the mother figure, as all-knowing, all-powerful, and all-rewarding and receives a sense of elation and idyllic unity with the mother (Noshpitz, 1994). On the other hand, if the central caregiver is immature, depressed, drug addicted, and/or neglectful of the child, the child may experience rejection, rough handling, abandonment, neglect, and/or abuse from the central caregiver. The feelings evoked from such negative situations will be just as intense and exaggerated, but rather than a sense of elation and unity, the child will experience such feelings as loss, injury, fear, despair, and a sense of worthlessness.

Noshpitz (1994) contended that these feelings create internalized positive and negative ideals of the self and the world. As the child matures, these positive and negative ideals form the personality and function separately. Each opposite ideal dramatically affects one's emotions and drives behavior. Forming the positive and negative ideal is an unconscious process. If a child

is provided with the security and nurturance of positive parenting, the child internalizes feeling supported and at peace. In the negative parenting situation, the child will have more difficulty feeling supported and at peace. The negative ideal can imprint feelings of "badness" and a malevolent inner voice that fixates on the destruction of self and others. When one is largely influenced by the negative ideal, the young person may exhibit depressive symptoms and suicidal behaviors, or aggressive behaviors toward others. Paradoxes and inconsistencies can also emerge, because people simultaneously embody both ideals, negative and positive. That is, a person may be angry, hateful, and hostile and also have feelings of regret, guilt, and remorse (Noshpitz, 1994).

What is important about Noshpitz's (1994) theory for practice is that it recognizes that both the positive and negative worldviews exist within the same individual. A person who is dominated by the positive ideal will have a strong empathic inner voice that gives feedback of self-approval and love. In contrast, a person dominated by the negative ideal will have a critical inner voice that provides feedback that is self-punishing and hateful. The environment can be an important influence for which ideal becomes dominant. For instance, criticism may motivate the negative ideal to react destructively. In contrast, praise or supportive responses may stimulate a person to act constructively. According to Noshpitz's theory, either the positive or negative ideal will be a dominant influence on how youth view themselves, their world, and their actions (Noshpitz, 1994). It also must be noted that some individuals have positive attachments and negative outcomes, while others have negative attachments with positive outcomes.

METHODS

Data Collection

The study used in-depth semi-structured interviews and case record reviews with nine juvenile- justice-involved youth with histories of mental health problems and violence. The interview guide, the Adjudicated Youth Questionnaire, was developed for this study and guided by Patton's (2002) guidelines. The topics for the questionnaire were grounded in the literature on mental health and juvenile justice and pilot tested with key informants who worked with youth with histories of trauma and mental health problems in the juvenile justice system. Based on feedback, major categories for the survey were corroborated for significant life events, family, service use histories, and behavioral health histories and categories were added to assess for subjective experiences related to significant life events.

The interview questions asked youth to discuss their past and present experiences and future hopes. Youth were asked to discuss important life experiences, including family and friends, school, and juvenile justice

involvement. Youth were also asked about the impact of life experiences that included prior histories of mental health, substance use, and emotional reactions, such as anger, grief, sadness, coping responses, and future hopes.

The interviews took place in an interview room located in the mental health office in a Northeastern United States prison. A trained research assistant conducted the interviews with each youth separately. The interviews lasted 1.5 to 2 hours and were taperecorded on an audiocassette. The study was Institutional Review Board (IRB) approved. All nine youth (all over the age of 18) were administered informed consent by a trained research assistant. They were informed of the purpose and procedures of the study and agreed to participate in an interview and granted permission for the researcher to review their case records. Pseudonyms were used to protect the confidentiality of participants.

Case record reviews were conducted in order to corroborate the youth's significant life events and mental health histories. In some instances, the case records reported information not disclosed by the participants, especially related to details about their mental health and psychotropic medication histories. In other cases, information in the case records contradicted information given at the interview. For instance, in one record review domestic violence in the home was documented, whereas in the interview this same participant denied it. These discrepancies were handled by coding evidence of abuse when documented in official records but not reported during youth self-report responses.

Sampling

Purposive criterion sampling methods were used. Eligible participants were diagnosed with a mental health disorder and incarcerated. The participants were identified by mental health records that identified a mental health diagnosis, violent offense history, and secure care juvenile justice involvement.

Description of the Sample

Demographics

Table 1 provides an overview of the sample characteristics. The nine participants ranged in age from 18–20 years. The majority of the youth were Caucasian ($n = 4$), followed by African-American ($n = 3$), and then Hispanic ($n = 2$) and were raised in urban communities. At the time of the study, none of the participants had obtained their high school diploma but were required to attend school while incarcerated. All participants were imprisoned in a medium-security prison for adolescent males at the time of the interviews. Their sentences ranged from 1 to 4 years. All participants committed multiple offenses that included one violent offense, such as aggravated physical or sexual assault.

