PSYCHOSOCIAL CHARACTERISTICS OF VIOLENT JUVENILE OFFENDERS WITH SERIOUS MENTAL/BEHAVIORAL DISORDERS

By

MAMADOU M. SECK

Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy

Dissertation Adviser: MARK I. SINGER PhD

Mandel School of Applied Social Science
CASE WESTERN RESERVE UNIVERSITY

May, 2007
Dedication

- To my late father, Mandaw, G. Seck and my mother, for teaching me patience, tolerance, and focus on education and hard work.

- To my wife and children for accepting my long absences from home;

- Special thanks to my Professor, adviser, and committee chair Mark I. Singer Ph.D. for his resourceful and insightful feedback, and for his encouragements and unique support.

- My dissertation committee members: Dr. K. Farkas, Dr. D. Flannery, Dr. D. Miller, all Mandel School of Applied Social Science professors, the late Arol Shack, and all administrative staff for their constant advice and support that facilitated my work and raised its quality.

- To my friends who supported me during these long years, sharing their time, and allowing me to extend my social capital: William and the late Janet Avery, James and Joan McAuley, the late Professor Ralph and Phyllis Brody, Dorothy Faller, and the Honorable Judge Leodis Harris and family.
# TABLE OF CONTENTS

Dedication ii

Table of contents iii

List of tables vi

List of abbreviations viii

Acknowledgements xii

Abstract xiii

## CHAPTER 1

Introduction - Problem Statement 1

Background Information 7

Description of Procedures and Definitions 7

Rates and Types of status offenses and delinquency cases in the United States 9

## CHAPTER 2

Theoretical Framework and Review of the Literature 15

Theoretical Framework 15

Analysis of Systems and Social Learning Theories 27

Implications for policy and practice 31

Review of the literature 33

Community Violence 33

Parenting and Family Disruption 38

The Generational Factor 40

Physical and Sexual Abuse 42
Peer Interaction and Bullying

Drug Use

Mental and General Health Problems

Education and Training

Special education and detention services

CHAPTER 3 AND 4

Research Questions and Methodology

Research Questions

Methodology

Sample

Instruments

Statistical Analyses

Protection of Human Subjects

Results

Question 1: What are the personal characteristics of youthful offenders referred by the courts for mental health/behavioral disorders?

Question 2: What social problems did youthful offenders referred by the courts for mental health/behavioral disorders experience?

Question 3: What psychological and psycho-affective/ cognitive problems are experienced by youthful offenders referred by the courts for mental health/behavioral disorders?

Question 4: What are the family functioning and structure of youthful offenders referred by the courts for mental health/behavioral disorders?
CHAPTER 5

Overview of Findings 112

Discussion 116

Implications 134

Implications for practice 134

Implication for Policy 140

Implications for research 144

Limits of this study 144

Future Research 144

Conclusion 146

APPENDICES

Appendix A: Definitions and recording of the variables 147

Appendix B: List of instruments 165

Appendix C: commenting results of crosstabulations of disorders 166

Appendix D: Program overview: Lorain County 169

REFERENCES 170
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Number</th>
<th>Table title</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Areas contributing to the risk for future criminal activity</td>
<td>73</td>
</tr>
<tr>
<td>Table 2</td>
<td>Key events precipitating youths’ behavior change or incarceration</td>
<td>74</td>
</tr>
<tr>
<td>Table 3</td>
<td>Participants’ number of incarcerations</td>
<td>75</td>
</tr>
<tr>
<td>Table 4</td>
<td>Participants’ number of legal problems</td>
<td>76</td>
</tr>
<tr>
<td>Table 5</td>
<td>Cross-tabulations of key variables</td>
<td>77</td>
</tr>
<tr>
<td>Table 6</td>
<td>Results cross-tabulation: suicidal gestures and suicidal threats</td>
<td>79</td>
</tr>
<tr>
<td>Table 7</td>
<td>Results cross-tabulation suicidal attempts, suicidal gestures and suicidal threats</td>
<td>80</td>
</tr>
<tr>
<td>Table 8</td>
<td>Types of interactions with peers</td>
<td>82</td>
</tr>
<tr>
<td>Table 9</td>
<td>Types of interactions with siblings</td>
<td>82</td>
</tr>
<tr>
<td>Table 10</td>
<td>Youth witnessing or victims of domestic violence between parents</td>
<td>84</td>
</tr>
<tr>
<td>Table 11</td>
<td>Youth perpetrators of domestic violence</td>
<td>85</td>
</tr>
<tr>
<td>Table 12</td>
<td>Results cross-tabulation: gender, sexual and physical abuse victims</td>
<td>86</td>
</tr>
<tr>
<td>Table 13</td>
<td>Results cross-tabulation gender, sex abuse victims, and sex predators</td>
<td>87</td>
</tr>
<tr>
<td>Table 14</td>
<td>Results cross-tabulation attempted suicide, sexual abuse victims, physical abuse victims, victims of both sexual and physical abuse, and self mutilators</td>
<td>88</td>
</tr>
<tr>
<td>Table 15</td>
<td>Cross-tabulation gender, runaway, and removal from home</td>
<td>89</td>
</tr>
</tbody>
</table>
Table 16  Diagnoses on DSM IV Axis I  
Table 17  Diagnoses related to Learning Disorders  
Table 18  Crosstabulation: reading, math disorder, and disorder of the written expression  
Table 19  Intellectual quotient scores (IQ)  
Table 20  DSM IV:  V codes Problems  
Table 21  DSM Axis III: General medical conditions  
Table 22  GAF scores: current and highest in the past year  
Table 23  Cross-tabulation disorders, problems, sex abuse victims and sex predators  
Table 24  Reasons for home removal  
Table 25  Parents’ use of substances  
Table 26  Youth’s perception of the family system  
Table 27  Persons who influenced most the youth
LIST OF ABBREVIATIONS

ACT: anger control training
ADA: American with Disabilities Act
ADD: attention deficit disorder
ADHD: attention deficit hyperactivity disorder
AGIL: adaptation, goal attainment, integration, and latency
AP: antisocial potential
ART: aggression replacement training
BJCB: Bellefaire Jewish Children’s Bureau
BJS: Bureau of Justice Statistics
BOTH: both physical and sexual abuse
BSPAV: both sex and physical abuse victim
CCJC: Cuyahoga County Juvenile Court
CCJDC: Cuyahoga County Juvenile Detention Center
CCMHI: Cuyahoga County Mental Health Institute
CD: conduct disorder
CDC: Center for Disease Control
CWRU: Case Western Reserve University
DIR: Disposition Investigation Report
DMC: disproportionate minority confinement
DSM IV: Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition
ED: emotionally disturbed
EDJJ: Education, Disability and Juvenile Justice (The National Center on)
EMR: Educable mentally retarded
EPQ: Eysencks Personality Questionnaire
FAS: Fetal alcohol syndrome
FAST: Family System Test
FERPA: Family Educational Rights and Privacy Act
FFCMH: Federation of Families for Children’s Mental Health
GAF: Global Assessment Functioning
G1, G2, G3: generation 1, 2, 3
HIV: Human immunodeficiency virus
ICAP: Integrated cognitive antisocial potential
IDDT: Integrated Dual Disorder Treatment
IDEA: Individuals with Disabilities Education Act
IEP: Individualized education program
IQ: Intelligence quotient
IRB: Institutional Review Board
ISPV: Institute for the Study and Prevention of Violence
JD: Juvenile delinquents
J.J.B: Juvenile Justice Bulletin
J.J.J: Juvenile Justice Journal
JMHCt: Juvenile Mental Health Courts
LD: Learning disabled
MACI: Millon Adolescent Clinical Inventory
MAPI: Millon Adolescent Personality Inventory
MRDD: Mental retardation developmental disorder
MSASS: Mandel School of Applied Social Sciences
NASW: National Association of Social Workers
NCMHJJ: National Center for Mental Health and Juvenile Justice
NCVS: National Crime Victimization Survey
NIDA: National Institute on Drug abuse
NLSY: National Longitudinal Survey of Youths
NMHA: National Mental Health Association
NOS: Not otherwise Specified
NSDUH: National Survey on Drug Use and Health
NSPAV: Neither sexual nor physical abuse victim
NVSS: National Vital Statistics System
OCJS: Office of Criminal Justice Services
ODJFS: Ohio Department of Job and Family Services
ODMH: Ohio Department of Mental Health
ODYS: Ohio Department of Youth Services
OJJDP: Office of Juvenile Justice and Delinquency Prevention
OYPFS: Ohio Youth Problem, Functioning, and Satisfaction Scales
PAO: physical abuse only
PAVO: physical abuse victim only
PESQ: Personal Experience Screening Questionnaire
PTSD: Post-traumatic syndrome disorder
SAMHSA: Substance Abuse and Mental Health Services Administration
SAMI-CCOE: Substance Abuse and Mental Illness-Coordinating Center of Excellence.

SAO: sexual abuse only

SAVO: sex abuse victim only

SED: serious emotional disturbance

S-O-R: stimulus- organism- response

SPAV: sex and/or physical abuse

S-R: stimulus-response

TSC-C: Trauma Symptom Checklist for Children

WAIS-III: Wechsler Adult Intelligence scale-III

WIAT: Wechsler Individual Achievement Test-Screener

WISC-III: Wechsler Intelligence Scale for Children, 3rd edition-Short Form

WISC-R: Wechsler Intelligence Scale for Children revised version

YLS/CMI: Youth Level of Service/Case Management Inventory
ACKNOWLEDGEMENTS

I am taking this opportunity to formally thank the many people and organizations that have, in one way or another, contributed to my completing this doctoral program.

- The Government of Senegal for allowing me to attend the program at Cases Western Reserve University and the Mandel School of Applied Social Science (MSASS) for accepting my application.
- The Cuyahoga County Mental Health Institute (CCMHI): a joint program between the Mandel School of Applied Social Science and the Cuyahoga County Board of Mental Health for granting me a fellowship in 2000.
- Grace F. Brody Institute for Parent-child Studies for providing financial support to complete my dissertation.
- The Institute for the Study and Prevention of Violence (ISPV) at Kent State University in particular Daniel Flannery, Ph.D., Laura Buckeye, M.P.H., Kelly L. Wester, Ph.D. and Mark I. Singer, Ph.D., at the Mandel School of Applied Social Sciences who conducted the study that provided this research data.
- The Cuyahoga County Juvenile Detention Center (CCJDC), the Cuyahoga County Juvenile Court (CCJC), for contributing to my curriculum practice as a detention officer.
- The Gestalt Institute of Cleveland for enhancing my intervener’s skills in practice.

Please, find in these few lines my appreciation of your contribution to this work.

- The Cleveland International Program which brought me in Cleveland and the Myer, Horning, Doll, and Farr families that hosted me and introduced me to the American life.
Psychosocial Characteristics of Violent Juvenile Offenders with Serious Mental/Behavioral Disorders

ABSTRACT

by

Mamadou Mansor Seck

According to the literature and professionals in the field, incarcerated youths with mental and behavior disorders are overrepresented in juvenile correctional institutions. In 2002, every day over 110,000 youths under the age of 18 were arrested and resided in detention and correctional facilities; among them between 65 and 100% had a diagnosable mental disorder and approximately 20% had a serious mental health disorder. More and more individuals and organizations are becoming aware of this overrepresentation and lack of appropriate services to these youths with special needs. Many of them are not identified as such before and during their involvement with the juvenile justice system and therefore their sentencing and service provision are inadequate. As an exploratory research, this study aims at identifying personal, social, psychological, and psycho-affective/cognitive characteristics as well as the family structure and functioning of 88 violent youth offenders referred by the court for psychological evaluation for mental health/behavioral disorders. The early identification of this population by juvenile justice professionals will impact their sentencing and conditions of incarceration because it may contribute to a stronger knowledge of their psychosocial characteristics, enhance professionals and policy makers’ awareness and understanding of these youths’ needs, and finally, improve the provision of services.
Chapter 1

Problem Statement

Juvenile courts’ philosophy favoring treatment strategies that meet offenders’ needs for treatment over punitive strategies derives from the “parens patriae” philosophy (Snyder & Sickmund, 2006). Proponents of this philosophy postulate that juvenile courts have the responsibility to act in place of a child’s parents when they are considered unable to provide appropriate care and supervision to their child. This philosophy has led the court to commit youthful offenders to treatment programs that meet their needs and to divert those who committed their first time offense from progressive involvement in the criminal justice system. The emergence of juvenile courts in the United States was a result of a paradigm shift, as the courts started treating juveniles differently by trying them as children not adults. Contributing to this shift were Dr Philippe (Claparede, 1931) as well as many other psychologists and educators such as Jean Jacques Rousseau, and Alain who supported that children were not adults with reduced sizes but adults in becoming, launching a new trend in child psychology that considered children as individuals whose body and mind were in the process of maturation, and their intellectual potentials still in the making even though developmental delays and disorders could alter them and hamper their expected performance. As the system of juvenile courts evolves, its actions reflect more and more this new trend which considers children as different from adults. According to the National Center for Mental Health and Juvenile Justice (NCMHJJ, 2005), 2.3 million youths under the age of 18 were arrested in 2002 and every day over 110,000 youths were dwelling in juvenile detention and correctional facilities.
across the United States; among these youths, the NCMHJJ reported that 65 to 100% had a diagnosable mental disorder, and approximately 20% had a serious mental health disorder. Ballard (2000) stated that a significant number of youths who committed violent crimes and who were incarcerated in juvenile justice institutions had moderate to severe mental and emotional disorders. The rate of serious emotional disturbance among youths in the general population of the United States was estimated at 9 to 13% (OJJDP, 2000). Researchers found that nearly two thirds of boys and 75% of girls in juvenile detention had at least one psychiatric disorder showing that psychiatric disorders were common among detained youths (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Previously, in a report on youth offenders aged 12 to 18 years in juvenile prisons, the Bureau of Justice Statistics (BJS, 1997) noted that 90% of the incarcerated youths had substance abuse problems with marijuana, crack, heroin and/or alcohol; 30% had mental disorders; 5% were homeless; almost 25% had their own children; 6 to 10% lived with single mothers; 8 out of 15 came from a household with income below $10,000 per year.

For these youths with special needs, many assessment and treatment programs such as Multisystemic Therapy programs (Hengeler, 2000) have been initiated to assist the court in accomplishing its mission. In addition, diversion programs are being carried out in collaboration with juvenile courts whose mission is deemed difficult to fulfill because many juvenile offenders experience psychosocial and educational problems (Brown, Borduin, & Henggeler, 2001), psychological trauma including depression, post-traumatic stress disorder (PTSD), anxiety, anger, dissociation, and sexual problems (Burton, Foy, Bwanausi, Johnson, & Moore, 1994; Singer, Slovak, Frierson, & York, 1998; Spilsbury et al., in print).
The increasing awareness of mental health problems among youths, particularly among those in the juvenile system has contributed to the emergence of a large number of organizations promoting children’s mental health care. Organizations such as the Federation of Families for Children’s Mental Health (FFCMH), the National Mental Health Association (NMHA), and the National Association of Social Workers (NASW) celebrate every year the Children Mental Health Awareness Day by carrying out activities aiming to raise people’s knowledge about children’s mental health and to eliminate stigma about mental health that still continues within many communities. The NCMHJJ was created to raise people’s awareness of the mental health needs of youths in contact with the juvenile justice system. Furthermore, many states including Ohio, Florida, and California created Juvenile Mental Health Courts (JMHCt) with the specific goal of serving areas youth offenders with mental health needs (NCMHJJ, 2005).

Despite these actions, and the general public’s increasing awareness of the prevalence of mental health issues in the juvenile system, there is limited research that focuses on juvenile offenders to explain the offending behavior and to describe unmet needs for mental health services. A better understanding of these youths’ conditions would ease the increasing public concern about the rise of the number of violent crimes committed by children under eighteen; this public reaction is one of the leading factors contributing to raise the need for changing the law regarding indictment, conviction, and incarceration of juveniles (Ghetti & Redlich, 2001). The Bureau of Justice Statistics (BJS, 1997), in its mid-decade status report, notes that between 1984 and 1993, violent crimes significantly increased. During that period, “arrests on people under age 18 for murder and non-negligent manslaughter increased by 168 %, arrests for aggravated
assault increased by 98 %. Arrests for forcible rape increased by 9 %, arrests for other
assault increased by 112 %, and arrests for weapons possession rose by 126 %” (BJS,
1997, p. 4). Further, it is reported that, in 1994, 20 % of all arrests for violent crimes and
35 % of all arrests for property crimes were made on persons under the age of 18 years
(Brown et al, 2001, p. 445). Besides, more and more youths are tried as adults in
criminal courts because of the violence and type of crime committed (OJJDP, 1999;
Ghetti & Redlich, 2001). This trend reinforces the BJS report that in the period 1988
through 1992, juvenile court judges waived 1.6 % of formal delinquency filings to adult
court and that the number of juvenile cases filed directly in criminal courts range from
less than 1 % to 13 %. Due to this trend, the BJS predicts that juvenile arrests will rise 22
% between now (1997) and the year 2010. This somber prediction of the BJS was not
supported by the 2005 report on the results of the National Crime Victimization Survey
(NCVS); in this report, the BJS notes that the number of victimizations by violent crime
per 1000 teenagers dropped from about 130 victimizations in 1993 to about 60 in 2003,
and that the average annual rates of violent crime from 1993-1995 to 2001-2003 declined
for all age groups across all types of crime measured, but the strongest declines were
among younger teens12-14 year old. This report emphasizes the decline of the rates of
robbery, aggravated assault and simple assault between 1995 and 2003 (Snyder &
Sickmund, 2006).