TABLE 1 Matrices of Psychosocial Characteristics of Participants ($N = 9$).

Characteristic	George	Mickey	Craig	William	Adam	Damon	Malik	Alvin	Lester
Demographics									
Age	18	19	18	20	18	18	18	18	18
Race	Caucasian	Caucasian	Caucasian	Caucasian	Latino	Latino	African Am	African Am	African Am
Incarceration									
Sentence length	12 months	48 months	12 months	24 months	18 months	18 months	36 months	30 months	12 months
Family History									
Parents' marital status	Divorced	Never married, Separated	Mother widowed	Divorced	Divorced	Never married, Separated	Never married, Separated	Divorced	Both parents Deceased
Father									
Absent	Yes Estranged Relation	Yes Never knew him	Yes Age 11, dad died	No Lives with father	Yes Since 3, no contact	Yes, until age 11, then placed w/father	Yes Never knew him	Yes Removed from father by DYFS	Yes Father deceased.
Substance use	Yes Alcohol	Unknown	Yes Heroin	Denied	Yes Alcohol	Yes Marijuana	Unknown	Yes Alcohol	Unknown
Mother									
Absent	No	Yes Between 2–8	No	Yes Age 12, divorced	No	Yes At age 7	Yes At age 7	Yes At age 12	Yes At age 2
Substance use	Denied	Yes Alcohol	Denied	Denied	Denied	Yes Crack	Yes Drugs	Yes Drugs	Yes Crack
Child welfare									
DYFS involvement	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes
Reason for DYFS involvement	Behavior problems	Neglect, child abuse	Alleged abuse	None	None	Neglect, substance abuse	Neglect, substance abuse	Child abuse	Parental loss, DYFS care
Foster care placements	0	3	0	0	0	4	3	30	4
Program placements	2-Violated	2-Violated	1-Violated	0	1-Violated	0	0	5-Violated	9-Violated
Home									
Family members	Mother/ Stepfather	Aunt, Uncle	Mother	Father	Mother	Father	Grandparents	Grandma, Aunt	Adopted parents

Abuse history									
Victim of physical abuse	Yes by brother	Yes by stepfather	Yes by father	Yes by father	Yes by father	Yes by father, uncles	Denied	Yes by father	Yes adoptive mother
Victim of sexual abuse	Denied	Yes Age 8 by adult male family friend	Denied	Denied	Denied	Denied	Yes Age 15 by woman in 40's	Yes Age 7 by female cousin age 16	Yes Age 8 by adult male foster parent
Witness to domestic violence	Yes Father beating mother	Yes Uncle beating aunt	Yes Father beating mother	Denied Admits parents argued	Yes Father beating mother	Yes Father beating mother	Denied	Yes Father beating mother	Yes Foster parents
Neighborhood violence	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Grief and loss									
Death of parent, grandparent, caretaker	Great grandfather At age 15	Cousin Jimmy At age 8	Father At age 11	Grandfather	Grandmother At age 17	Grandfather At age 7 (witnessed death)	Denied	Mother At age 12	Mother and father At age 2
Special education									
CST classification	ED	ED	ED	ED	LD/Math, Read	None	ED	ED	ED
Grade classified	8th	4th	8th	7th	3rd	N/A	4th	2nd	7th
Psychiatric									
Psychiatric diagnoses	Major depressive disorder recurrent, intermittent explosive disorder, borderline personality traits	ADHD by Hx, impulse control disorder	Major depressive disorder, recurrent	Hx ADHD, Major depressive disorder, conduct disorder, Xanax abuse in remission	Psychotic disorder, depressive disorder, NOS	Impulse control disorder	Dysthymic disorder, impulse control disorder, conduct disorder, polysubstance abuse	Schizophrenia: paranoid type	Intermittent explosive disorder, conduct disorder, Hx ADHD, impulse control disorder

(*Continued*)

TABLE 1 Continued

Characteristic	George	Mickey	Craig	William	Adam	Damon	Malik	Alvin	Lester
Currently medications	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes
Psychotropic medications	Depakote, Remeron, Effexor, Risperidol	Ritalin, Wellbutrin	Lithium, Depakote, Wellbutrin, Trazodone	Elavil, Depakote, Paxil, Ritalin, Imapramine, Prozac, Risperidol	Risperidol, Benadryl	Hx of Clonidine	Hx of Paxil and Risperidol	Hx of Thorazine, haHaldol, Ritalin, Remeron	Depakote, Paxil, Risperidol, Haldol, Lithium, Hx of Ritalin
Hx of psychiatric hospitalization	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
History of self-destructive behaviors									
Suicide attempts	2	2	3	3	2	2	2	3	10
Method of suicide attempt	Slitting wrists	Slitting wrists	Hanging, slitting wrists	Drug overdoses	Hanging, slitting wrists	Hanging	Hanging, slit ting wrists	2 hanging, 1 jumping out window	Hanging, slitting wrists, jumping of buildings
Self-mutilation	Yes Multiple scars, Cutting up arms, banging head, punching walls	Yes Multiple scars, cutting up arms, banging head, punching the wall	Yes Multiple scars, cutting up arms, banging head, punching walls	No	No	No	Yes Cutting arm	No	Yes Multiple scars, cutting up arms
Substance abuse	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Age started	14	12	12	12	13	14	14	12	14
Drugs used	Marijuana, alcohol, LSD	Marijuana	Marijuana, alcohol	Marijuana	Marijuana, alcohol, heroin	Marijuana	Marijuana, alcohol	Marijuana, alcohol, PCP	Marijuana

Notes. DYSF = Department of Youth and Family Services; ED = Emotionally Disturbed; LD = Learning Disabled; ADHD = Attention Deficit Hyperactivity Disorder; Hx = By History; NOS = Not Otherwise Specified.

Mental health history

Nine participants had been diagnosed with at least one *DSM-IV* mental disorder, with seven of the participants diagnosed with multiple diagnoses. The most common mental disorders were depressive disorders ($n = 6$) and impulse control disorders ($n = 6$), followed by psychotic disorders ($n = 2$). Educationally, the majority of the adolescents ($n = 7$) were classified as emotionally disturbed, one was classified as learning disabled, and one was unclassified. At some point in their lives, all of the participants ($n = 9$) were prescribed some type of psychotropic medication to control depression, impulse control, and/or psychoses. Five participants were currently on psychotropic medication.

Prior service use

Prior to incarceration, the majority of the participants ($n = 8$) had received outpatient mental health treatment. The remaining participant ($n = 1$) became involved with mental health treatment after becoming incarcerated. Eight participants had prior psychiatric hospitalizations for suicide attempts. In addition, most of the sample ($n = 7$) reported past involvement with the Department of Youth and Family Services (DYFS) because of child abuse allegations ($n = 5$) and parental substance abuse and neglect ($n = 2$). Five participants reported multiple foster placements ranging from 3 to 30 different homes. Five of the participants had attended court-mandated residential programs in the past and reported violating them, four due to aggressive and inappropriate behavior while in the program and one for escaping the program.

Data Analysis

An inductive approach to content analysis was conducted using transcripts of each interview by two research team members using Berg's (2004) and Neuendorf's (2002) content analysis guidelines. Each researcher conducted the analysis independently following these steps: each interview was read in its entirety, central ideas were coded, counts of textual variables were used as a means for identifying and organizing data, and interpretations were recorded. Conceptually-clustered matrices were then constructed to detect patterns in the themes across the interviews (Miles & Huberman, 1994).

RESULTS

Three major themes identified in the youth's narratives related to trauma and responses were (a) exposure to a violent world, (b) death and loss of significant others, and (c) negative–positive responses.

Exposure to a Violent World

Victims of physical abuse

Eight participants reported a history of physical abuse. Five of the young men reported being physically abused by their father or stepfather, two by their grandfathers, one by his brother (who had been physically abused by their father), and one by his foster parents. Two participants reported acts of severe abuse by the father. Mickey reported his stepfather broke his nose. Alvin reported, “One time when my father beat me, he knocked my two front teeth out.”

All eight of the young men with histories of physical abuse reported feelings of anger, powerlessness, apathy, sadness, and thoughts of confusion in relation to being victims of physical abuse.

> Damon: I was hit a lot of times. A lot of times. With a belt. My grandfather, my uncles. I don’t know why but I got a lot of hittin’. Yeah and it hurt. I cried. Probably like it happen everyday. They didn’t really hit me and like stop, but once in a while they would just beat me and shit. They were hittin’ me with a belt. I used to cry. It didn’t used to bother me. I got used to it.
>
> Mickey: My stepfather hit me a couple of times. One time he got drunk and broke my nose. I was eight or nine. I had to go to foster care after that. I know what it was. I was eating cereal on the kitchen floor. My mom called from work and he wanted to me to talk to her. So I said, “I love you mama, goodbye.” He grabbed my hand and said, “Come here and talk to your mom”. And I said, “No, I already talked to her.” Then he got up and said, “You don’t love your mother.” And then, he hit me and then he went and crashed on his bed. I called the cops, then my mom came. He couldn’t be in the house when I was there. And one time he was still there so then I called the hospital and they took me in foster care. They lied to me. They said that I wouldn’t be gone for more than two days. And I didn’t come back for two years.