The NCMHJJ (2005) acknowledges that there is a growing awareness of mental
health disorders among youths in the general population, that more and more treatment
and prevention programs are being implemented, and progressive actions are being
initiated within the juvenile justice system to meet the needs of youth offenders, curb
recidivism rates, and divert first time offenders into structured organizations that turn them into law-abiding individuals. Despite all these actions to address the prevalence of mental health problems among youths in the juvenile justice system, surprisingly, no in-depth studies using psychological reports specifically focused on this particular population of violent juveniles with mental and behavioral problems is conducted. This gap in the literature can be attributed to difficulties related to sampling, data collection, and access to the incarcerated offenders but also to the overlap of mental health problems with other problem behaviors such as substance abuse, gang membership, and various disorders. It is clear that a considerable number of youths in the juvenile justice system have complex psychosocial problems that influence their illegal behaviors. For a significant subset of these youths, the illegal behaviors are violent and sometimes lethal. Yet, very little is known about the mental health status/backgrounds of violent juveniles. This current research will contribute to fill the gap in the literature on juvenile offenders with mental and behavioral problems.

As part of an Ohio Department of Mental Health grant to the Institute for the Study and Prevention of Violence at Kent State University, an opportunity has been afforded to investigate a sample of juveniles referred for mental health evaluation due to their violent behaviors. According to the final report on the Program Evaluation for Mental Health Services to Juvenile Offenders (Flannery, Buckeye, Wester, & Singer, 2003) the goals of these pilot projects were to: "1) Improve the system’s knowledge regarding the profiles of these youths; 2) Improve the system’s ability to divert appropriate youths to the mental health system for treatment; 3) Provide jurists with alternatives to ODYS commitment; and 4) Demonstrate effectiveness of community
based interventions" (p. 2). These goals reflect the conviction of professionals in the field and in institutions that despite their histories of aggressive tendencies and offending behaviors, these youths deserve protection, support and particularly medical, psychiatric and counseling services. Aware of the lack of adequate support systems, efficient care, and appropriate services within juvenile institutions, the Ohio Departments of Mental Health, Youth Services, Job and Family Services, and the Office of Criminal Justice Services, in accordance with Juvenile Courts’ philosophy, set forth these projects; for each project these organizations had to "(1) secure treatment beds for offending mentally ill youths; (2) enhance the local continuum of care for this population; and (3) increase collaboration among key systems and agencies in the provision of culturally competent and gender specific services" (Flannery et al., 2003). For this study, the sample used is exclusively composed of youths from Lorain County (Appendix D); they received in-depth psychological evaluations which included information from families, family and child welfare systems, schools, court records and other sources to inform the evaluation. Data from these evaluations will be used to study the history and profiles of violent juveniles referred for mental health evaluations and to examine potential commonalities and psychosocial correlates within this population.
Background Information

Description of Procedures and Definitions

The OJJDP in its 2006 National Report (Snyder, & Sickmund, 2006) describes status offense and delinquency cases handled by U.S juvenile courts between 1994 and 2004. The authors acknowledge that case processing of juvenile law violators varies from state to state, and even within states, case processing may vary from one community to another. It provides a general outline of juvenile court procedures, and presents various categories of crimes committed by youths referred to this institution. When law enforcement officials refer youths to juvenile courts, the intake offices within the courts proceed with a screening of each case. Intake officers have three options. One is to dismiss the case if they do not find legal sufficiency to warrant a decision by a judge; another option is to informally resolve the matter; consequently, they may opt for voluntary referrals to social service agencies, an informal probation, or payment of a fine or some form of voluntary restitution. The third option for the officers is to formally resolve the case by filing a petition; therefore, they schedule the case for a waiver or an adjudicatory hearing. A waiver hearing is scheduled if they file a petition asking the judge to waive jurisdiction over the case because there is legal sufficiency to have the case removed from juvenile court and handled in criminal (adult) court. If intake officers file a petition for an adjudicatory hearing or trial, the validity of the allegations is to be determined in court. If the allegations are sustained, the court proceeds to the disposition stage and indicates who will have custody of the child and under what circumstances as the youth involved is adjudicated status offender or delinquent for law violations.
Status offenses are “behaviors that are law violations only if committed by a person of juvenile status” (Snyder, & Sickmund, 2006); these acts, illegal only because the person committing them is of juvenile status vary from running away from home, ungovernability (being over the control of the parents or guardians), truancy and under age drinking, curfew violations, to tobacco offenses. Judges may decide to place a status offender either on probation or out of home placement. Only juveniles, individuals under the age of 18 years may be adjudicated status offenders. The OJJDP defines a delinquency offense as an offense for which an adult could be prosecuted in criminal court. Delinquent cases involve acts or conducts committed by juveniles in violation of criminal law. Cases of delinquency include four (4) categories of crimes: crimes against persons, crimes against property, drug law violations and other offenses against public order.

- Crimes against persons include criminal homicide, defined as causing the death of another person without legal justification or excuse; forcible rape defined as sexual intercourse or attempted sexual intercourse with female against her will by force, or threat of force; robbery seen as the unlawful taking of property that is in the immediate possession of another by force or threat of force; also aggravated assault, defined as the unlawful intentional infliction of injury upon the person of another; and finally other offenses against or person including kidnapping, violent sex acts other than forcible rape (incest, sodomy), custody interference, unlawful restraint, false imprisonment, reckless endangerment, harassment, and attempts to commit any such acts.
• The second category, crimes against property, includes burglary, larceny theft, motor vehicle theft, arson, vandalism, stolen property offenses, trespassing, and others such as extortion, and all fraud offenses.

• Drug law violations, the third category, include unlawful sale, distribution, purchase, manufacture, cultivation, transport, possession, or use of a controlled or prohibited substance or drug paraphernalia, or attempts to commit these acts.

• The fourth category, offenses against public order, relates for example to weapon offenses; nonviolent sex offenses; liquor law violations, not status; disorderly conduct; obstruction of justice; and other such as games bribery, and gambling.

Law enforcement agencies, social service agencies, victims, probation officers, schools or parents refer status offense and delinquency cases to juvenile courts.

Rates and Types of status offenses and delinquency cases in the United States

Snyder, and Sickmund noted in the 2006 OJJDP National Report that with the data available they could not provide national estimates of the trends and volume of petitioned status offenses (formal cases). Consequently they present sample based profiles of cases by showing that between 1985 and 2002, of all status offenses cases reported, 34% were truancy violations, 30% liquor law violations, 19% running away, and 17% ungovernability. Regarding delinquency cases, Snyder, and Sickmund, reported that in 2002, the courts handled more than 1.6 million delinquency cases; that is 4,400 cases of delinquency processed a day. This number showed an increase of 41% in delinquency cases from 1985 to 2002. These authors showed that law enforcement agencies referred 82% of these cases, specifically: 87% of the 387,500 person offense cases, 91% of the
624,900 property offense cases, 90% of the 193,200 drug offense cases, and 61% of the 409,800 public offense cases. Based on the gender factor, Snyder, and Sickmund noted the rise in the proportion of females entering the juvenile system, showing that in 1980, 20% of all juvenile arrests were female arrests and in 2003 the percentage increased to 29% of all 2.2 million arrests of persons under age 18. On the juvenile violent crime arrest rate a 47% increase in the female rate was noted in 2003. On Violent Crime Index offenses, female rates increased from 10% to 18% between 1980 and 2003; this change stemmed from the increase in the female proportion of juvenile arrests for aggravated assault from 15% to 24%, and in arrest cases for simple assault from 21% to 32%. For property crime index offenses during the same period (1980-2003), female rates increased from 19% to 32%; for drug violations, the rate (16%) did not change. Based on the ethnicity factor, Snyder and Sickmund reported that between 1988 and 1994, all racial groups experienced increases in their juvenile Violent Crimes Index arrest rates but between 1994 and 2003, large declines occurred. They observed that in 2002, whites, blacks and other races respectively made up 78%, 16%, and 6% of the juvenile population and that a disproportionate number of delinquency cases involved black juveniles. Whites represented 67% of the delinquency cases; blacks and other races respectively constituted 29% (or 473,100) and 3% of the delinquency caseload. The racial profile of delinquency cases in 2002 shows that of person offenses whites committed 60%, blacks 37% and others 3%; on property offenses whites accounted for 68%, blacks 28% and others 4%; on drug offenses whites reported for 76%, blacks 21% and other races 3%; and for public order offenses 68% of the delinquency case were committed by whites, 29% by blacks, and 3% by other races. The offense profile of
delinquency cases for each race in 2002 shows that whites committed 22% person offenses, 39% property offenses, 13% drug offenses and 26% public order offenses. Blacks committed 30% person offenses, 36% property offenses, 9% drug offenses, and 25% public order offenses. For the other races, the rates on each of these offenses were respectively 22%, 45%, 10% and 23%.

In 2002, the teenage birth rate for older juveniles (15-17 year old) was 23.2 live births for every 1,000 women. Based on the race factor, the rates were 13.1% for White non-Hispanic, 41% for Black non-Hispanic, and 50.7 for Hispanic. Acknowledging that family structure is related to juveniles’ problem behaviors, Snyder and Sickmund reports that in 2002, about 7 of every 10 children lived with married parents and 3% of children lived in household headed by other relatives, with about three of every 5 of these children living with a grand parent. They noted also that across all household types, 8% of the children lived in households that included a grand parent. After recognizing the link between educational failure and law-violating behavior, they reported that 4.8% of the children enrolled in high school in October 1999 left school before October 2000 without successfully completing a high school program. This rate represents about 488,000 drop out for the school year.

Regarding victimization of children, Snyder and Sickmund noted that in 2002 homicide was the third leading cause of death for juveniles ages 12-17, with the more common cause of death being unintentional injury and suicide; on average four juveniles were murdered daily in the U.S. and 3 of every 4 murder victims ages 15-17 were killed with a firearm. Considering only murders in 2002 for which the offender was known, Snyder and Sickmund reported that a stranger killed 4% of the murdered children under
age 6, while parents killed 61%, other family members 7%, and acquaintances 28%.

They stated that older juveniles were far more likely to be murdered by non-family
members as 5% of the victims, ages 15-17, were killed by parents, 5% by other family
members, 32% by strangers, and 58% by acquaintances; they suggested also that youths
in single-parent families experienced a 50% greater risk of violence than youths in two-
parent families and that they were more likely to be the victim of a violent crime if they
lived in disadvantaged communities with high percentages of persons living in poverty,
single parent families with children, unemployment, and households receiving public
assistance. Snyder and Sickmund, using the National Vital Statistics System (NVSS)
provided information on suicide rates in the U.S.; they indicated that 23,900 juveniles
ages 7-17 died by suicide between 1981 and 2001. For this population, suicide was the
fourth leading cause of death over this period and 79% of all suicide victims were males.

After noting that crime against juveniles fell substantially between 1992 and 2001 both in
and out of school, the report’s authors showed that juveniles’ risk of victimization varies
over a 24-hour period; they were 140% more likely to be victimized between 3 and 4
p.m. on school days than in the same time period on weekends and the summer months.
On school days, juveniles were over 90% more likely to be violently victimized in the 4
hours between 3 and 7 p.m. than they were in the 4 hours between 8 pm and midnight;
the risk of violent juvenile victimization was deemed 60% greater in the 4 hours after
school than in the 8 p.m. to midnight period on nonschool days.

Snyder and Sickmund provided information on the characteristics of the youths who
ran away or were thrown away from home. They stated that teens ages 15-17 accounted
for 68% of the estimated 1.7 million youths in 1999 who were gone from their homes
either because they had run away or because their caretakers threw them out. Among them 4% were aged 7-11, 28% were 12-14, and 68% were 15-17; regarding their gender, 50% were male; and racially the larger group was composed of white not Hispanic (57%). Estimating placements of children in foster care, Snyder and Sickmund showed that in 2002, children ages 11-15 made up the largest share (29%) of foster care entries but 14% were younger than 1 year; 25% were 1-5; 22% were 6-10; and 11% were 16-18. In 2003, an estimated 297,000 children entered foster care raising the total number of youths’ placements in foster care to 523,000 on September 30, 2003 (data are reported every 12 months as of this date). The number of children adopted in 2003, reached 49,000 youths who exited the public foster care.

Snyder and Sickmund tried to develop a portrait of juvenile law-violating behaviors detailing that 8% of 17 year-olds reported ever belonging to a gang, 16% sold drugs, and 16% carried handgun; about ¼ of juveniles who offended at age 16-17 also offended at ages 18-19. Based on the results of the National Survey on Drug Use and Health (NSDUH), the Substance Abuse and Mental Health Services Administration (SAMHSA, 2002) reveals that among youths aged 12 to 17, 11.6% were current drug users, and the prevalence of current alcohol use increased with increasing age in 2002, from 2.0% at age 12 to 36.2% at age 17. The use of cocaine increased from 2.3 to 2.7% among youths aged 12 to 17 who had ever used this drug. Rates of cigarette smoking in this age category, has increased steadily by year from 1.7% at age 12 to 28.1% at age 17. Regarding marijuana use, there was a decline (21.9 to 20.6%) from 2001 to 2002. Heroin use among youths 12-17 increased from 0.1 to 0.4%; meanwhile a decline in the prevalence of lifetime hallucinogen use was estimated from 6.1 in 2001 to 5.7% in 2002.
The extent of drug use among youths aged 12 to 17 may be assessed through the large number of children (4.8 million) who received treatment or counseling for emotional or behavioral problems in 2002.

With Snyder and Sickmund’s report, other findings of the Bureau of Justice Statistics (BJS) from the National Longitudinal Survey of Youths (NLSY), the Center for Disease Control (CDC), information from the National Institute on Drug abuse (NIDA) and the Substance Abuse and Mental Health Service Administration (SAMHSA), law violating behaviors, circumstances of their occurrences and the characteristics and portraits of youth offenders are described. The current study aims at determining the personal, social, psychological, and psychiatric characteristics as well as the family structure and functioning of a particular subset of youth offenders; these are not only violent offenders but they are diagnosed with mental and behavioral problems as well.
Chapter 2: Theoretical Framework and Review of the Literature

Theoretical Framework

Historically, numerous theories of delinquency have been set forth and explored. According to Shoemaker (1984), demonology was an early model that viewed criminality and delinquent behavior as caused by demonic possession. He states that this view “could be traced to primitive societies [but] still maintains some popularity today among laypersons” (p.4). He asserts that proponents of more observable causal explanations of delinquency argue that criminal behavior is caused by factors that can be empirically identified since such factors always precede the effect (Shoemaker, 1984). Considering these factors as biological in nature, some theorists provide biological explanations of delinquency. They support that “The criminal’s mind is affected by biological composition” (Shoemaker, 1984, p.13).

Shoemaker (1984) reported that Cesare Lombroso, an early proponent of the biological model, viewed criminality as a type of degeneracy and referred to some criminals as “‘atavists’ or throwback to an earlier form of human life on the evolutionary scale” (p. 16). He stated that Lombroso argued that “a large portion of criminal behavior was inborn” and believed that criminal characteristics included features such as “a large jaw, high cheekbones, handle-shape ears, and even tattoos” (p. 16). Another researcher, William Sheldon (1949), related specific body traits systematically with delinquency as he defined three basic body types: endomorphic, mesomorphic, and ectomorphic. The endomorphic type presents a “predominance of the vegetative system and a consequent tendency to put on fat easily” (p.15); individuals with this type of body are soft, round,
and fat; the mesomorphic type is that of individuals with muscular and hard body, with “chiefly bones, muscles and connective tissues” (p.15); and ectomorphic type with a little body mass and a “predominance of the skin” (p. 15) represents individuals with thin, frail, and weak body. Further, Sheldon believed that there was a link between inheritance and delinquency, claiming that “like tends to produce like” (p.771) suggesting that “behavior in general is determined by factors that are not only present at birth, but are transmitted, biologically, from parent to child” (Shoemaker, 1984, p.20).

According to Shoemaker, psychological theories explain criminality and delinquency based on the assumption that delinquent behavior is a manifestation of internal underlying disturbances that began to develop during childhood, and that these disturbances are mental deficiency, psychiatric problems and general personality configurations. Therefore even if biological characteristics are factors of delinquency, it is essentially the individual’s psychological abnormalities, such as low mental abilities, subconscious conflicts, and general personality traits that contribute to the individual’s delinquency (Shoemaker, 1984).

In contrast, social control theorists such as Hirschi (1969) argue that personality characteristics are not factors of delinquency. This author states that “delinquent acts result when an individual’s bond to society is weak or broken. Social bonds to conventional society are composed of four elements ‘attachment, commitment, involvement, and belief’” (p.16). He supports that each of these elements is related to delinquency and all of them are related to each other. When individuals experience a lack of attachment to others, a lack of commitment to conformity, do not get involved in conventional activities, and do not follow group’s rules, they are likely to become
deviants or delinquents. Gottfredson who collaborated with Hirshi stresses that in their relationship with others, all people “are motivated to pursue self-interest and that individual behavior is motivated by the pursuit of pleasure and avoidance of pain” (Gottfredson, 2005, p. 7). Meanwhile, he acknowledges that the unrestrained pursuit of these wants in everyday life inevitably leads to conflict with the wants and rights of others; and he recognizes that “controls are established by social groups (including parents, communities and states) to channel the pursuit of these wants in ways that minimize harm to others” (p.7). This proponent of Self-Control Theory supports that the legal system is the formal method of control set forth along with non-legal mechanisms, such as the approval, respect and affection of family, teachers, and friends, in order to help control unwanted behaviors. Further, he admits that controls may be referred as external, when they “need always be present in the environment to be effective” or self-control when “the process of socialization during the early years of life establishes a tendency to be concerned about others and about the long-term costs of behaviors” (Gottfredson 2005, p.8). Specifically, this author states that “self-control is the tendency to delay short-term personal gain for long-term personal and collective interests” (p.8); and infers that “those with lower levels of self-control are, all things equal, more likely than those with higher levels of self-control, to behave violently, to commit crime or to engage in delinquent acts … they also tend to have relatively high rates of school and employment failure and difficulty forming lasting interpersonal relationships” (p.8). He stresses delinquent acts committed “provide some immediate benefit for the actor (money, pleasure, the end of a troubling dispute), as do many other behaviors. But each also carries with it the possibility of harmful consequences to the actor or to others” (p.8).
These behaviors may lead society to label an individual as delinquent; when this happens the positive effects of certain social factors could be annihilated; and in doing so, society alters “a person’s self-image to the point where the person begins to identify himself as a delinquent and act accordingly” (Shoemaker, 1984, p.181). This idea supports one important assumption of labeling theory, which assumes that being formally labeled as a delinquent is a primary factor in the repetition of delinquency (Shoemaker, 1984).

According to social disorganization theory (Shaw & McKay, 1942), and anomie promoted by Durkheim (1951) and Merton (1968), “Disruption and instability in social structures and institutions [generate] uncertainty and confusion concerning appropriate behavior and connection between present conforming behavior and future rewards. This weakens the effectiveness of social structures and institutions as controls of delinquent behavior, [the ultimate consequence of this situation being] delinquency” (as cited in Shoemaker, 1984, p.72). Therefore, these theories assume that when a community’s institutional and formal means of social control are weakened, social disorganization may occur, leading to a rise in the delinquency rate. However, they fail to suggest any association between offending behavior and the consequences of traumatic life events, with the exception of psychological theories, which assume that violent behavior is due to underlying disturbances that develop during childhood. In fact, traumatic life events may lead youths to experience a variety of mental health and behavioral consequences (Eitle & Turner, 2002; Scarpa, 2001; Singer, Anglin, Song, & Langhofer, 1995). Further, these events are likely to occur within the youths’ home, neighborhood, or school, involving their parents, relatives, peers, and others. Therefore, it is necessary to more deeply explore theories that identify numerous environmental factors and how these factors
become internalized in relation to delinquent behaviors. Developing a theory to explain the origins of violent behavior over the lifespan, Farrington (2005) describes risk as well as protective factors for violence. According to this writer, these risk factors include biological, family, peer, socioeconomic, and neighborhood factors, situational, and effects of life events; as such, these factors may lead to committing violent offending behavior including homicide, assault, robbery, and rape. Farrington’s “Integrated Cognitive Antisocial Potential” (ICAP) defines violence as “behavior that is intended to cause, and that actually causes, physical or psychological injury” (p. 1). The key concept of this theory is antisocial potential (AP) which according to Farrington “refers to the potential to commit antisocial acts, including violence” (p.28). This author notes that long-term AP may be “high if people are exposed to and influenced by antisocial models, such as criminal parents, delinquent peers, for example in high crime schools and neighborhoods. Long-term AP will also be high for impulsive people, because they tend to act without thinking about the consequences” (p.29). The ICAP theory suggests “that long-term individual, family, peer, school, and neighborhood influences lead to the development of long-term, fairly stable, slowly changing differences between individuals in the potential for violence” (p. 28). It also suggests that “Generally, the probability of violence increases with the risk factors” (p.27). According to Farrington, this theory includes cognitive elements (perception, memory, decision-making) as well as the social learning and causal risk factor approaches. Analyzing situational factors, Farrington supports that the latter represent another set of influences which explain how the potential for violence becomes the actuality in any given situation as they explain “short-term within-individual differences: why a person is more likely to commit violence in some
situations than in others” (p.20). He suggests that “the convergence in time and place of a
motivated offender and a suitable target, in the absence of a capable guardian” is a
situational factor favoring the occurrence of predatory crimes such as robberies and
rapes. These concepts of situational and environmental factors are key constructs of
Systems theory (Robbins, Chatterjee, & Canda, 1998) and social learning theory
(Bandura, 1969) which help determine factors leading to delinquency and facilitate the
understanding of how internalization of environmental/social factors can have an impact
on offending behavior.

Robbins, et al., (1998) suggest that systems theories include four interrelated
theories: structural functionalism, ecological perspective, dynamic systems theory or
general systems theory developed as early as the 1920s by Bertalanffy, and deep ecology
coined by Naess (as cited in Robbins et al., 1998). Robbins et al. (1998) define systems
theories as a “group of theories based on the idea that human systems from the micro to
the macro, are intricately connected to one another and must be viewed holistically”
(p.25). Adding a social dimension to Bertalanffy’s general systems theory, Talcott
Parsons’ work (as cited in Turner, 1991) provides new dimensions to systems theory.
Parsons views individuals as actors who are oriented by their motives and values when
acting in the social system. What do these two “modes of orientation” mean? Turner
defines the concept of motives as “needs and readiness to mobilize energy” (p.56) and
argues that there are three types of motives: cognitive, cathectic and evaluative, which
fulfill respectively an individual’s need for information, for emotional attachment and for
assessment. The concept of value is defined as “conception about what is appropriate”
by Turner (1991, p. 56) who identifies three types of values: cognitive, appreciative, and
moral which allow the evaluation of individuals respectively in terms of objective standards, aesthetic standards, and absolute rightness and wrongness.

According to Parsons (as cited in Turner, 1991) social systems influence individual actors with the requirements of its role system and with cultural patterns that may “either fail to define a minimum of order or place impossible demands on people and thereby generate deviance and conflict” (p. 47). Systems theory is briefly summarized as follows: each social system (family, organization, society) is a combination of many personality systems (individuals) that are interdependent and complementary. Turner notes that in order to maintain homeostasis (stability and harmony), social systems integrate personality systems, using “mechanisms of socialization and mechanisms of social control” (p. 60). Each personality subsystem has its own specific and independent tasks and functions. Meanwhile, whenever one individual is deficient and does not function properly, the others may be affected and have to adjust to the new situation; if they don’t, the whole social system is affected. Social systems may be either open or closed. Open systems admit exchanges of energy across their boundaries (Turner, 1991) with their surrounding environment. This means that individuals may easily enter and leave the group, which takes in not only the energy they bring but matter and information as well; the group uses them to improve its quality. This new energy or information contributes to the adjustment of members and to the improvement of their behavior. Moreover, it reinforces the stability of the community whose control over potentially disruptive behavior may be increased. Closed systems do not easily allow an exchange between themselves and the surrounding environment. They do not easily accept a new
member, do not allow an exchange of energy across their boundaries, and do not provide feedback. The same patterns of behavior are observed from one generation to another. This continued pattern may contribute to weaken the systems’ functioning and therefore its ability to regulate the interrelationship of its components.

How does this theory explain violent offending behavior? How does it explain the association between serious violent offending behavior and mental/behavior disorders in children? Systems theory suggests that personality systems are integrated into social systems through different mechanisms of socialization and social control. Children integrate these various mechanisms of socialization, values, beliefs, language, and other symbols; also through interaction and communication processes, parents influence their children transmitting to them values and principles they integrate, contributing to the homeostasis of the family system. The integration of personality systems within the social system is not always successful since the mechanism may allow deviance and social change to occur.

Parsons and Bales (as cited in Robbins et al., 1954) identified several socialization and social control mechanisms that, when not functioning, can lead to violent offending behaviors. These four functions are adaptation, goal attainment, integration, and latency (the AGIL model). Deviance may occur when the adaptation process fails because the system cannot “cope with external demands by securing the necessary resources from the environment” (Robbins et al., 1998). For example, scarcity of resources due to financial constraints, decent housing, food, healthcare, and education in a community may lead to widespread and pervasive delinquent behaviors. Deviance may also occur because of the inability of the system to complete the goal attainment process since the system cannot
prioritize goals and mobilize the necessary resources to attain them. For example a lack of “social capital, source of assistance and exchange based on the strength of personal

ties characterized by mutual obligation and reciprocity, information, and norms and
effective sanctions” (Kowaleski-Jones, 2000, p. 451), may lead to more deviant acts in
the community. When the system is unable to facilitate the internal process of integration
by coordinating the interrelationships of the various units of the system, deviance may
occur. For example, social disorganization may be linked to adolescent problematic
behaviors (Shaw & McKay, 1942). Lastly, deviance may be observed when the latency
process by which a system maintains motivation and deals with internal tensions, is
ineffective. For example, when children’s victimization and abuse are common practices
in a family (OJJDP, 1997) and when children are exposed to violence as victims or
passive witnesses (Moses, 1999; Singer et al, 1995; Spilsbury et al., in press), they are
more likely to deal with internal tensions that may result in distress symptoms such as
depression, hostility, and other psychological trauma. Thus, an inadequate standard of
living, weak family and social supports, social disorganization, poverty, abuse and
victimization, can lead to weak controls and lay the groundwork for future violent
offending behavior, which may be associated with negative psychological effects in
children.

According to Robbins et al. (1998), social learning theory is the school of thought
that has best combined internal and external processes. They note that the main
proponents of this theory are Clark Hull, Miller and Dollard, and Bandura and Walters.
These authors indicate that Hull, Miller, and Dollard developed the concept of “stimulus-
organism- response” (S-O-R) from Pavlov’s concept of “stimulus-response” (S-R),
arguing that the organism is an intervening variable based on internal processes, that
influences the external, observable S-R. They state that Dollard and Miller suggest four
“fundamental factors that influence learning: drives, cues, responses, and rewards”
(p.329). Drives are defined either as innate or learned tendencies, and are related to
motivation. A cue is defined as “an environmental stimulus that serves as a signal when
a response (attitude) is rewarded or unrewarded (positively or negatively sanctioned)”
(Robbins et al., 1998, p. 329).

Bandura, another Social Learning theorist, agrees with behaviorists that “one’s
environment causes one’s behavior” and hypothesized that “environment causes behavior
but behavior causes environment as well” (as cited in Boeree, 1998, p.1). Bandura (1969)
defines social learning as a reciprocal influence process because “persons, far from being
ruled by an imposing environment, play an active role in constructing their own
reinforcement contingencies through their characteristic modes of response” (p. 46). In his
studies, Bandura added imagery to language. He developed two concepts: observational
learning, and self-regulation. Observational learning or modeling can be defined as a
process by which children learn from previously observed actions in order to perform acts
similar to the one they observed. This process involves different steps: attention, retention,
reproduction, motivation. In effect, in order to learn a behavior, the observer should pay
attention to the way the behavior is acted out because “Anything that puts a damper on
attention is going to decrease learning” (Boeree, 1998, p.2). Boeree (1998) suggests that
certain characteristics of the model contribute to raise the level of attention to the behavior
as individuals pay more attention to a behavior when the model is attractive, colorful,
prestigious, or competent. Robbins et al.(1998) reinforce this idea, saying that “children are
most likely to imitate models who they regard as prestigious, who receive social recognition and monetary rewards, or who are perceived as similar to themselves and are those of their same gender” (p. 333). They note also that children do not imitate models punished for their actions. Experimenting with a group of youths who watched a movie in which a clown was punched, Bandura found that when the youths met a clown after the movie, they started punching him as they had seen in the movie. Therefore, the genesis of youth offending behaviors may reside in their observing and imitating other individuals’ offending attitudes.

In addition, the concept of retention supposes that the observers are able to remember what they have seen in order to replicate it; they should be able to describe the image seen before reproducing it by imitation. The concept of motivation is a key factor in the learning process. The observers should be motivated to pay attention, retain, and reproduce the behavior. The observers’ motivation may be enhanced by a positive reinforcement while a negative motivation may be reason not to imitate someone’s action (Boeree, 1998). The other term developed by Bandura, self-regulation, can be defined as the aptitude to control one’s own behavior. According to Bandura, it involves three steps: self-observation, judgment, and self-response. The concept of self-observation supposes that the observers are able to have a precise image of their own behavior for the purpose of comparison with a norm or standard. The ability to compare refers to the ability to judge, which stems from an internal process. If observers’ judgment results in a positive performance then the individuals reward themselves; if the performance is poor, the individuals punish themselves. The reward and punishment are the observers’ self-responses to their performance. In gaining self-control, the youths may eliminate antisocial behaviors.
How does this theory define violent offending behavior? How does it explain the linkage between violent offending behavior and mental and behavioral problems? Bandura believes that “behavior is based on the interaction between internal and external influences and an appreciation of the role of symbolization in cognition” (Robbins et al., 1998, p. 331). Social Learning theorists would consequently support that offending behaviors are learned through observation of models who behave aggressively. When children are exposed to behaviors performed by significant others, parents, siblings, or people such as teachers, artists, or sports figures they admire and consider as role-models because of their competence and prestige, they have the tendency to imitate their behaviors both positive and negative. Concerning the negative behaviors, this happens particularly, when children value the anticipated consequences of the behaviors they see, for example, when sport figures receive large sums of money and are acclaimed even though they may be involved in such inappropriate behaviors as drug taking and violence. The judgment adolescents make, stemming from an internal cognitive processing of personal and environmental factors, leads either to socially accepted behaviors or to deviant behaviors, but the youths may choose to copy the deviant behaviors because of the perceived reward.

The association of offending behavior and serious mental/behavior disorders may be explained through the quest for self-reinforcement and the conditions under which the internal cognitive processing of personal and environmental factors takes place. According to Bandura “people regulate their behavior based on both external standards set by others as well as standards they set for themselves” (Robbins et al. 1998, p. 334). Robbins et al. support the idea that when people set standards for themselves and meet...
them, they reward themselves with self-reinforcement. When the standards are not met, they punish themselves by self-imposed negative feelings, such as guilt, shame, and low self esteem. These feelings may impede the internal cognitive processing of the personal and environmental determinants and then translate into anxiety, depression, anger, posttraumatic stress, or dissociation.

Analysis of Systems and Social Learning Theories

Systems and social learning theories both contain concepts that are theoretically and operationally defined in various studies (Shaw & Mckay, 1942; Kowaleski-Jones, 2000, Singer et al., 1995) which demonstrate the empirical testability of both theories. Concepts such as systems, personality systems, input, output, feedback, homeostasis, and interaction have been operationalized in studies using systems theory as a theoretical framework. Shaw and McKay (1942) reveal how community disorganization (systems) influences (input) individuals (personality systems) who may adopt criminal behavior in their interactions (output). These authors have also been able to find linkage between community characteristics such as residential stability, socioeconomic status, and juvenile violent behaviors. Kowaleski-Jones (2000) supports that “residential stability has strong protective effects on adolescents’ likelihood of taking risks” (p. 461) and that “living in a community with a higher proportion of high school dropout promotes risk taking attitudes and problem behavior” (p. 461). These two examples illustrate Parson’s concept of social system, “a plurality of individual actors, interacting with each other in a situation which has at least a physical or environmental aspect” (as cited in Ritzer, 1996, p.103) and its influencing factors are operationalized and measured in research.
Social Learning Theory also has adopted such constructs as modeling, motivation, self-regulation, that are operationally defined and used in different studies. For example, Singer et al. (1995) found how exposure to violence (modeling) may lead children to see (observation) learn (internal processing) and retain (retention) various types of violent behaviors (response) which are associated with psychological trauma.

Not only have systems and social learning theories generated authentic concepts that have been operationalized and measured, they also have allowed the development of theoretical statements, which have prompted a movement from a descriptive perspective to an analytical one. These two theories provide an explanation of violent offending behavior; systems theory has integrated the ecological perspective and is based on assumptions similar to those of social control, social disorganization, and anomie. Systems theory is applicable not only to micro level analysis but also to analysis at the meso, and macro level. This theory provides a framework for studying relationships between one individual and another, between individuals and groups, and between communities. The large scope of this theory enables researchers to study the etiology, development, and treatment of juvenile offending attitudes. Social learning theory also provides frameworks that may be used to study the causes, prevention, and treatment interventions with offenders, but its strength lies in its focus on individual level (micro) and to a lesser extent at the meso level between individuals and groups. For example, regarding the etiology of offending behavior, systems theorists argue that certain changes in the social environment may influence the youths and lead to offending behaviors; for example parents’ use of drugs may bring the extended family’s intervention, changing the family structure leading the children to more emotional damage and instability (Barnard,
2003). Social learning theory’s proponents stress that the lack of internal integration of community values may lead to delinquency. For example, running away from home is associated with problem behaviors (Mitchell, 2003).