Victims of sexual abuse

Four participants reported being sexually abused between the ages of eight and fifteen. Lester recalled being abused by a male foster parent:

> I was sexually abused as a child. It was in Queens. Only in Queens when I was separated from my brother. I was nine, or ten, or eleven. One of those. I felt scared, trapped, until we went to a meeting. I told on him. I just got enough strength to tell on him. I said, “I can’t go back and do this again, yo. I’m tired of this.” I was there for a year straight. A year of my life that really didn’t mean nothin’, didn’t teach me nothin. Nothin. It was a waste of time. I mean I learned more things in prison!

Mickey, who was sexually abused when he was 9 years old, fluctuated between feelings of anger and sadness and thoughts of confusion. He described his sexual abuse experience:

> He was my babysitter. He asked to be my babysitter. It was for about a month and a half. He was like a regular person. He was nice. It happened like six times. You think he is your friend. He starts telling you these things. When I sit down and think about it, it makes me cry. Then I forget about it like, I don't care about it no more. I blame it on other people. My mom should have never left me alone with him. My mom should have never trusted him. I didn't do anything wrong. I said, "Mom, he does these things to me. He does these things, like icky things or nasty stuff." She didn't believe me. It hurt because why would my mom believe someone else over me? (Crying) Sometimes it hurts, and other times, fuck it, I don't care anymore.

Witnesses to domestic violence

Eight participants admitted to domestic violence in the home. George and Alvin felt angry because they felt unable to protect their mothers.

> George: I saw him put my brother through a wall. He was about seven years old and I was about five. He used to beat my mother too. I didn't know what was going on. I just wanted to help my mom. And I ran to my room and hid under my bed. I was afraid that he was going to get me next. I never got hit. I was the baby so I never got hit. I just wanted it to stop and I couldn't do anything to stop it. I wanted to do something about it. It might have been an emotional reaction. I knew that there was something wrong going on, and I was somehow powerless to do something about it, maybe pin him down or tie him up, or do whatever it would take to make him stop.
>
> Alvin: My dad used to beat my mom up a lot, you know what I'm saying. He did it right in front of me and my brother. He used to punch her and stuff. Sometimes in the face. He used to smack her and kick her and stuff because she used to do drugs and stuff. And I used to try and fight him and he used to throw me around. All the time I was trying to protect mom. But what could I do! It just made me real angry. And I couldn't do nothing with that anger. And I still got it in me until this day.

Witnesses to neighborhood violence

Among all nine participants, witnessing acts of neighborhood violence was a common occurrence. Two participants reported seeing someone murdered.

Lester gave a detailed account of being an eyewitness to a murder in a New York City park:

> I've seen death in my life. I've seen somebody get shot. Right in the head. Oh! He got hit with a .45 right up close. And that was nasty. I was in the streets of New York. I remember, I remember, it was broad daylight, and he had a snake, and there was kids around him, but he, but, everybody was comin' around, "damn, that's a snake," you know what I mean. Then I remember cars comin' up, "rrrrrr," and I remember goin' back to the court and playin' basketball. Then after that, I seen a whole bunch a guys start gatherin' up, gatherin' up, you know, you know how people get, and I looked and I seen a dude pull out a gun and they's arguin'. Then, straight to his head, "boom." Everybody scattered, runnin', screamin'. Police come and nobody . . . that was nasty, yo. I thought they was gonna fight. And then he had a gun and—"bang." Then you see the chalk, the chalk of the body. I never knew what that meant until that day. I seen a lot of those. A lot of those. Even around my building. Chalk. Scared me, yo. It felt like spirit was there and waitin' on me. I was a strange kid, you know what I mean. I always thought—thought things. I always thought, "what if the spirit is still here?"

Death and Loss of Significant Others

Death of a significant person in their lives, a situation they were powerless to change, was another common situation among the participants ($n = 8$). Three of the participants reported the death of a parent, four reported the death of grandparents, and one reported the death of a favorite cousin. One participant's father died before he was born and his mother died of a drug overdose when he was a toddler. Lester described losing his parents:

> I remember bein' so little you know, seein' her, I could only see her knees, she was a heavyset lady. I can't see her face. It's blank, yo. My dad's face is blank. Makes me sometimes wanna cry, yo. Ah man.