When communities undergo changes such as when the small nuclear family becomes the reference instead of the extended family, grandparents and relatives’ responsibility over the supervision of the youths shifts to the parents who alone become responsible for their child’s supervision. This family structure offers fewer opportunities for positive reinforcement and adult supervision and may be detrimental to the child’s socialization. A study by Huey, Henggeler, Brondino, & Pickrel (2000) demonstrated that “changes in family relations and delinquent peer affiliation mediated the relationship between caregiver-rated and reductions in delinquent behavior” (p.451). Social learning theorists would predict offending behavior by using as independent variables concepts such as “exposure to violent movies” or “youths’ preference for action and fighting programs” (Singer, Slovak, Frierson, & York, 1998). These concepts would be operationalized as stimuli that are internally processed by the youths, who copy the violent behaviors they watch and adopt.

Proponents of systems theory and social learning theory explain delinquency in a simple but condensed way. Systems theorists may define delinquency as follows: when subsystems do not function appropriately, the system cannot maintain homeostasis. In other words, when the socialization process fails, the child is negatively influenced, and antisocial behaviors may occur. Bandura’s social learning theory can be summed up in two concepts: modeling and self-regulation. Through modeling, children who choose to observe negative behaviors may try to imitate the model they are offered. Thus they
learn offending behaviors by copying the model. If they cannot self-regulate or control their own attitudes, they may not be able to avoid disruptive, anti-social behaviors.

These theories provide adaptable frameworks that can be tested extensively. For example, Martin and Swartz-Kulstad (2000) use a version of systems theory entitled: person-environment psychology in order to assess factors influencing an individual’s life within the community and neighborhood; Moses (1999) uses this type of assessment based on systems principles to find a relationship between “exposure to violence and symptoms of depression. Social learning theory is based on learning principles that are used by many theorists who set up intervention programs for behavior modification such as aggression replacement training (ART), anger control training (ACT), moral education (Goldstein, Glick & Gibbs, 1998), and reality therapy (Glasser, 1965). These techniques based on social learning theory principles are replicated by social work clinicians, whose mission is to treat serious violent juvenile offenders placed in various settings.

As it has been noted previously, the two theories emphasize two different aspects that could affect violent offenders. Systems theory focuses on relationships among external conditions that can affect behaviors and is very useful to understand exogenous factors. In contrast, social learning theory emphasizes the internalizing of external conditions, experiences, and models. Both are therefore necessary to help explain offending behavior and are complimentary.
Implications for policy and practice

In the field of social work, the use of systems theory framework for the purpose of assessment or diagnosis is frequent (Martin & Swartz-Kulstad, 2000). In contrast, for treatment purpose, many programs are based on Social Learning Theory framework. The main implications drawn from the analysis of these two complementary theories is the use of an analytical framework drawn from an interlocking theoretical perspective (Turner, 1996) based on principles defined in both theories. This framework not only helps the researcher in discussing the results of this study but also in the field can contribute:

1) To strengthen mental health professionals and social workers’ ability to assess children who experience traumatic events in order to formulate and initiate primary, secondary, and tertiary prevention programs. They would be able to better serve their clients and to work with them before they commit serious violent offending behaviors (primary prevention), after they commit their first offense and become involved with the juvenile court system (secondary prevention), and if they become recidivists (tertiary prevention). For example, youth-serving professionals could conduct early diagnoses in order to prevent offending behavior among children who experience psychological symptomatology. Further, early diagnoses may impact juvenile court judges’ decisions to incarcerate or to send juvenile offenders to treatment facilities because these diagnoses would raise judges’ awareness of the social history and traumatic psychological experiences of the youthful offenders. An early diagnosis may encourage juvenile court administrative judges to provide more resources to Court Diagnostic and Psychology
Departments who would be able to screen all the youths involved with the court and assess their level of symptomatology.

2) To strengthen social workers’ ability for treatment using principles and methods based on both theories. The development of multisystemic therapy programs (Henggeler, 1997) illustrates this trend. Further, social workers apply increasingly behavior modification techniques, such as ART, ACT, moral reasoning strategies, and reality therapy techniques.

Both implications raise the need for valid and reliable assessment tools. In the field, many instruments have been already used either to assess families of delinquents (e.g. “Family Adaptability and Cohesion” by Olson, Tiesel, & Gorall, 1996), parents of offenders (e.g. “Juvenile Court Parent Questionnaire” by Rose, 2000), and offenders, few referred as standardized self-report measures. Among these self-report measures, the Trauma Symptom Checklist for Children (TSC-C) developed by John Briere (Singer et al., 1998) is used to evaluate children who have experienced traumatic events. For the present study, many others instruments have been used during the assessment of these children who experience multiple problems some of which have been addressed in the literature.
REVIEW OF THE LITERATURE

The following literature review focuses on factors that are associated with youths’ offending behaviors. Many of the studies indicate co-occurrence of problems, for example, mental health and substance abuse, and a high degree of correlation between various intra and extra personal factors of delinquency for example, gender and victimization or age and exposure to violence. These articles are sorted according to their themes so empirical findings in each area can be presented and compared. The selected themes vary from community and gang violence, exposure to violence in general and domestic violence in particular, parenting and family disruption, continuity in antisocial behavior across family generations, the relationship between physical and sexual abuse with delinquency and youths’ mental health problems. This review includes also studies on youth- peer interaction and bullying in schools and in prison, youths’ involvement with trafficking and abusing drugs, mental health disorders and education and training.

Community Violence

The OJJDP reports that in 1999, of all victims killed by juveniles, 2% were parents, 12% were other family members, 55% were acquaintances, and 31% were strangers; further, a firearm was involved in 53% of the murders committed by these youths (Snyder, 2001). The author of this report found that youths were most likely to kill persons of their own race, and that same race killing was most common for white youths (90%) and less common for blacks (77%), Asian/Pacific Islanders (59%), and American Indians (45%). The same trend was noted by Snyder and Sickmund (2006) who reported that in 2002, juvenile offenders were involved in an estimated 1,300 murders; 52% of the
murders were committed by juveniles who acted alone; family members accounted for 60% of the victims, acquaintances 47% and strangers 37%. Firearms were used in 69% of the 1,300 murders. The authors report that 82% of the victims of juvenile murderers were male, 51% were white, and 46% were black. These statistics show how violence may affect communities, and who may be the targets of violent actions. The use of firearms is also a factor of community violence. Research has shown that witnessing community violence is associated with criminal behavior, as well as a variety of behavioral, emotional, and cognitive-functioning problems (Edleson, 1999; Eitle and Turner, 2002; Scarpa, 2001, Spilsbury, et al., in press).

Eitle and Turner (2002) focused their study on the association between witnessing community violence and criminal behavior. They acknowledged that studies that examined the consequences of exposure to community violence identified elevated psychological distress, low self-esteem, a heightened risk for displaying trauma-related symptoms, lower social competence, and poor school performance. Meanwhile, these authors contended that this work presented many limits related to the failure to differentiate the effects of witnessing domestic violence from the effects of being abused, limits due to sampling methods, and those due to the use of mother’s reports of their child’s problems. These limitations taken into account, the authors examined the relationships between antisocial behavior and both witnessed community violence and hearing about the violent victimization of significant others; these associations are considered in the context of other forms of stress exposure (Eitle & Turner, 2002). They hypothesized that witnessing community violence is positively associated with young adult criminal behavior, independent of exposure to other stressors and of prior
deviance and peer criminality. Two dimensions of witnessed violence: witnessing community violence, and witnessing domestic violence were distinguished. For each of them, the researchers considered two counts: events witnessed during the past year (proximal violence) and those witnessed prior to the past year (distal violence).

Regarding domestic violence, the authors deemed necessary to know who was the victim of the physical or emotional abuse; was it the mother of the respondent or another close female relative? In addition to witnessing community and domestic violence as predictor of youths’ criminal behavior, Eitle and Turner included “receiving traumatic news” and “stressful recent life events” among their variables. They contended that in doing so, they were able to consider whether the actual witnessing of trauma is more potentially criminogenic than merely learning about a traumatic event occurring to a loved one. The analyses led to the conclusion that male respondents were much more likely than female respondents to report exposure to community and domestic violence; that blacks reported such experiences at much greater rates than other ethnic or racial groups and they were at a significant elevated risk; that experiences involving witnessing violence and those involving receiving traumatic news were significant predictors of criminal behavior. The authors also found that the prevalence rates for witnessing non-domestic violent victimizations in the community were substantially greater for male respondents than female respondents. Further the data supported that whether considered separately or in combination, both witnessing community violence and receiving traumatic news significantly predicted criminal behavior, whereas witnessing domestic violence did not. Regarding the consequences of domestic violence on children, other researchers (Spilsbury, et al., in press) raised the need for caution in attributing observed
child problems solely to witnessing violence, because they found that “child co-victimization (i.e., Child also assaulted/attacked during the domestic violence event) led to increased odds of that child reaching clinically significant levels of traumatic symptoms compared to children who witnessed the event but were not victimized.”

These authors hypothesized that specific characteristics of the violent act(s) would be associated with behavioral outcomes in children; that increased chronicity of violence, as well as the type of exposure to violence would be associated with greater behavior problems and symptoms of trauma in children; that boys would show more externalizing behaviors than girls and that younger children would exhibit greater traumatic symptoms or behavioral problems than older children and that children’s perception of the violent act would be associated with psychological symptoms. Spilsbury et al.’s results suggest that children who are directly victimized during domestic violence events should be differentiated from children who “only” witness these events because the consequences differ from one group to another. They found also that the frequency of the incidents, the child’s perceived control over the event, and the perceived threats to personal safety were associated with greater odds of clinically significant levels of several trauma symptoms including anxiety, depression, anger, PTSD, dissociation, and sexual concerns; and behavior problems in the case of perceived threats. These researchers’ resolution to differentiate children who witness from victims of domestic violence had been considered in previous research.

In effect, Scarpa (2001) made that differentiation between children who witnessed violence as direct victims and the passive witnesses of violence. This author noted that early research findings described the consequences of violence exposure on various age
groups. She noted that 6 to 10-year-old children who had experienced community violence as either a direct victim or a witness, showed higher ratings of psychological distress (i.e. a combined measure of depression, anxiety/intrusive thoughts, and sleep problems); that 6 to 12-year-old children could be classified as having “depressive symptoms reflecting clinical concern or a suspected diagnosis particularly including low self-esteem, depressed mood, morbid thoughts, and excessive weeping” or “increased distress, trauma-related symptomatology and sadness” (Scarpa, 2001, p.37). Then, the researcher reported her findings on the association between violence and antisocial behavior, as well as between violence and internalizing and externalizing behavior problems assessed both currently and at 2-year follow up. The author noted that a study of the prevalence and consequences of community violence exposure in a young adult sample would aid in the advancement of the literature. She argued that because only high-risk samples have been used in studies of community violence, high rates of victimization or witnessing have been reported; therefore, it may be expected that with low risk populations the rates should decrease. Consequently, Scarpa used a sample of 476 college students with a mean age of 20.26, and found that males obtained higher total scores than females on witnessing (M= 21.79 versus 13.38), and victimization (M= 8.31 versus 4.65). Males reported higher rates of witnessing someone being chased, threatened, hit by a non-family member, beaten/mugged, stabbed, shot, or wounded and being exposed to guns/knives as weapons, gunfire, and dead bodies. Males also reported higher rates of victimization as being chased, threatened, hit by a non-family member, beaten/mugged, stabbed, and shot. Females reported higher rates of sexual assault.
After defining prevalence of community violence exposure as “the percentage of respondents who reported (a) exposure to any item at least three times in their lifetime and (b) exposure to three or more different forms of violence in their lifetime” (p.44), Scarpa (2001) found that 95.6% of respondents reported witnessing and 82% being victimized by some form of violence at least once in their lifetime. This result enabled the author to distinguish two groups among witnesses (low –high) and two groups among victimized (low-high). The high victim group reported significantly greater levels of depression and aggression compared to the low-victim group; that on the aggression scale, the high victim group reported significantly more physical aggression, verbal aggression, and hostility. There were non-significant group differences for anger and anxiety. The high-witness group reported significantly greater levels of depression and aggression compared to the low- witness group; and within the aggression scale, the high-witness group reported significantly more physical aggression.

Parenting and Family Disruption

Researchers have found that disruptions to parenting and to family processes may contribute to juvenile delinquency (Radosh, 2002; Smith & Farrington, 2004; Stewart, Simons, Conger, & Ramella, 2002). Other findings suggest that the concentration of offenders in families, and family criminality could be used for predicting boys’ delinquency (Farrington, Jolliffe, Loeber, Stouthamer-Loeber, & Kalb, 2001).

The incarceration of both parents, particularly, that of the mother is a factor of parenting disruption. Radosh (2002) reported that in 1999, there were about 87,000 women incarcerated in the United States and estimates indicate that 80% of them had
dependent children at the time they were incarcerated. She noted that, in 1999 there were at least 126,100 children with jailed mothers and many more had fathers in prison; their incarceration affects children as it deprive them from the emotional attachment, and supervision they need from their parents.

Stewart et al (2002) contended that research had shown that unsupportive parents increase the probability of delinquency among their children. Empirical findings showed that children were at risk of developing antisocial patterns of behavior when exposed to ineffective parenting practices such as low supervision, rejection, and harsh and inconsistent discipline. Stewart et al. stated that this view led researchers to argue that children subjected to inadequate supervision and discipline were likely to manifest antisocial behavior and affiliate with deviant peers. The authors noted that the proponents of these theories failed to consider the reciprocal relationship between delinquency and parenting. Therefore, they deemed essential for their study to review Interactional Theory and Labeling Theory. The former suggests that there is a bidirectional relationship between parenting and delinquency, while the latter predicts that formal labels from social agents in the criminal justice system create stigmas and deviant identities, which increases the juvenile’s commitment to a delinquent career.

The authors’ analysis of empirical findings led them to hypothesize that legal sanctions would not only lead to subsequent delinquent behavior but also would function as an intervening variable that would mediate or explain the relationship between delinquent behavior and disruptions in parenting. They found that legal sanctions reduced the stability of delinquency by almost 31%, and poor parenting practices by 28%; legal sanctions also mediated the relationship between time 1 delinquency and poor parenting
practices at time 3. Poor parenting behavior continued to predict delinquency even after
the effects of legal sanctions were introduced in the equations. These findings suggest
that legal sanctions mediate the relationship between earlier delinquency and later poor
parenting behaviors and between parenting and later delinquency; in other words the
findings support both Interactional and labeling theories.

The Generational Factor

The concept of observational learning or modeling, developed by Bandura (1969),
refers to the process by which children learn from actions they observed first and later,
tried to perform. Parents or caretakers are children’s first models; thus parents/
caretakers’ antisocial behavior may impact children’s attitude. Moffitt (in press) points
out that “Environmental effects on children’s aggression have now been documented for
exposure to parents’ domestic violence, being reared by an antisocial father, being reared
by a depressed mother, being a recipient of maternal hostility, and being a victim of child
maltreatment” (p. 27). Other researchers have investigated the continuities in antisocial
behavior and parenting across family generations, concentration of offenders in families,
and family criminality in the prediction of boys’ delinquency, the extent to which
criminal relatives predict a boy’s delinquency (Farrington, Jolliffe, Loeber, Stouthamer-
Loeber, & Kalb, 2004; Smith & Farrington, 2004).

Studying the concentration of arrested persons in a sample of 1395 families,
Farrington et al. (2001) found for example that in 171 families with a total of 1104
members, there were 437 arrested persons; in another group of 475 families with
2702 members there were 741 arrested people. Another finding suggests that the number of arrested persons in a family was a predictor of a boy’s delinquency. These findings have been referred to by Smith and Farrington (2004), who studied the extent to which antisocial behavior in parents predicts antisocial behavior in children in two successive generations: the first generation, the grandparents referred to as “generation 1” (G1), the second generation, the parents’ as “generation 2” (G2), and the third, that of the grandchildren as “generation 3” (G3). The researchers hypothesized first that antisocial behavior of G1 leads to antisocial behavior in G2; that G1 antisocial behavior influences G2 behavior both directly and indirectly, via the quality of G1 parenting. They also predicted that G2 antisocial behavior leads to G3 antisocial behavior directly and also indirectly through G2’s parenting. The third hypothesis is that parenting attitudes and practices in G1 are directly related to the parenting delivered by their (male) G2 children. The authors considered two time periods: one for the parenting of G2 when they were around the age of 8 and one for the parenting of G3 aged 3 to 15 years.

To test their hypotheses, Smith and Farrington (2004) addressed the following four questions: to what extent does antisocial behavior in parents predict antisocial behavior in children in two successive generations? To what extent does antisocial behavior in childhood in one generation predict antisocial behavior in childhood in subsequent generations? Are parenting variables similarly related to child antisocial behavior in two successive generations? To what extent is parenting, particularly by fathers, a mediating mechanism for continuities in antisocial behavior across generations? Smith and Farrington found that there were intergenerational continuities in antisocial behavior. This means that “Antisocial behavior in G1, as assessed through official records of
convictions of both parents, is clearly a long-lasting risk factor for antisocial behavior in male G2 children” (Smith & Farrington, 2004); that both father and mother’s convictions were significantly related to having a child with a high level of troublesomeness; statistically, the prevalence of troublesome behavior in children of convicted G1 fathers was 36.5%, compared with 18.3% of children of non-convicted fathers; convicted mothers also predicted children’s antisocial behavior at young age: 48.6% of the convicted mothers had troublesome children, compared with 19.8% of children of non-convicted mothers. Regarding the role of parenting practices as a mediating mechanism between the antisocial behavior of parents and children, the researchers found that troublesomeness was more prevalent in homes marked by authoritarianism in fathers and mothers, poor supervision, low father involvement, inconsistency and partner conflict, compared with homes without these parenting problems. This finding suggests that at time 2, 41.5% of authoritarian G2 fathers had G3 children with conduct problems compared with only 24.8% of non-authoritarian G2 fathers; that authoritarian attitudes displayed by the G2 father’s female partner, as well as partner conflict, were also significantly related to having a G3 child with conduct problems.

Physical and Sexual Abuse

Child abuse, “The recurrent infliction of physical or emotional injury on a dependent minor, through intentional beatings, uncontrolled corporal punishment, persistent ridicule and degradation, or sexual abuse” (Barker, 1999, p. 70) and its consequences have different effects on children (Ackerman, Newton, McPherson, Jones,
& Dykman, 1998). Also, a linkage between its effects and violence among adolescents has been established (Benda & Corwyn 2002; Farmer & Pollock, 2003; Moses, 1999).

In a sample of sexually abused and abusing children, Farmer and Pollock (2003) found that half of the sexually abused youths had sexually abused another child at some stage, either when they were living at home or in one or more placements in care. These authors found that 90% of the sample had been victims of sexual abuse and 50% had acted out sexually abusive behavior (perpetrators); a diagnosis of mild to moderate learning disability was found in 28% of the participants. Farmer and Pollock (2003) noted that the most commonly reported type of abuse was full vaginal intercourse for the girls (67%) and for the boys, anal intercourse (33%) or masturbation of the child by the offender (33%). Among these children, 13% showed compulsive masturbation in public and 38% shown overt sexualized behavior to other children and/or adults. Further, the authors found that over 12% of the youths appeared to be involved in prostitution; also children, who reported more severe experience of sexual abuse, generated more professional and legal interventions than those who did not have that experience. These findings led Farmer and Pollock to recommend high level of supervision, effective sex education, modification of behaviors and therapeutic attention to the needs that underlay the behaviors.

Ackerman et al. (1998) studied the consequences of abuse on three groups of children who experienced sexual abuse only (SAO), physical abuse only (PAO) and both physical and sexual abuse (BOTH). Their review of the literature led them to acknowledge that many children who suffered extreme physical and/or psychological trauma from events such as wars, hurricanes, kidnapping, bombings, shootings and
sexual and physical abuse do not develop post-traumatic stress disorder (PTSD) or psychiatric disorders due to resiliency, but many others develop PTSD and other psychiatric disorders. They hypothesized that abused girls would exhibit relatively higher rates of internalizing disorders and abused boys would exhibit relatively higher rates of externalizing disorders. The researchers, using a sample of 204 children referred either for physical abuse only (PAO) or sexual abuse only (SAO) or physical and sexual abuse (BOTH) found for example that abused boys regardless of the type of abuse, had higher rates of behavioral disorders and abused girls had higher rates of two internalizing disorders: separation anxiety and phobic disorder; they found also that behavior disorders were more prevalent in BOTH and PAO children than in SAO; another finding was that there was a gender difference in the behavioral disorders with children reporting higher male rates for ADHD, oppositional defiant disorder, and conduct disorder. The perpetrators of these types of abuses knowing the law and the consequences of their actions may engage in concealing the facts through various means including emotional abuse with constant criticism, withholding love, bribing and threatening to harm and worse to kill not only the victim but also a loved one. Therefore, the victimization would either go one for a long period or end in a dramatic way with the kidnapping and murder of the victim in a short interval of time. This phenomenon raises researchers’ concerns about the extent of the exposure to violence and its consequences.

Moses (1999) studied the levels of exposure to violence, depression, and hostility in high school children. After discussing the issue of gang violence, the causes of death among youths, safety concerns in neighborhoods, and the use of firearms, Moses studied the extent to which children were exposed to violence, the relationship between exposure
to violence and aggressive behaviors and symptoms of depression and anger. The author also analyzed emotional distress, hostility, and sex differences in abused victims. Exposure to violence was measured through six (6) events: violence against family, violence against friends, and violence against strangers, shot/stabbed, raped, and beaten up/jumped. Each participant provided the numbers of times he/she has witnessed or experienced each of these events. Moses found that males reported significantly more exposure to violence than females. This study revealed that although male and females reported exposure to roughly equal amount of violence against family members, males were exposed to greater amounts of violence against friends and strangers, and were more likely to have been shot/stabbed, beaten up/ jumped; females reported a high incidence of rape. Moses also found that depression and hostility scores for this sample were higher than those of “normative” population and that among her subjects, black children were more likely to have witnessed violence against family members, and more likely to having been raped. Moses’ sample included inner city high school youths who could have been exposed to violence at school too.

Peer Interaction and Bullying

The prevalence of victimizing behaviors among youth offenders has been the focus of studies (Ireland, 2002; Palmer & Farmer, 2002). Children’s isolation from peer groups or negative interactions with other peers may stem from their victimizing others or their victimization by others. Bullying behaviors draw many concerns from parents when occurring within the home or school environment. In juvenile institutions, they may be an expression of a subculture of violence illustrated by covert or overt actions that
researchers could use as a factor for differentiating perpetrators from victims of violence (Palmer & Farmer, 2002). Palmer and Farmer noted that bullying could be defined as aggressive behaviors repeated over time in a relationship where there is a power imbalance; they are premeditated and planned with the aim of hurting, threatening, or frightening the victim. Therefore, the authors suggested that for interactions to constitute bullying behaviors, five key elements should be looked for: a physical, verbal, or psychological assault; an imbalance of power; no provocation from the victim; repetition of the behavior by the perpetrators; and an intention to cause harm or fear on behalf of the perpetrators. Direct bullying behaviors are different from indirect bullying behaviors. The former are aggressive actions such as verbal abuse, threats, and physical aggression occurring during direct interactions between the bully and victims; the latter refers to covert actions such as rumor spreading, gossiping, and ostracizing people (Palmer & Farmer, 2002).

In the prison context, bullying behaviors include “initiation ceremonies” during which, offenders who have been in custody earlier, prepare the newly confined to certain practices; “taxing” behaviors such as asking for money or goods to the victim as a tax; and “baroning” when perpetrators lend goods and money to their victims and oblige them to pay high level of interest. The concept of bullying behaviors defined, the researchers studied the characteristics of the perpetrators and victims. Findings suggest that offenders most likely to become victims of bullying behaviors are those who are vulnerable or weak, new offenders, those who do not conform to the prison culture, those with few friends in the facility, sex offenders, drug users, those who are known to have informed against other prisoners. Bullies tend to have spent more time in prison (at least
one month in custody) than victims, they are likely to have been bullied previously; they have lower levels of empathy and less positive attitudes towards victims of bullying. Further, Palmer and Farmer found that the most common forms of bullying among offenders were “using hurtful names” or insulting remarks, threatening violence, and carrying out physical assaults against other inmates. They found also that victimizers themselves were significantly more likely to have previously experienced victimization than were non-victimizers; victimizers scored significantly higher on the deviance scale, on criticism of others, and on overall hostility. Due to these characteristics, interactions among victimizers as well as those between the latter and non-victimizers or non-offenders may result in isolation from peers or constant negative interactions leading to fights, acting out in defiance to staff authority. The relevance of this article to this study derives from its findings on the types of peer actions, the environments where these actions take place, the physical and emotional abuses and their consequences on children.

Drug Use

Involvement with illegal drugs is another factor of delinquency. Youths may be involved with using or trafficking with drugs. The consequences of the use of drug among youths have been studied (Dembo & Schmeidler, 2003; Sigurdsson & Gudjonsson 1996; Welte, Zhang, & Wieczorek, 2001). According to Sigurdsson and Gudjonsson (1996), juvenile offenders who use alcohol and drug, present a certain number of psychological characteristics. These authors found significant differences between offenders who use drugs and those not using drugs. On the Gough Socialization Scale
and on the lie scale of the Eysenck’s Personality Questionnaire (EPQ), drug users scored lower than non users; but on the addiction scale of the EPQ they scored higher than those who do not use drugs. On alcohol use, offenders, who use alcohol frequently, scored lower on the Gough socialization scale and on the lie scale; they scored higher on the addiction scale. Sigurdsson and Gudjonsson’s findings support that juveniles who consume alcohol frequently (i.e. weekly or more often) are more likely to have experimented with illicit drugs. These findings and others, linking alcohol or illicit drug use with juvenile offending behaviors (Bergen, Martin, Richardson, Allison, & Roeger, 2003; Brecklin & Ullman, 2001; Kingree & Phan, 2002) have led researchers (Welte, et al., 2001) to hypothesize that there is a causal relationship between substance use and criminal offending behavior. Welte et al. noted that researchers have previously demonstrated that there is a positive correlation between substance use and delinquency but, “the causal relationship has proved difficult to demonstrate” (p. 416). They pointed out that three classes of causal connection between substance use and crime have been established. They suggested that the first type of causal connection was illustrated in studies showing that the short-term effect of alcohol use seems to promote aggressive or violent behavior; for example, heavy drinking was positively correlated to violent offending, hostility, deviant attitudes, severity of spouse abuse, and the extent of injury to the victim. Welte et al. suggested that researchers have demonstrated the second type of causal connection by finding that remunerative crimes are committed to get money for drugs; for example heroin addiction leads to property crime to raise money to support the heroin habit; they illustrated this finding by referring to studies that reported that rates of remunerative crimes were six times higher when the user’s habits were at peak level than
when they were abstinent. The third type of causal connection between substance use and crime was illustrated in studies showing that violent conflict and robbery were among activities taking place in drug trafficking. The authors acknowledged the current controversy on the causal connection between substance use and crime; they noted that researchers have argued that the temporal order may change because delinquency can lead to drug use.

Welte et al.’s study (2001) aimed at further examining the causal relationship between substance use and criminal behavior. They conceptualized delinquency in five types: minor, general, index, property, and violent offenses; they used separately in their analysis alcohol use and drug use. The study longitudinal with two wave interviews; there was an interval of eighteen months between the two waves. A sample of 625 males, aged 16 to 19 participated to the first interview and for the second one 596 (attrition rate 4.6). The authors obtained two groups: early onset delinquents and late onset (or non-delinquent). Age of onset of delinquency was used to distinguish the two groups. Children who told they committed their first delinquent act at age 12 or younger were in the early-onset group; the others who responded 13 or older were put in the late-onset group. Having these two groups allowed the authors to study between group differences so they could depart from previous studies’ within group findings.

The authors hypothesized that the relationship between substance use and delinquency is more likely to be causal for the late-onset males than for the early-onset ones. This hypothesis was supported as they found significant causal effects of substance abuse on criminal offending, and vice versa among late-onset delinquents, not among early-onset males. This finding led the authors to suggest that for the early-onset
offenders “the strong correlations among these various manifestations of deviance are spurious and probably attributable to the influence of a latent antisocial personality trait that was established in early childhood and is stable in late adolescence” (p. 435). This paper contributed to the classification of offenders into groups for more focused research on youth antisocial behavior; it illustrated the taxonomic theory as described by Moffitt (in press). This writer completed a meta-analysis of studies on a developmental taxonomy of antisocial behavior that proposed two hypothetical prototypes: life-course persistent versus adolescence-limited offenders. Moffitt suggested that the taxonomic theory supports that “life-course persistent offenders’ antisocial behavior has its origins in neurodevelopment processes, and it begins in childhood and continues persistently thereafter. In contrast, adolescence-limited offenders’ antisocial behavior has its origins in social processes, it begins in adolescence and desists in young adulthood” (p. 2). Moffitt stressed that this theory also supports that “life-course persistent antisocial individuals are few, persistent, and pathological. Adolescence-limited antisocial individuals are common, relatively transient, and near normative” (p. 2). This author noted that a series of implications for intervention ranging from prevention to treatment has been extracted from this theory.

The influence of subgroups on the use of illegal substances by children has been investigated by Allen, Donohue, Griffin, Ryan and Turner (2003). These researchers found that peers as well as parents are sources of influence on children’s use of substances such as tobacco, alcohol, marijuana, and hard drugs; these authors reported that there was a positive association between the overall use of drugs and parental influence over that decision. Further, they found a positive correlation between the size of
the effect of the influence of the parents and peers on children’s decision to use substances; they also found that peers’ influence increased as the children got older. This phenomenon is understandable as children most likely imitate models they “perceive as similar to themselves and are those of their same gender” (Robbins et al., 1998); the parents are the youths’ first role models whose behaviors are observed, integrated and imitated. Smith and Farrington (2004) stressed this phenomenon as they found that there were continuities in antisocial behaviors not only between but within generations as well; not only parents but grand parents also are among the most influential persons in the youths’ decision making.

Mental and General Health Problems

Violent, incarcerated youths are considered a medically underserved population, with a high prevalence of sexually transmitted diseases, pregnancy, risk for human immunodeficiency virus (HIV) infection, and suicidal behavior (Anderson & Farraw, 1998). Bilchik (1998), and Building Blocks for Youth (2004) stressed the high level of substance use and mental disorders among incarcerated youths, as well as the offenders’ unmet need for mental health and drug abuse services due to the inadequate and fragmented services provided by the juvenile justice system. Bilchik (1998) notes that among youths who come in contact with the Juvenile Justice 150,000 meet the diagnostic criteria for at least one mental disorder, and 225,000 suffer from a diagnosable alcohol abuse or dependent disorder. The U.S Surgeon General, in his Report (1999), recognized the extent of mental disorders among the general youth population, noting that “Almost 21 percent of children and adolescents (ages 9 to 17) had
some evidence of distress or impairment associated with a specific diagnosis and also had at least minimal level of impairment on a global assessment measure” (p. 420). He also admitted that a majority with mental disorders do not receive any care.

Despite this large number of youths with mental health problems and those with other acute health problems such as dermatologic, respiratory, and sexually transmitted diseases, Anderson and Farrow (1998) found that detention facilities are ill prepared to provide adequate health services mainly because of the lack of mental health screening at the intake stage of the court process. This failing may be one consequence of the late recognition of the mental health needs of incarcerated youths. In effect, Cocozza and Skowyra (2000) acknowledged that at the federal level, the mental health needs of youths in the juvenile justice system have received more attention in the last two years than in the past three decades combined. These authors also recognized the difficulty in addressing this issue because of the varying uses and definitions of the terms “mental health disorder” and “mental illness”.

The Juvenile Justice Journal (J.J.J., 2000) defined youths “with a diagnosable mental health disorder as those who meet the formal criteria for any of the disorders listed in the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (DSM IV)” (p.1); for example they cited psychotic, learning, conduct, and substance abuse disorders. The constructs of youths with “serious mental health disorder” or “serious emotional disturbance (SED)” are used to identify those who experience more severe conditions that substantially interfere with their functioning (J.J.J., 2000). According to the author, the concept “serious mental health disorder” refers to specific diagnostic categories such as schizophrenia, major depression, and bipolar disorder, while “SED” is a term used for
youths with a diagnosable disorder that “has resulted in functional impairment affecting family, school, or community activities” (p.1). The author also reported that 80% or more of the juvenile justice population are diagnosed with conduct disorder. It was stressed that many of these youths have co-occurring substance abuse disorder. This finding suggests that the court should implement a systematic screening of all youths listed for appearance in order to determine the health status of each of them before sentencing (Dolan, Holloway, Bailey & Smith, 1999).