Two participants witnessed the death of an important family member. Craig described his thoughts and feelings on watching the slow death of his father from drug-related complications:

> In a way I am mad, and in a way I'm sad, but in a way I am happy, because he ain't in misery anymore. A lot of people I tell I am happy that my dad is dead, it doesn't sound right, but you have to understand. He was suffering. He would just stare in front of a black TV screen for hours. Every time my mom would say, "You are going to the hospital," he would phase in and say, "No I'm not." And she would let it go until he

> urinated in the bed. She said, "That's it. You are going into the hospital." He had blotches on his skin and they were turning dark green and light green, cause he shot up with a bad needle and the needle must have been dirty and it got into his blood. Now I am not going to be like that, because I know that I grown without a father around my teenage years. I know how it feels and I am not going to leave my kids like that.

Damon witnessed his grandfather's death, which occurred during a drug raid, as the police searched the house for his mother, who was dealing drugs. He expressed fear and confusion over what happened when his grandfather died:

> I was in the house and my motha' wasn't there and people came with guns and stuff. I was scared as hell. I was under the sofa. And they said they were looking for my motha'. And she was sellin' crack at the time. And then um . . . I heard loud, loud, loud, my grandfather say, "She's not here, she's not here." And then my grandfather thought they was takin' me. And I looked up and I was shakin' and stuff. He was in the hallway and I saw him, he fell down a whole flight of stairs. And then these people just left while my grandfather was laying there. They called the ambulance but they came about four hours later. My grandfather was layin' down at the bottom of the steps for four hours. It was a steel door. A metal door at the bottom of the steps.

Negative Reponses: Reactive and Self-Injurious Behaviors

The youth reported traumatic situations over which, as children, the participants had little or no control, especially related to having turbulent family histories. The adverse life events reported by these youth included the absence of at least one parental figure ($n = 9$), physical and sexual victimization ($n = 9$), death of a significant person in their lives ($n = 8$), and incarceration ($n = 9$). All of these events engendered a sense of loss: loss of an important relationship, loss of personal safety, and loss of freedom. The theme of "reactive powerlessness" that emerged from the data was defined as the youth's attempt to regain personal power through emotional, cognitive, and behavioral reactions to traumatic life events.

The common emotional reactions to these past events reported by these young men were feelings of anger and rage ($n = 8$), apathy ($n = 6$), grief and sadness ($n = 9$), and confusion ($n = 5$). An ambiguity of feelings about the future ranged between the polar opposites of hopefulness and hopelessness. Seven of the participants expressed a hope that they would be able to make positive changes in their lives. In contrast, two of the participants expressed a sense of hopelessness and fear of the future ($n = 2$). Damon admitted, "I am afraid that I am going to go out there and do the same bad things again."

The common cognitive reactions to these significant life events were denial, minimization, rationalization, and projection of blame onto others. Damon, for example, rationalized stealing $80,000 from his drug-dealing uncle by projecting the blame onto his father who did not buy him the things that he wanted. The common behavioral reaction was self-destructive acts, such as self-mutilation, attempted suicide, substance abuse, and violence toward others. However, these youth also expressed personal power in a positive way when discussing their propensity for kindness and hopes for the future.

Suicide attempts

There were a number of self-destructive behaviors that the participants engaged in. All of the participants ($n = 9$) had more than one suicide attempt. Participants reported hanging themselves ($n = 8$), slitting their wrists ($n = 5$), banging their heads ($n = 4$), jumping off of buildings ($n = 2$), setting themselves on fire ($n = 1$), and overdosing on drugs ($n = 1$). All nine participants reported their attempt after a type of loss: either the death of a significant person ($n = 6$) or the loss of freedom due to incarceration ($n = 8$). All of the participants ($n = 9$) reported feeling lost, separated, or disconnected from their families, whether due to a family death or their incarceration. Mickey said, "First time I attempted suicide I was nine. After little Jimmy died. Second time was when I was in jail here. I tried to hang up." Lester explained his thoughts and feelings that influenced his choice to make multiple suicide attempts:

> I tried to kill myself over ten times. Over ten times. By hangin' myself, uh, bangin' my head against the wall, tryin' to knock myself out, and cuttin' myself, slittin' my wrist, I did that. Some of the scars went away though. I was young. When I moved to Jersey, after I was in a program. So, about 15, 16 years old. I tried ten times in the last two or three years. It was all the stress in programs. Not seein' my brother. That was the main reason. That's when I started. Not seein' my brother. So uh, well I did it. I did it outa anger too. I was angry at everything, man. Everything. They said you get war scars. A symbol. You understand. There's no way to hide that. I felt depressed and angry at the same time. When you start thinkin' . . . I always had one problem. And I used to say "Dag, man . . . you see, this leads onto this, and that's why this and this is happenin,'" you know what I mean.

Alvin, at 12 years old, attempted suicide after his mother died of AIDS, and again while in prison. He recalled the time around his mother's death:

> I tried to do it like five times. Before and after my mom died. I remember one time I got into a fight at school, everybody suspended me and I

> didn't really do shit. I just tried, you know, that thing that you pull up to make the window shade go up. I didn't do shit. I just tied the thing around my neck and they blew it up and took me to the hospital for that shit.

SELF-MUTILATION

Five of the participants reported histories of self-mutilation. All five of the youth who had a history of self-mutilation also had a history of suicide attempts. Lester pointed to both arms that showed a series of about 100 scars that he calls his "war scars" running in different directions from his wrists to his elbows. Lester gave an explanation for his self-mutilative behaviors:

> You see it comes in different waves. Every time I cut myself I cut it in a different way so I would cut this one "kshew," and wait till I bleed, wait till I start bleedin,' then I would calm down. So, I went like this just once "kshew, kshew, kshew, kshew, kshew," and then watchin' myself bleed I would calm down. I just wanted to see myself bleed. It calmed me down. Instead of fightin' somebody, I'd fight myself. So I just cause myself pain. Ending all my problems. Just forget about everything that ever happened to me that was bad. I was depressed, angry, sad. I was feelin' angry at a problem and I would get depressed, in levels like. This led up to this, led up to this. I went from anger to depression. I didn't feel I could change it. I felt as though I just needed to be in pain. I just had to be in some pain. I woulda hit somebody, but I can't. So I take the anger out on myself and it feels good. Not only does it feel good to have pain from me, but it makes me feel like I was in a fight and I see myself bleed.

Like Lester, Craig also practiced self-mutilation. Craig's arms have thick scars from deep cutting. He also has the name of his ex-girlfriend, "Christine," boldly cut into his left arm. According to Craig, self-mutilation served these purposes for him:

> I started cutting up right after my dad died, that when it all started. That is the thing that most hurt me. We weren't close, close, but we were good friends. And after he died, I was so stressed out. That was the only way that I could think about getting my anger out. My family was never raised to show emotions, cry or stuff like that. Now I look at my arms and I regret it.

SUBSTANCE ABUSE

All nine participants reported histories of substance abuse. Of the entire sample, all participants reported marijuana use. The majority of the participants

reported alcohol use ($n = 5$). Three participants reported using LSD, and one participant reported being addicted to heroin. The majority of the participants ($n = 8$) admitted that drugs and alcohol use had been a problem in their life, such as in the case of Damon. He explained why he used heroin:

> I did drugs. I was using drugs to use them. I likeded [sic] the high. I likeded the way they made me feel. Heroin. Every day. For a year. I likeded the high. The high was makeded me forget about my family. Don't care about nobody, don't care about what I do, don't care about work, nothin.' Don't care about nothing,' just gettin' high. I lost a lot of friends like that.

Positive Responses: Altruism and Hope

All the participants reported positive responses that included altruism and hope for the future.

Altruism

All the participants reported engaging in altruism, as in the case of Alvin, who kindly accepted responsibility for his brother's crime to enable the brother to be home with his newborn child. He described a selfless act of a loving brother for his brother, "Doing this bid for my brother. Well he ain't in jail, I'm in jail. He's out there having fun. He just got freedom, and I'm locked up".

Out of nine participants, eight of the participants were able to identify situations in which they were unkind and admit feelings of remorse. Only one participant was unable to provide an example. William said, "I don't know, I must have done something, but I can't answer that." When Lester was asked what the most hurtful thing was that he had done to another person, his reply was

> Ah, man! I curse people out—I'm not, I don't like people to be mad at me, man. I do NOT like people to be mad at me. I think about people, like damn, I said something wrong to that person. And I was wrong. That's why I think I'm goin' to heaven. 'Cause I love. I'm a good kid. I am, yo! And people don't realize it. I don't like to hurt nobody. I gotta play this game, that's how I figure it. I gotta be rough, like tough, you know what I mean. I can't show my real self like some others. I like, I like, I wanna get back all those childhood things, like I never had a childhood, and I'm gonna make up for all that, yo. I don't wanna treat nobody bad. And if I do, I'll just ask God for forgiveness. Ask God to forgive me for doin' stuff to that person.