Education and Training

Research has shown that many delinquent youths present specific educational characteristics, experience serious emotional disturbances, and are diagnosed with learning disabilities and/or deficiencies (Daley & Onwuegbuzie, 2001; Foley, 2001; Reilly, Wheeler & Etlinger, 1985). Reilly et al.(1985) have compared the intelligence level and academic achievement of juvenile delinquents (JD) with special education classifications: emotionally disturbed (ED), educable mentally retarded (EMR), and learning disabled (LD). Findings suggest that the EMR significantly differed from the other classifications and JD in all significant mean scores of verbal IQ and performance IQ and significant differences between the different classifications in academic achievement. These findings were supported by other studies reviewed by Foley (2001). Introducing her study with an extensive literature review of articles studying characteristics of incarcerated youths and correctional educational programs, Foley noted that due to the rehabilitative mission of the court, judges were committing more youths to diversion and educational programs but estimated that approximately 105,000
delinquents were held in public and private juvenile detention, correctional, and shelter facilities. This author stated that youths enter correctional settings with a variety of interrelated academic, social, emotional, health, and behavioral needs but 43% of the youths participating in correctional remediation programs do not return to school following their release from correctional facilities. This phenomenon may derive from the fact that children with disabilities comprise a substantial portion of the incarcerated juvenile population (12% to 70%), but also because, after release, many of them recidivate within six months and return to incarceration. Foley reported findings that suggest that incarcerated youths appear to function within below-average to average levels of intelligence with a mean full IQ score of 80 to 100; their intellectual functioning has been higher performance IQs than verbal IQs; also the average verbal-performance discrepancy appears to be 8 to 12 points. Further, comparing incarcerated adolescents who received remedial reading or math instruction, it was found that the verbal, performance, and full scale IQs of youths in the remedial math group were significantly lower than those of the youths in the remedial reading group. The comparison of recidivists and non-recidivists showed that the two groups differed on the verbal and Full Scale IQs. Other findings suggested that the academic achievement of incarcerated youths was consistently being reported as one year to several years below expected grade levels and that their academic functioning ranged between fifth and ninth-grade levels. It was also reported that incarcerated youths experienced significant reading deficits because 50% of incarcerated youths who indicated completing eighth-grade were reading at or above the eighth grade level according to Foley. This author noted also that the comparison of delinquent with non-delinquent youths on oral language showed that the
former had significantly poorer oral language skills, higher percentage of utterances with one or more discourse errors than do non-delinquents. The math achievement scores of incarcerated juveniles indicated performance below expected grade level, extending from fifth-grade level to ninth-grade level. Incarcerated young men had significantly lower math scores than their nondelinquent peers; on the issue of failing grades, Foley reported that three fourths of the delinquents with and without disabilities surveyed received a grade of F in at least one class, that approximately 40 to 50% experienced grade retention. Other study findings revealed that 60% of the participants stated they liked school and their teachers and other view school as important and necessary to secure employment.

Special education and detention services

A series of public laws and regulations related to individuals with disabilities have been enacted. Specific dispositions in favor of children with disabilities in general and incarcerated youth offenders with learning disabilities in particular have been spelled out. A requirement of title II of the American with Disabilities Act (ADA) related to public entities, including detention facilities and prisons, provides accommodations in programs and services to individuals with disabilities. In addition, the 1997 amendments of the Individuals with Disabilities Education Act (IDEA) assert that whenever a school reports a crime allegedly committed by a youth with a disability, school officials must provide copies of the youth’s special education and disciplinary records to the appropriate authorities to whom the school reports the crime, but only to the extent that the Family Educational Rights and Privacy Act (FERPA) permits the transmission (J.J.B, 2000).
This provision means that the FERPA allows officials to transmit school records to law enforcement officials only if parents consent in writing to the transmission and in certain other narrowly tailored situations. All these regulations set forth by the ADA, IDEA, and FERPA merge toward the same goals which are to recognize the special needs and rights of this category of youths and to ensure that they are provided with proper services.

Learning disabled (LD) is one category of special education. The U.S. Office of Education defines learning disability as “a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which manifest itself in an imperfect ability to listen, think, read, write, spell, or do mathematical calculations” (Winters, 1997). The U.S. Office of Education suggests that LD includes perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. After studying “how special education information may be helpful as cases make their way through juvenile court”, researchers at the Juvenile Justice Department suggest that juvenile justice professionals be alert from the earliest moment for clues to the youth’s special education status or existing unidentified disabilities. In effect, due to the lack of screening during their admission process to an institution consecutive to their adjudication, many LD could not be identified as such. Previous to the enactment of P.L.94-142 (the education for all handicapped children Act of 1975) only few education programs run by the juvenile justice system assessed youths who might have disabilities. Under this law, incarcerated children with disabilities were entitled to the same right to a free, appropriate education as any other youth with a disability; therefore, even though it was difficult to implement these provisions of the law, correctional education programs in detention centers, training and reform schools
had to develop systems for screening, identifying, assessing, and instructing incarcerated youths with special education needs.

Research findings show the overrepresentation of disabled youths in detention facilities (Leone, 1991; Quinn, Rutherford, & Leone, 2001; Wilkinson, 2000). For example, Wilkinson (2000) acknowledged that there were between 6 and 15% or 283,000 adults in jails and prisons reported to live with a diagnosable mental illness. Leone (1991) stated that among 84,000 juveniles incarcerated in detention centers, 28% had been identified as having disabilities. These youths were diagnosed with mild to moderate mental retardation, learning disabilities and behavior disorders. This author noted that these youths were more likely to be committed to correctional facilities for a certain number of reasons: not understanding the rights read to them, confess or say what they think another person (the investigator) wants to hear, have difficulty communicating with lawyers and court personnel, and not be recognized as mentally retarded. Leone found that disabled offenders were more likely to plea bargain for reduced sentences, more often convicted, and less likely have their sentence appealed or placed on probation or parole. Leone stigmatized the mobility of the youths which makes providing due process, protection, and assessment very difficult. Other problems raised were teachers’ employment, and student-teacher relationships. In order to overcome many of the difficulties, the author suggested that when sentencing, and making placement decisions, judges should take into account the youths’ special needs; that educational records be transferred with the offenders into and out of correctional facilities education; and that a linkage be set forth between parole, aftercare programs, and schools.
All the above factors impact the number of LD in detention facilities as supported in another article (Winters, 1997). Winters noted that in order to be classified as Learning Disable(LD), and placed in appropriate special services a student must meet one of the five criteria: there must be an intrinsic neurological problem (i.e., faulty processing of information in the brain); intra-individual differences must be present (i.e., the student must manifest problems in learning that are unique for that child only); there must be a discrepancy between the student’s potential (as illustrated by testing) and his, or her academic achievements; the student must not exhibit any exclusionary factors (e.g., the learning problem must not be the result of mental retardation, sensory problems, limited command of English, cultural differences, and emotional illness); and the student must exhibit developmental and/or academic problems. Winters noted that if a student’s learning difficulty can be explained by other factors not attributable to a developmental or academic problem, that student does not meet the criteria for special education. He reported that educationally handicapped children have the constitutional right to an education as provided through the P.L. 94-142, enacted in 1975, calling on school districts to conduct a systematic screening by qualified professionals to determine which children require special education. Many incarcerated youth fall within this category (Winters, 1997).

The EDJJ (2005) stressed that the Individuals with Disabilities Education Act (IDEA) entitles youths with disabilities to special education and related services, but admitted that the provision of appropriate special education services in correction facilities was impacted by four phenomena: transience of the student population, conflicting organizational goals for security and rehabilitation, shortage of adequately
prepared personnel, and limited interagency coordination. All these issues should be addressed by the Juvenile Justice Administration to fulfill its mission.

As demonstrated in this literature review, studies suggest that violent adolescent offenders’ problems should be viewed in holistic terms (Dembo & Schmeidler, 2003) because as shown above, youths are on one hand influenced by distal contextual risk factors such as community, school violence, family disruptions following incarceration or separation with parents, physical, sexual abuse, neglect, and substance abuse; and on the other hand by proximal risk factors such as lack of supervision, the multiple consequences of abuse, and the youths’ levels of emotional disturbance, intellectual as well as functioning abilities. These factors contribute to the shaping of the profile of the youths whose personal, social, psychological, psychiatric, and family characteristics this study aims at determining.
Chapter 3

Research Questions and Methodology

Research Questions

1. What are the personal characteristics of violent juvenile offenders referred by the courts for mental health/behavioral disorders?

2. What social problems do violent juvenile offenders referred by the courts for mental health/behavioral disorders experience?

3. What psychological and psycho-affective/cognitive problems do violent juvenile offenders referred by the courts for mental health/behavioral disorders experience?

4. What are the family functioning and structure of violent juvenile offenders referred by the courts for mental health/behavioral disorders?

Methodology

This research is a secondary data analysis. Psychosocial reports on youth offenders considered for Lorain County Juvenile court diversion program were major primary sources of data for this study. Licensed psychologists tested each youth and presented results of their assessments in individual reports. In addition, information was collected from a report of a program evaluation ordered by the Ohio Department of Youth Services (ODYS), the Ohio Department of Job and Family Services (ODJFS), and the Office of Criminal Justice Services (OCJS) conducted by Daniel Flannery, Ph.D., Laura Buckeye, M.P.H., and Kelly L. Wester, Ph.D. at the Institute for the Study and Prevention of Violence (ISPV), at Kent State University and by
Mark I. Singer, Ph.D., at the Mandel School of Applied Social Sciences (MSASS), at Case Western Reserve University (CWRU).

Psychological evaluation reports contain both narrative and test scores.

Narrative information was coded directly from each psychological evaluation report. For example, each report includes a section on the youth’s referral, family history and background, social and legal history; other sections provide information on the offender’s substance abuse, educational, medical, psychiatric, and treatment services. In addition, there are narratives on the youth’s mental status, behavior, and assessment results; the report includes also sections on the subject’s intellectual and achievement functioning, family functioning, substance abuse screening, and personality functioning. The evaluators also present the offender’s level of risk, and diagnoses on Axis I, II, III, IV, and V, before concluding with a comprehensive summary and subsequent recommendations. Variables coded from narrative information are listed in appendix A.

Sample

This exploratory study uses a convenience sample of eighty-eight (88) youth offenders (71 males and 17 females), referred for evaluation, by Juvenile courts located in Lorain County. The Bellefaire Jewish Children’s Bureau (BJCB), a social agency located in Shaker Heights, in the Cleveland area, implemented a full psychological evaluation of each juvenile. Each referred juvenile underwent a series of interviews and assessments. Besides, their biological, adoptive or step-parents, relatives, school officials, social service and mental health professionals have been
interviewed for more information. The Juvenile Court Diagnostic Clinic, which
carried out initial psychological assessments, also provided data on the youths. All
the offenders referred to this program met the following criteria: being between age
11 and 17, having committed a violent offense, being identified as having a
diagnosable mental disorder resulting in a significant mental impairment, and being
viewed as progressing toward a commitment to ODYS “due to failure in less
restrictive programs.” They underwent a series of assessments measuring their
intellectual and achievement functioning, social environment, psychological,
psychiatric, and legal problems, personal experience, substance abuse, level of risk of
future criminal activity, and also, mental health needs and services received. Final
assessment evaluations were in the form of a written psychological report including
test scores, diagnoses, historical information, and narrative and clinical conclusions.

Instruments

The evaluators used nine (9) instruments to collect data on each participant. These
instruments were: the Juvenile Record Review, the Family’s Clinical Records, a Clinical
Interview with client, Wechsler Intelligence Scale for Children, 3rd edition-Short Form
(WISC-III), the Wechsler Individual Achievement Test-Screener (WIAT), the Personal
Experience Screening Questionnaire (PESQ), the Family System Test (FAST), the Millon
Adolescent Clinical Inventory (MACI), and the Youth Level of Service/Case
Management Inventory (YLS/CMI). Besides, the evaluators have used some other
instruments such as the Ohio Scales (Youth, Parent, and Worker) and the Disposition
Investigation Report (DIR).
The Wechsler Intelligence Scale for Children (WISC) is a test designed to identify
cognitive functioning in children. A WISC score represents a combination of two scores
made by a child on the verbal and performance subtests. For example, a child may
achieve a Full Scale IQ of 85 on the WISC from the score of a Verbal IQ of 87 and a
Performance IQ of 86. Revisions of the WISC have led to the revised version (WISC-R),
and to the WISC, 3rd. ed. (WISC-III). This test, also used to detect gifted children,
includes six (6) verbal and seven (7) performance subtests (Groth-Marnat, 2003). In order
to evaluate the IQ of younger subjects in this sample, the psychologists administered the
WISC-III and the WIAT-Screener; with older subjects, they used the Wechsler Adult
Intelligence scale-III (WAIS-III).

Wechsler Individual Achievement Test-Screener (WIAT) designed in 1992, is an
instrument used for more in-depth assessment of achievement; it is also used for the
diagnosis and assessment of mental retardation. High to moderate correlations were
found between the Wechsler Adult Intelligence scale-III (WAIS-III) and the WIAT
(Groth-Marnat, 2003).

The Personal Experience Screening Questionnaire (PESQ), developed by Ken
Winters in 1991, is a 40 item-instrument administered to screen 12-to 18- year- old
children suspected of abusing alcohol or other drugs. It is a self-report questionnaire with
three (3) subscales: drug use problem severity (18 items; coefficient alpha .91-.95),
psychological problem (8 items), and drug use history (6 items); a response distortion
tendencies domain (faking good or bad tendencies) is also included (8 items). As a self-
administered test, the PESQ requires ten (10) minutes for identifying children with
chemical dependency problems. This test is estimated accurate at 87% in predicting needs for further drug assessment (Winters, 1992).

The Millon Adolescent Clinical Inventory (MACI) evolves from the Millon Adolescent Personality Inventory (MAPI). It is composed of 31 scales: 12 personality patterns; 8 expressed concerns; 7 clinical syndromes; 3 modifying indices; 1 validity scale. It was developed in 1993, primarily for use in clinical, residential, and correctional settings for the initial evaluation of troubled adolescents, 13-19 year-old. It is used for diagnostic hypotheses, for planning and assessing outcome of treatment programs. Its 31 scales measure for example avoidance, depression, self demeaning, borderline, and narcissism (personality patterns, Axis II); identity confusion, peer insecurity, social insensitivity, and family discord (expressed concerns); eating dysfunctions, substance abuse proneness, anxious feelings, and suicidal tendencies (clinical syndromes); disclosure, desirability (modifying indices).

The Family System Test (FAST) developed by Gehring (2002) is used for the analysis of the respondent’s family structures, perception and interaction; diagnosis of bio-psychosocial problems; and the planning and evaluation of preventive and therapeutic interventions. This instrument helps represent emotional bonds, and hierarchical structures in the family. It is based on the assumptions that, in Western societies, non-clinical families are characterized by balanced structures, cohesiveness and moderate hierarchy, and have clear generational boundaries and a flexible organization.

The Youth Level of Service/Case Management Inventory (YLS/CMI) is an instrument developed by Hodge, and Andrews (2002). It is used for an initial assessment of risk of failure, needs for services, and responsibility factors in young offenders. It
involves a face-to-face interview and a review of case records. The YLS/CMI provides data in eight (8) areas: the history of conduct disorder, prior and current adjudications/offenses (5 items); family circumstances and parenting (6 items); current school or employment problems (7 items); peer relations or some criminal friends (4 items); alcohol/drug problems (5 items); leisure/recreation (3 items); personality/behavior (7 items); and attitudes/orientation (5 items) (Canada Justice, 2003; Flores, Travis, & Latessa, 2004). Flannery et al. (2003) report that the overall scale score resulted in $\alpha = 0.93$. The overall total score for Risk and Need Factors are considered low (0-8), moderate (9-22), high (23-34) or very high (35-42).

The Disposition Investigation Report (DIR) is another instrument used in the assessment process. It is described by Flannery et al. (2003) as a multiple page form used by the ODYS to collect information on youthful offenders. These researchers assert that it provides for over 600 pieces of information if fully filled out; it covers Demographics, Committing Offense Information, Victim Information, Court History, Family Members and Family Information, Youth Information, Religion, School and Employment History, Mental Retardation/Developmental Delay Issues, Mental Health Issues, Medical Information, Alcohol and Drug History, Personal/Social Information, Post-Disposition Information, Prior Court Referrals, and Victim Impact Information. This instrument is completed in a semi-structured interview format and no reliability or validity data are provided.

The short form of the Ohio Youth Problem, Functioning and Satisfaction Scales (Ogles, Melendez, Davis, & Lunnen, 2001) has also been used in the data collection process. This instrument has three versions: the Youth form, the Parent form, and the
Agency Worker form. While the youth and Parent forms are identical in content, they differ in perspective as the youths and their parents address two sets of 20 items assessing respectively the youths’ Problem Severity and Functioning; in addition, they both respond to two other sets of 4 items that assess respectively Hopefulness and Satisfaction with Behavioral Health Services. In their form, Agency Workers address the 40 items assessing the youths’ problem severity and functioning but instead of responding to the 8 items related to Hopefulness and Satisfaction, they rate the youths’ placement in various setting during the past 90 days, provide information on school placement and suspensions, psychoactive medications, and on arrests, and self-harm attempts.

The evaluators wrote a report on each participant’s results and the diagnoses they made. In each report, the researcher identified the variables in order to complete a database, which includes 147 variables coded for a quantitative research. For the purpose of this thesis, all the reports were used in their anonymous form; they were coded by the researcher, so no participant’s name or information that could help identify specific individuals would appear. These variables are studied in clusters or individually according to their nature and the domain investigated (refer to list of variables). For example, these are some of the clusters and individual variables:

*Demographic variables*: the age, ethnic origin, gender and personal characteristics of all the respondents are determined for an in-depth description of the sample composition.

*Academic performances*: how these youths perform in school is affected by the types of problems they experience. How disruptive the youths are in school? Are they experiencing attention deficit, hyperactivity, hearing disease, developmental delay,
reading or mathematic disorders? The report narrative provides answers to these questions.

*Aggressive behavior (aggresbh)*: three levels of aggressive behaviors have been defined: violent (1) extremely violent (2) and severe and extremely violent (3).

Assessing the Personality and Behavior of the youths with the YLS/CMI, the tester noted how verbally and physically aggressive they were. Another factor that contributed to the determination of the level of aggression is the violent nature of the offense committed by the youths. Were the offenses considered crimes against property or against person? Did they commit assaults on individuals? Did the offenders use weapons during the commission of the crimes? Answers to these questions helped determine the youths’ level of aggressive behavior.

Various items in the YLS/CMI allowed the evaluators to assess the youths’ *defiance to authority* (defyauth), *self-image* (sfesteem), *social skills* (socialsk), and *attention span* (adeficit). Defiance to authority was valued on a likert scale from not defiant (0) to oppositional defiant disorder (3) with “hostile toward authority” and “disobedient toward authority” being respectively 1 and 2. Self-esteem and social skills were valued 0 for low or “no information” and 1 for “high” self-esteem. The youths’ *types of interactions with siblings and peers* (intrsibl, intrpeer) are also assessed with the YLS/CMI. Each one is valued on a likert scale from close (0) to verbally and physically aggressive (4) with isolated (1), verbally (2) and physically aggressive (3).

*Health and disorders*: the number of hospitalizations and diseases that affect these offenders have been documented. Referring to the General Medical Conditions (Axis III of the DSM IV), the diseases affecting each of these youths is listed. Besides, diagnoses
for other disorders such as dissociation, eating and sensorimotor (motor skills) disorders have been made. Furthermore, the number of psychotropic medications prescribed to each youth is provided.

*Global Assessment Functioning* (GAF: current and highest score in the past year): The overall level of functioning of the youths was assessed using the Global Assessment of Functioning Scale. This instrument rates “the relative degree to which a client is able to function psychologically, socially, and occupationally, not due to physical or environmental limitations” (Barker, 2003). The client is rated from 100 corresponding to “superior functioning in a wide range of activities and no symptoms, to 0 meaning “persistent danger of severely hurting self or others, or persistent inability to maintain minimal hygiene or serious suicidal act with clear expectation of death” (DSM IV). A comparison of the current GAF score with the highest GAF score in the past year provides information on the youths’ functioning trend. The evaluators assessed the subjects and recoded their scores.

*The family system’s* composition and extent, how it is perceived by the participants, the parents’ alcohol and drug use, their marital (pmaritus) and legal status (momlegpb; dadlegpb), the persons who most influenced the youths (mostinfl), are recorded. The family history of domestic violence (domviolp), their history of mental health and interaction with the youths are documented. The reason the child was removed from the home (wyhmrmvl) is specified.

*The DIR provided information on the* participants’ number of charges, the types of legal problems they were involved in, their court history, and even their victim’s information. A Risk and Need Factors variable (riskfact) and another variable
representing a score of Risk of Future Criminal Activity (riskfca) have been attributed to the youths. The Risk and Need Factors variable identifies all the areas contributing most to the risks of future criminal activities and raise the likelihood of recidivism in an offender. These risk factors may reside in eight (8) assessed areas: prior and current offenses, family, education, peer relation, substance abuse, leisure and recreation, personality and behavior, attitude and orientation. The scores made by the youths in each of these areas are added and the total represents their score of Risk of Future Criminal Activity, which ranges from low (0-8), moderate (9-22), high (23-34) to very high (35-42).

Statistical Analyses

Descriptive Statistics were run for descriptive information on all variables. Analyses provided frequencies, and percentages for all categorical variables; in addition, the means, and standard deviations were given for continuous variables.

Pearson correlation coefficients tests (r) were conducted to evaluate the level of association between selected variables. Cross-tabulation tests helped provide more details when certain variables showed overlapping groups or when significant positive or negative relationship was found between certain variables. Student’s t-tests and chi square were used to analyze differences in the demographic and sociologic characteristics of some subgroups.
Protection of Human Subjects

A CWRU IRB New Proposal Application was submitted and approved (Protocol # 20030806). The above study used secondary data collected by the Institute for the Study and Prevention of Violence at Kent State University. These data were collected as part of a study funded by the Ohio Department of Mental Health. Data for this dissertation were supplied by the Institute for the Study and Prevention of Violence and did not contain names or information that could identify specific individuals. Data for this study were reported in the aggregate and were stored in a locked file in a locked room at MSASS. Secondary data only were used and no new client information/data were collected.
Chapter 4

Results

Question 1: What are the personal characteristics of youthful offenders referred by the courts for mental health/behavioral disorders?

Results question 1: The sample used for this study is composed of 88 juvenile offenders: 71 boys and 17 girls aged 12 to 17 years at the time of the evaluation (mean age = 14.95, SD: 1.41). There are 24 (27.3%) African Americans (19 males, 5 females); 53 (60.2%) Caucasians (42 males, 11 females); and 11(12.5%) Hispanics (10 males, 1 female).

The subjects’ ranks among their siblings were as follows: 29 (33%) were first born; 23 (26.1%) were second born; 16 (18.2%) were third; 9 (10.2%) were fourth; 2 (2.3%) were fifth and 3 (3.4%) were seventh born. No information was given on the rank of six participants. The number of siblings for each child was reported (mean = 3.36, [SD: 2.72]; median = 3; mode = 2). Five (5.7%) youths did not have any reported sibling; 13 (14.8%) had only one; 23 (26.1%) had 2, and 17 (19.3%) had 3. The other 20 had up to 17 siblings. The only youth who had 17 siblings had been living with adoptive parents who, beside their own biological children, had adopted other children. As noted by the examiners in the psychological reports, by five years of age almost one in three youths (29.5%) had started exhibiting behavior problems, and by the age of ten an additional 38.7% had displayed such behavior. By 15 years of age, all the youths in the sample had exhibited problem behavior; and by the age of 16 all the youths had their first contact with the juvenile court system.
Based on the Youth Level of Service/Case Management Inventory (YLS/CMI) developed by Hoge and Andrew (1994), and used to assess the level of risk and related service needs for each youth, four levels were determined; at each level the number of youths assessed were: low 6 (7%), moderate 33 (38%), high 47 (53%), very high 2 (2%). Thus, over half the subjects in this sample (55.7%) were assessed as being at high or very high risk of committing future criminal acts.

Narratives in the psychological reports describe the main areas generating factors contributing to the risk for future criminal activities (table 1); these factors include: educational problems (A), family circumstances (B), lack of positive leisure/recreational activities (C), peer relations (D), personality factors (E), substance abuse (F) and others factors not specified (G). A cross-tabulation of these variables showed that except in 2 cases, combinations of factors stemming from various areas contributed to the youths’ risks for committing future criminal acts. None of these factors alone was found as the “only factor” that raised the level of risk for future criminal activity in these offenders.
Table 1

Areas contributing to the risk for future criminal activity

<table>
<thead>
<tr>
<th>Areas contributing to the risk of future criminal activity</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combination A,B,C,D,E,F, G</td>
<td>29</td>
<td>33</td>
</tr>
<tr>
<td>Combination A,B,D,E,F</td>
<td>24</td>
<td>27.3</td>
</tr>
<tr>
<td>Combinations of fewer factors than above</td>
<td>33</td>
<td>37.5</td>
</tr>
<tr>
<td>No stated contributing factor</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
<td>100</td>
</tr>
</tbody>
</table>

Education problem: A  
Family circumstances: B  
Lack of positive leisure/recreational activities: C  
Peer relations: D  
Personality factors: E  
Substance abuse: F  
Other factors: G

The Disposition Investigation Report (DIR) provided information on events that impacted the youths’ lives as the evaluators asked the participants if they had experienced a recent significant loss or family change. The evaluators reported the occurrence of one or a number of important events in the life of the child a key event that may have precipitated a youth’s change of behavior or incarceration. For example the death of a close relative affected 6 (6.8%) youths; the separation from or incarceration of a parent or a close relative impacted 22 (25%) children, affecting their behavior or their involvement in offending behavior. Lack of supervision was the precipitating event of the involvement of 2 (2.3%) youths with the juvenile court while a combination of “parent’s death” and “lack of supervision” affected the behavior of two other offenders who were sent to jail.
Another combination of “incarceration of a relative/separation” and “lack of supervision” precipitated behavior change or offending deeds in 28 (31.8%) cases and “personal conditions” contributed to 20 (22.7%) youths’ incarceration (Table 2).

Table 2

<table>
<thead>
<tr>
<th>Events</th>
<th>Youths affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Combination of incarceration of a relative/separation and Lack of supervision</td>
<td>28 (31.8)</td>
</tr>
<tr>
<td>2- Incarceration of a relative/separation</td>
<td>22 (25)</td>
</tr>
<tr>
<td>3- Personal conditions</td>
<td>20 (22.7)</td>
</tr>
<tr>
<td>4- Combination of Death of a close relative and incarceration of a relative/separation</td>
<td>8 (9.1)</td>
</tr>
<tr>
<td>5- Death of a close relative</td>
<td>6 (6.8)</td>
</tr>
<tr>
<td>6- Lack of supervision</td>
<td>2 (2.3)</td>
</tr>
<tr>
<td>7- Combination Death of a close relative and Lack of supervision</td>
<td>2 (2.3)</td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
</tr>
</tbody>
</table>

The DIR also provided information to the evaluators who were able to collect data on the court history of each offender, the original and current charges, the current and past incarceration, and the successful or unsuccessful completion of prior or current probation. The number and dates of the youths’ incarcerations were provided through the
DIR. All subjects but 3 (3.4%) had been incarcerated between 1 and 12 times (mean = 3.5; SD = 2.72; median = 3; mode = 2) (Table 3).

Table 3

<table>
<thead>
<tr>
<th>#of incarcerations</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>1</td>
<td>17</td>
<td>19.3</td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>22.7</td>
</tr>
<tr>
<td>3</td>
<td>10</td>
<td>11.4</td>
</tr>
<tr>
<td>4</td>
<td>17</td>
<td>19.3</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>11.4</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>11</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>12</td>
<td>2</td>
<td>2.3</td>
</tr>
</tbody>
</table>

At the time of the assessment, 18 (20.5%) participants were released from detention, 21 (23.9%) youths were on probation, while 49 (55.7%) were in a detention facility. Of the 88 youths, 3 had only one legal charge (mean 7.6; SD = 5.20; median 6; mode 4) and one outlier had 35 charges (Table 4).
<table>
<thead>
<tr>
<th>Number of legal problems</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>5.7</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>9.1</td>
</tr>
<tr>
<td>4</td>
<td>11</td>
<td>12.5</td>
</tr>
<tr>
<td>5</td>
<td>10</td>
<td>11.4</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>9.1</td>
</tr>
<tr>
<td>7</td>
<td>7</td>
<td>8.0</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>5.7</td>
</tr>
<tr>
<td>9</td>
<td>8</td>
<td>9.1</td>
</tr>
<tr>
<td>10</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>13</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>15</td>
<td>5</td>
<td>5.7</td>
</tr>
<tr>
<td>16</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>35</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
<td>100</td>
</tr>
</tbody>
</table>
Age when first behavior problems occurred, age at first contact with juvenile court, number of legal problems or charges, risk for future criminal activity score, and number of incarcerations are common characteristics of the subjects. Correlation tests were performed on these key continuous variables to determine the presence of a significant relationship; when a significant association was found, the direction and strength of the association were noted below in table 5.

Table 5

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age 1st behavior problem occurred</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Age at 1st contact with juvenile court</td>
<td>.24*</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Number of legal problems</td>
<td>-.13</td>
<td>-.38**</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Risk for future criminal activity</td>
<td>.07</td>
<td>-.04</td>
<td>.32**</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>5. Number of incarcerations</td>
<td>.03</td>
<td>-.13</td>
<td>.59**</td>
<td>.29**</td>
<td>---</td>
</tr>
</tbody>
</table>

* p < .05  
** p < .01

Question 2: What social problems did youthful offenders referred by the courts for mental health/behavioral disorders experience?
Results question 2: Based on the YLS/CMI, and the DIR, the evaluators were able to provide information on the youths’ social skills rated as poor or appropriate, level of self esteem (low or high), engaging in denial, inability to control behavior, throwing tantrums, suicide attempts and threatening others. Only 5 subjects (5.7%) were rated as exhibiting appropriate social skills. All youths were assessed as having low self esteem; and almost all (84; 95.5%) were assessed as having poor coping skills. Almost half the sample (42; 47.7%) was judged as having a lying problem.

Based on the YLS/CMI item on difficulty in controlling behavior, and on the evaluators’ reports, it was found that 77 (87.5%) youths had impulsive behavior and 61 (69.3%) were craving for attention. Of the 88 subjects, 64 (72.7%) were reported as having made suicide threats, and 50 (56.8%) were reported as having exhibited suicidal gestures by committing an act or making a statement that could lead someone else to attempt to hurt or kill them. The results of a cross-tabulation of suicidal threats and suicidal gesture show that 23 (26.1%) never made threats nor suicidal gesture; 1 (1.1%) never made threats but made suicidal gesture; 15 (17.5%) made threats but did not commit any suicidal gesture; and 49 (55.7%) made both suicidal threats and gestures (Table 6).

Table 6

Results cross-tabulation suicidal gestures, suicidal threats
<table>
<thead>
<tr>
<th>Suicidal gesture</th>
<th>No</th>
<th>Yes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>23</td>
<td>1</td>
<td>24</td>
</tr>
</tbody>
</table>

Suicidal threats

| Yes | 15   | 49   | 64    |

Total

38  50  88

Thirty four (38.6%) youths including 8 girls were noted as having attempted suicide. Results of a cross-tabulation of suicidal attempts, suicidal gestures and suicidal threats are presented in table 7.

A large group of offenders (77; 87.5%) had made threats to kill or harm others. Also, 37 (42%) engaged in self-mutilation, cutting their body particularly their arms or banging their head against walls, which could lead to bleeding.

Table 7

Results cross-tabulation suicidal attempts, suicidal gestures, and suicidal threats
<table>
<thead>
<tr>
<th></th>
<th>Suicidal gesture</th>
<th></th>
<th>Suicidal threats</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>38</td>
<td>16</td>
<td>24</td>
<td>30</td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
<td>34</td>
<td>0</td>
<td>34</td>
</tr>
</tbody>
</table>

Suicidal attempts

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>38</td>
<td>50</td>
</tr>
</tbody>
</table>

The youths’ levels of aggressive behavior were also assessed. Based on the information provided by the YLS/CMI and the Ohio Youth Problem, Functioning, and Satisfaction Scales (OYPFS) the testers noted the level of frustration tolerance of the youths, and how verbally and physically aggressive they were. It was found that 14 (15.9%) of youths in this sample had verbal outbursts threatening violence but did not commit any person or property crimes; 12 (13.6%) were found as extremely violent as they had been physically aggressive, committed offenses related to domestic violence and/or assault on individuals. A high number of subjects characterized as severely and extremely violent offenders (62; 70.5%) were assessed as both verbally and physically aggressive and/or had committed crimes against persons during which they used a weapon as specified in the DIR. One quarter of youths in the sample (22) had perpetrated violent acts on animal pets such as dogs and cats by killing, mutilating, or burning them. A cross-tabulation of this variable and sexual predators showed that among these 22 youths, 5 (23.3%) had been adjudicated sexual predators.
From the DIR and the OYPFS the evaluators were able to collect data on the types of relationship the youths had with their peers (Table 8) and siblings (Table 9). They were considered isolated, and having negative or strained relationship when they had argued, yelled, swore, or screamed at peers or siblings or gotten into fights with them. It was found that 32 (36.4%) and 6 (6.8%) youths had close (positive) relationships with respectively their siblings and peers; 25 (28.4%) and 30 (34.1%) were assessed as isolated respectively from their siblings and peers due to negative, or strained relationships. Further, 2 (2.3%) offenders were verbally aggressive with their siblings while 8 (9.1%) developed this same attitude toward their peers; physical aggression strained the relationship of 13 (14.8%) youths with their siblings and 15 others (17%) with their peers. Two groups of 16 (18.2%) and 29 (33%) offenders were both verbally and physically aggressive respectively with their siblings and peers.

Table 8:

Types of interactions with peers
The DIR and the YLS/CMI provided information on the youths’ affiliation with gangs, delinquent...
acquaintances or friends. Some youths were noted as being involved in gangs (9 cases; 10.2%) or in cult activities (2; 2.3%). The birth order of the offenders who reported gang membership was as follows: 3 were first-born; 2 were second-born, 1 fourth-born; and 2 seventh-born. The rank of one youth was not known. A group of 51 (58%) offenders were assessed as having a stealing problem; among them, 18 (20.5%) had records of stealing cars or motorbikes.

From the court history presented in the DIR, the evaluators could describe each youth’s involvement with the court. The number of legal problems or charges recorded for many offenders included the successful and unsuccessful current and prior probations, as well as the original and subsequent charges amended or dismissed. It was found that all subjects were involved in a number of legal problems at various times in their lives (mean = 7.63; SD = 5.20; median = 6; mode = 4). By nine, 2 (2.3%) youths had their first contact with the juvenile court system; by fifteen, 80 (90.9%) more juveniles had their first contact with the court. They appeared before the judge for a variety of offenses among which vandalism, destruction of property, and arson; 37(42%) youths had been charged with vandalism or had committed acts of vandalism but were not charged; 62 (70.5%) were destructive to property and 37 (42%) initiated fire setting that would constitute arson.