HOPEFULNESS

All participants expressed hope about their personal futures when asked, "What do you imagine your life being like ten years from now?" Among the participants' replies were

Damon: I wanna go out there and do some good. Get on the basketball team. I'm one o' the best players in the shack. I think I'm the best player on grounds, man. I'm good, man. Good as hell. I wanna make it to the NBA. If I don't do that I'm gonna have to do something that makes a lot of money, yo.

Alvin: I would probably have a degree or something. I will try to have a degree, I want to be an actor, I want to be a lawyer, I want to be a singer, those are my main goals. I want to do all three. I know that I am going to be doing something positive, I am going to be making legal money. I don't know; I'll probably own my own business. I probably won't be married, but I'd have some kids. And have my own house. I'll be alright.

Lester: Ah man, I see myself ten years from now, I'll hopefully be married, have two kids, a nice job, um have a nice house, being there for my family, seeing my brother.

DISCUSSION

The purpose of this qualitative inquiry was to illuminate the depth and breadth of the issues facing juvenile-justice-involved youth with histories of mental health issues and violence. It does so through the youths' own eyes and using their own words. Themes related to helplessness, loss of control, powerlessness, and prison as a source of revictimization arose from these youth's narratives. All nine participants provided thick descriptions of traumatic and stressful life events and associated thoughts, feelings, and actions they associated with these events. In response to other childhood trauma, such as witnessing family or community violence, the participants commonly described them as situations in which they felt they could exert little or no control. The feelings expressed by these youth were feelings of anger and rage, apathy, sadness and grief, and self destructive and self-injurious behavior even a decade after these events occurred. Despite circumstances of adversity, the participants reported altruistic behavior and positive hopes for the future.

These findings build up the extant literature (Maschi, 2006; Smith & Thornberry, 1995) by detailing youth's psychological, emotional, and behavioral consequences to a host of traumatic and stressful life experiences. As evidenced, these young men reported multiple instances in their lives in which they were exposed to violence as a victim or witness and experienced other stressful life events, such as the loss of a loved one and

turbulent family lives. Moreover, these youth generally reported their views prior to social service involvement as a detrimental experience. These youths' qualitative reports also document their patterns and triggers for self-destructive behaviors, such as self-mutilation, suicide attempts, and substance abuse.

These findings also have important implications for forensic social work practice, especially for theory development that explores the intervening mechanisms between trauma, mental health, and criminal behavior. In particular, the narratives of these youth provide evidence for a broad-based trauma theory that can explain their lives. For example, van der Kolk's and Fisler's (1994) theory of childhood trauma purports that a child's positive world view is impaired by traumatic events that are often cumulative. The feeling of powerlessness, as described by Herman (1992), resounded in these youth's narratives, such as when George described being unable to stop his father from beating his mother when he was only 5. This study also uncovered emergent themes consistent with Noshpitz's (1994) theory of the positive and negative ideal. The participants clearly expressed a duality of self in which they exhibited both antisocial tendencies and altruistic behaviors and hope for the future. While these young men disclosed they had official records for criminal acts such as theft, harassment, terroristic threats, and aggravated assault, they also expressed a positive self that was both helpful and loving toward others. For example, Alvin revealed that he was incarcerated because he took the "rap" for a crime his brother committed in order for his brother to avoid imprisonment.

It is hopeful to note that there have been very recent initiatives by the Substance Abuse and Mental Health Services Administration (SAMHSA; 2011) that have targeted trauma and justice. The comorbid experiences of trauma, mental health issues, and self-destructive behaviors (such as substance abuse, self-mutilation, and delinquency) underscore the importance of conducting holistic life history assessment to determine the underlying traumatic symptoms that might fuel these adverse behaviors. From a policy perspective, these stories underscore the importance of the forensic social work perspective of a two-pronged approach to practice that addresses the psychosocial situations of the juvenile justice youth and policy level legal reform. Currently, there are no consistent assessment and intervention strategies that address trauma among youth in the juvenile justice system. It would be worthwhile for the new SAMSHA initiative to focus attention and resources on these issues.

The first necessary step is adequate assessment during the intake process. Adapting rapid assessment instruments during the intake process can be used to help identify and rehabilitate youth from incarceration to community release. A few of the well-validated trauma screening tools include the UCLA PTSD Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004), Trauma Symptom Checklist for Children (TSCC) (Briere, 1996), and

the Child Sexual Behavior Inventory (Friedrich et al., 2001). Judges and lawyers should use professionals experienced in administering and interpreting these assessments in order to make appropriate treatment recommendations to the court.

The next major implications these findings warrant are for effective trauma-informed practice. As social workers in juvenile and criminal justice settings, it is important to be aware to practice empathic neutrality, which is to remain objective and neutral as well as empathic when dealing with juvenile offenders (Maschi, Bradley, & Morgen, 2009). Forensic social workers in the juvenile justice system have the potential to work with youth to strengthen their potential to express the positive ideal in the context of the working relationship. Providing positive feedback in the context of a trusting relationship can decrease the influence of the negative ideal and increase these youths' positive self-image and behaviors. The social worker's use of unconditional positive regard in the context of the working relationship with youth can be used to promote healing. A Rogerian nonjudgmental approach to "being there" constituted an important conduit for intervention so that the youths were able to release their pain, contemplate their wrongdoings, and embrace their capacity for goodness.

In further thinking about the findings with regard to practice, these youth have time on their hands in prison. It would be ideal if a large majority of that time could be utilized with implementation of effective interventions that target the traumatic experiences revealed in these narratives, which may be at the root of both the mental health issues and criminal behaviors. One of the new promising interventions that is being piloted in the criminal justice system is eye movement desensitization and reprocessing (EMDR) (Kitchiner, 2000). EMDR is very much in line with van der Kolk's (1987) theory that the adverse life experiences of these youth manifest into mental health symptoms and potentially criminal behavior. Similarly, according to Shapiro (1989) it is imperative for individuals to "reprocess" their traumatic experiences in order to think, feel, and behave more adaptively in their life and consequently in society. As a result of reprocessing core traumatic experiences, the experiences will have a much lesser effect on one's behavior and reactivity in the future. Consequently, utilizing prison time effectively would involve treating these youth with treatments such as EMDR in order to allow for reprocessing of the adverse life experiences, similar to those that have been described in this article, resulting in greater affect regulation and impulse control. Previous research with incarcerated juveniles shows that EMDR can work in reducing post-traumatic stress reactivity resulting in less violent behavior and conduct problems among samples (Soberman, Greenwald, & Rule, 2002). Furthermore, the utility of trauma-focused group therapy for incarcerated youth with trauma histories also could be of significant value. While a few studies are examining the efficacy of such, more effort needs to be put in this arena, given the narratives of these youth (Greenwald, 2002).

Finally, due to the intrinsic relationship between trauma and impulse control and affect regulation, both of which play significant roles in criminal behavior, another promising intervention that requires further attention is that of yoga therapy. Yoga involves a mindfulness that allows for a tuning in to one's experience, controlling one's mind, connecting with others, holding positive thoughts, all of which are critical in easing the stress, fear, pain, and powerlessness that the troubled youths have expressed in this study. As a result of yoga therapy, youth are able to be mindful and turn their attention to their breath rather than reacting based on anger or sadness (Kachtick & Anderson, 2009).

There are a handful of programs around the country that are bringing yoga therapy into the juvenile justice system and behind bars to youth. These programs are reporting significant success with the youth exhibiting greater control of their emotions, increased peaceful resolution, decreased levels of stress and perceived stress, improvement in general health and mental health, and greater likelihood of them asking for help when they need it (Kachtick & Anderson, 2009). Despite these findings, there is very little funding for these programs leaving little room for expansion. This is the direction that social work must move, toward artful and comprehensive interventions such as EMDR and yoga therapy, in order to embrace these youth in a structured, safe treatment system rather than a punitive one. On a policy level, this work is imperative because evidence suggests that untreated trauma and grief is related to increased recidivism rates, which means increased cost on the state and federal level, and increased crime on the human level (Leach, Burgess, & Holmwood, 2008).

This study has methodological limitations that warrant discussion. The study used a retrospective data of asked about events that may have occurred a decade earlier and therefore may be subject to retrospective recall bias. There may also have been a degree of interviewer effects since the first author (Tina Maschi) was an adult White female, part of the prison staff, interviewing multi-ethnic incarcerated males on sensitive topics. Communication barriers or social desirability bias may have affected these results. Despite these limitations, this study has important implications for social work research. It is imperative for further research to be conducted on this topic.

This article illustrates, on a very human level, the experiences of youth that are placed behind bars. Future research in this area should use mixed methods design to confirm or disconfirm patterns and themes found in this pilot study. Research studies are warranted that examine the individual, social, and environmental factors that act as risk and resilience factors. Furthermore, research energy and resources must go to investigating the suggestions put forth here, including early trauma assessment of these youth, and promising interventions such as EMDR and yoga therapy. Both quantitative studies, utilizing the assessment measures and efficacy of the

interventions, along with qualitative studies that capture the subjective essence of these youths' experiences prior to incarceration, while in the juvenile justice system, after treatment, and after release are necessary. Such studies will provide evidence for SAMSHA (during this time of their new initiative) and other policymaking entities to support effective policy creation and implementation for the sake of these youth and our society.

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