Based on information in the DIR and the YLS/CMI, the evaluators provided information on the physical and sexual victimization of the participants, the sexual offense perpetrations and the youths’ sexual activities. Sixty (68.2%) of these subjects had been reported as being victims of physical abuse perpetrated by a relative, a biological, adoptive, or stepparent. Among these victims of physical abuse, 29 (48.33%)
had been assessed as having problem behaviors primarily associated with physical abuse.

Sixty-six (75%) youths (50 males, 16 females) witnessed domestic violence at home (Table 10). The evaluators reported that 63 (71.6%) subjects including 51 boys and 12 girls had perpetrated violence toward their own biological, adoptive or stepparents, siblings and/or other relatives (Table 11); however, this high percentage of youths committing such domestic violence was not reflected in formal legal charges due to dismissal of a number of charges by the court. Violent acts committed by the youths against family members at home were recorded as domestic violence acts in the psychological report. The results of a cross-tabulation of “domestic violence perpetrated by parents”, and gender as well as “domestic violence perpetrated by the youth”, and “gender” are reported respectively in Table 10 and 11.

Table 10:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Domestic violence by parents</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes n(%)</td>
<td>No n(%)</td>
</tr>
<tr>
<td>Males</td>
<td>50 (70.4)</td>
<td>21 (29.6)</td>
</tr>
<tr>
<td>Females</td>
<td>16 (94.1)</td>
<td>1 (5.9)</td>
</tr>
<tr>
<td>Total</td>
<td>66 (75)</td>
<td>22 (25)</td>
</tr>
</tbody>
</table>
Youth perpetrators of domestic violence

<table>
<thead>
<tr>
<th>Gender</th>
<th>Domestic violence by youth</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes n(%)</td>
<td>No n(%)</td>
</tr>
<tr>
<td>Males</td>
<td>51 (71.8)</td>
<td>20 (28.2)</td>
</tr>
<tr>
<td>Females</td>
<td>12 (70.6)</td>
<td>5 (29.4)</td>
</tr>
<tr>
<td>Total</td>
<td>63 (71.6%)</td>
<td>25 (28.4)</td>
</tr>
</tbody>
</table>

It was noted that 28 (31.8%) children were victims of sexual abuse perpetrated by relatives, siblings, cousins, stepfathers, boyfriends or acquaintances. Eleven (12.5%) youths had committed at least one sexual offense and were adjudicated sexual predators (10 males, 1 female); 6 of whom committed their sexual offense at 12 years of age or younger. Among the 28 sexually abused victims including 18 boys, and 10 girls, there were 5 sexual predators (4 males, 1 female). A cross-tabulation of gender, sexual abuse victim, and physical abuse victim disclosed that all females in this sample were victims of either sexual, physical, or both sexual and physical abuse, while 49 of the 71 males were reported as having been sexually (n = 4), physically (n = 31) or both sexually and physically abused (n = 14) as shown in Table 12. Twenty one (23.9%) youths were recorded as being sexually active; and 23 committed indecent sexual gestures such as inappropriate touching (9; 10.2%), exhibitionism (7; 8%), and other objectionable sexual acts (7; 8%). A cross-tabulation of “perpetration of sexual offense/rape” and “sexual gesture” showed that among those who sexually touched inappropriately, 6 (66.7%) were sexual predators; among the youths who committed exhibitionism and the sexually active
youths, respectively 2 (28.6%) and 3 (14.3%) were sexual predators. A tendency for public masturbation was found in 9 (10.2%) cases.

Table 12:

Results cross-tabulation: gender, sexual and physical abuse victims

<table>
<thead>
<tr>
<th></th>
<th>SAV</th>
<th>PAV</th>
<th>SPAV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Male</td>
<td>53(74.6)</td>
<td>18(25.4)</td>
<td>26(36.6)</td>
</tr>
<tr>
<td>Fem.</td>
<td>7(41)</td>
<td>10(59)</td>
<td>2(11.8)</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>28</td>
<td>28</td>
</tr>
</tbody>
</table>

% Within group

SAVO: sex abuse victim only

PAVO: physical abuse victim only

SPAV: sex and/or physical abuse

BSPAV: both sex and physical abuse victim

NSPAV: neither sexual nor physical abuse victim

Due to the sexual nature of the variables “masturbation” and “sex offense perpetration, a cross-tabulation involving them was done; the results showed that among 9 youths who were masturbating, 5 had perpetrated a sex offense. A chi square result
shows a relationship between “perpetration of sex offense” and “masturbation” meaning that there is a difference between children who have no experience of known masturbation and those who masturbate on the variable “perpetration of sex offense”: $\chi^2 (1, N = 88) = 16.99, p < .00$. This finding suggests that children who have a propensity to openly masturbate are more at risk of committing a sex offense.

A cross-tabulation of sex abuse victims, sex predators and gender provided information as shown below in table 13. Among the 28 victims of sex abuse, 5 (4 males and 1 female) had committed a sex offense. There was no indication of sexual victimization among the other 6 sexual predators.

Table 13:

Results: cross-tabulation gender, sex abuse victims and sex predators.

<table>
<thead>
<tr>
<th>Sex abuse victims</th>
<th>Sex predators</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>M</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>F</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>1</td>
</tr>
</tbody>
</table>

A cross-tabulation of sex abuse victims, physical abuse victims, victims of both sexual and physical abuse, attempted suicide, and self mutilators (self harm) provided information shown in table 14.
Table 14

Results cross-tabulation attempted suicide, sexual abuse victims, physical abuse victims, victims of both sexual and physical abuse, and self mutilators.

<table>
<thead>
<tr>
<th></th>
<th>Self mutilators</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes(%)</td>
<td>No(%)</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>21</td>
<td>13</td>
</tr>
<tr>
<td>no</td>
<td>16</td>
<td>38</td>
</tr>
<tr>
<td>Sex abuse victims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>no</td>
<td>21</td>
<td>39</td>
</tr>
<tr>
<td>Physical abuse victims</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>26</td>
<td>34</td>
</tr>
<tr>
<td>no</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Sexual and physical abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>no</td>
<td>7</td>
<td>15</td>
</tr>
</tbody>
</table>

Thirty nine (44.3%) youths (29 males and 10 females) had run away from their home or residence of placement, at least once, and 40 (36 males and 4 females) were removed from their homes, foster home, or subsequent placement; of the 36 boys and 4 girls who had been removed from home respectively 19 and 3 had run away. These results show that the runaway youths represented respectively 52.8% of the males and 75% of the females who have been removed from home (Table 15).
Table 15:

Cross-tabulation gender, runaway, and removal from home

<table>
<thead>
<tr>
<th>Sex</th>
<th>Home removal</th>
<th>Runaway</th>
<th>Home removal and runaway</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Boys(n)</td>
<td>35</td>
<td>36</td>
<td>42</td>
</tr>
<tr>
<td>(%)</td>
<td>49.3</td>
<td>50.7</td>
<td>59.2</td>
</tr>
<tr>
<td>Girls (n)</td>
<td>13</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>(%)</td>
<td>76.5</td>
<td>23.5</td>
<td>41.2</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>40</td>
<td>49</td>
</tr>
<tr>
<td>(%)</td>
<td>54.5</td>
<td>45.5</td>
<td>55.7</td>
</tr>
</tbody>
</table>

A- not removed from home not runaway
B- not removed from home and runaway
C- removed from home not runaway
D- removed from home and runaway
Question 3: What psychological and psycho-affective/ cognitive problems are experienced by youthful offenders referred by the courts for mental health/behavioral disorders?

Results question 3: Based on the YLS/CMI, the evaluators reported data related to the youths’ disruptive behavior in class and on school property, their problems with peers and teachers, their attendance, and level of achievement. The OYPFS as well as the DIR provided information on the attitude of the youths toward school administration and staff, their ability to follow instructions and their school history in general. Almost all experienced problems in school (85; 96.6%) where they exhibited disruptive behavior in class (77; 87.5%) and truancy problems (46; 52.3%).

As can be seen in Table 16, most of these youths were diagnosed with some type of mental disorder related to aggressive/violent behavior. Over three-fourths of the subjects (71; 80.6%) were diagnosed with some type of conduct, oppositional, adjustment or disruptive behavior disorder. Mood disorders (with the exception of provisional diagnoses) were diagnosed in 34 (38.6%) adolescents. One or more substance use disorders were diagnosed in 26 (29.6%) adolescents. Finally, attention deficit disorders were diagnosed in almost one in three youths (28; 31.8%).
### Table 16

#### Diagnoses on DSM IV Axis I

<table>
<thead>
<tr>
<th>Axis I diagnoses</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>295.7 - Schizoaffective Disorder, Depressive Type, Provisional</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>296.22- Major Depressive Disorder, Single Episode</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>296.3 - Major Depression, recurrent, prior history</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>296.32- Major Depressive Disorder, Recurrent Moderate</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>296.4 - Bipolar I Disorder, Childhood onset Type</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>296.62- Bipolar I Disorder, Mixed episodes, Moderate</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>296.7 - Bipolar I Disorder Provisional</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>296.89- Bipolar II Disorder, Provisional</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>296.9 - Mood Disorder, NOS</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>298.9 - Psychotic Disorder NOS</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>299.8 - Pervasive Developmental Disorder NOS</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>300 - Anxiety Disorder NOS</td>
<td>5</td>
<td>5.7</td>
</tr>
<tr>
<td>300.02- Generalized Anxiety Disorder</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>300.15- Dissociative Disorder NOS</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>300.3 - Obsessive Compulsive Disorder</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>300.4 - Dysthymia</td>
<td>10</td>
<td>11.4</td>
</tr>
<tr>
<td>304.3 - Cannabis Dependence, in controlled Environment</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>304.8 - Polysubstance Abuse</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>305 - Alcohol Abuse</td>
<td>15</td>
<td>17.0</td>
</tr>
<tr>
<td>305.2 - Substance Abuse Cannabis (in controlled environment)</td>
<td>18</td>
<td>20.5</td>
</tr>
<tr>
<td>ICD-9 Code</td>
<td>Description</td>
<td>Count</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>305.6</td>
<td>Cannabis Abuse</td>
<td>3</td>
</tr>
<tr>
<td>307.23</td>
<td>Tourette’s Disorder, Provisional</td>
<td>1</td>
</tr>
<tr>
<td>307.5</td>
<td>Eating Disorder NOS</td>
<td>2</td>
</tr>
<tr>
<td>309.3</td>
<td>Adjustment Disorder with Disturbance of Conduct, chronic</td>
<td>2</td>
</tr>
<tr>
<td>309.4</td>
<td>Adjustment Disorder/mixed Disturbance of emotions/conduct chronic</td>
<td>1</td>
</tr>
<tr>
<td>309.81</td>
<td>PTSD chronic</td>
<td>4</td>
</tr>
<tr>
<td>311</td>
<td>Depressive Disorder NOS</td>
<td>13</td>
</tr>
<tr>
<td>312.8</td>
<td>Conduct Disorder, Adolescent onset, severe</td>
<td>9</td>
</tr>
<tr>
<td>312.81</td>
<td>Conduct Disorder, Childhood onset, Moderate</td>
<td>18</td>
</tr>
<tr>
<td>312.82</td>
<td>Conduct Disorder Adolescent onset</td>
<td>9</td>
</tr>
<tr>
<td>312.89</td>
<td>Conduct Disorder, Unspecified onset</td>
<td>1</td>
</tr>
<tr>
<td>312.9</td>
<td>Disruptive Behavior Disorder, NOS</td>
<td>6</td>
</tr>
<tr>
<td>313.81</td>
<td>Oppositional Defiant Disorder</td>
<td>24</td>
</tr>
<tr>
<td>313.82</td>
<td>Conduct Disorder Adolescent onset, Moderate/Identity Problem</td>
<td>1</td>
</tr>
<tr>
<td>314.01</td>
<td>ADHD Hyperactive Type</td>
<td>16</td>
</tr>
<tr>
<td>314.02</td>
<td>ADHD Inattentive Type</td>
<td>12</td>
</tr>
<tr>
<td>396.22</td>
<td>Major Depressive Episode, Single Episode, Moderate</td>
<td>1</td>
</tr>
<tr>
<td>995.53</td>
<td>Sexual Abuse of Child (victim)</td>
<td>2</td>
</tr>
<tr>
<td>995.54</td>
<td>Physical Abuse of Child (victim)</td>
<td>1</td>
</tr>
<tr>
<td>999.5</td>
<td>Physical Abuse, Neglect of Child (victim)</td>
<td>2</td>
</tr>
</tbody>
</table>

N = 88
Provisional diagnoses related to learning were given for 19 (21.60%) youths for reading disorder, mathematic disorder, disorder of written expression and learning disorder. An additional youth was diagnosed with a learning disorder (Table 17). A cross-tabulation of these three variables showed that in a certain number of cases, these disorders were mutually exclusive as presented in Table 18.

Table 17

Diagnoses related to Learning Disorders

<table>
<thead>
<tr>
<th>Disorders</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>315 - Reading Disorder, Provisional</td>
<td>10</td>
<td>11.4</td>
</tr>
<tr>
<td>315.09- Learning Disorder, Provisional NOS</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>315.1 - Mathematic Disorder Provisional</td>
<td>10</td>
<td>11.4</td>
</tr>
<tr>
<td>315.2 - Disorder of Written Expression Provisional</td>
<td>8</td>
<td>9.1</td>
</tr>
<tr>
<td>315.9 – Learning Disorder NOS</td>
<td>1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

N= 88
Table 18

Cross-tabulation reading, math disorder, and disorder of the written expression

<table>
<thead>
<tr>
<th>Disorders</th>
<th>Reading</th>
<th>Math</th>
<th>Written expression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Math</td>
<td>75</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Written Exp</td>
<td>76</td>
<td>4</td>
<td>74</td>
</tr>
<tr>
<td>Learning</td>
<td>75</td>
<td>10</td>
<td>75</td>
</tr>
</tbody>
</table>

Compromised intellectual functioning was indicated in almost half the sample (42; 47.7%) (Table: 19). Moderate mental retardation with full scale IQ scores of 35-54 was noted in three subjects, mild mental retardation with full scale IQ scores of 55 -70 was noted in 14 (15.9%) youths, and borderline intellectual functioning with full scale scores of 71-85 was noted in 25 (28.4%) offenders. An additional 29 (33.0%) subjects had a full-scale IQ in the low normal range (86-100), and 15 others had a high normal IQ score of over 101(Table 19). Statistical tests showed that, among the 42 subjects with low cognitive scores, 12 (28.6%) had a co-existing provisional learning disability diagnosis. Comparing these subjects with low IQ (N = 42) to the others with higher IQ on variables such as truancy, disruptive in school, and gang membership, chi-square results showed no significant between group differences on these three variables.
Table 19

<table>
<thead>
<tr>
<th>Scores</th>
<th>IQ full score</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate MRDD</td>
<td>3</td>
<td>92</td>
<td>3.4</td>
</tr>
<tr>
<td>35 - 54</td>
<td>3</td>
<td>92</td>
<td>3.4</td>
</tr>
<tr>
<td>Mild MRDD</td>
<td>14</td>
<td>92</td>
<td>16</td>
</tr>
<tr>
<td>55 - 70</td>
<td>14</td>
<td>92</td>
<td>16</td>
</tr>
<tr>
<td>Borderline</td>
<td>25</td>
<td>92</td>
<td>28.4</td>
</tr>
<tr>
<td>71 – 85</td>
<td>25</td>
<td>92</td>
<td>28.4</td>
</tr>
<tr>
<td>Low normal</td>
<td>29</td>
<td>92</td>
<td>33</td>
</tr>
<tr>
<td>86 -100</td>
<td>29</td>
<td>92</td>
<td>33</td>
</tr>
<tr>
<td>High normal</td>
<td>15</td>
<td>92</td>
<td>17</td>
</tr>
<tr>
<td>&gt; 101</td>
<td>15</td>
<td>92</td>
<td>17</td>
</tr>
<tr>
<td>No information</td>
<td>2</td>
<td>92</td>
<td>2.2</td>
</tr>
<tr>
<td>on score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

Comparing the firstborns’ IQ scores to those of the later-borns, a difference was found between the two groups. The t-test result showed a significant difference: $t = -2.45$, $df = 86$ $p < 0.5$ [firstborns $N = 29$; $M = 92$ (SD = 15.35); others $N = 59$; $M = 79.7$ (SD = 21.32)]. Therefore, firstborns had significantly higher IQ scores than the other youths who were ranked lower in the birth order.
Diagnoses on Axis II were deferred for these offenders due to their age; however, the evaluators nevertheless identified 8 (9.1%) subjects as having either antisocial personality traits (2) borderline personality traits (5) or narcissistic personality features (1). Additionally, the evaluators indicated DSM IV classified V code problems with 38 (43.2%) subjects (Table 20).

Table 20

<table>
<thead>
<tr>
<th>DSM IV: V codes Problems</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>V15.81- Noncompliance with treatment</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>V61.20- Parent-child relational problem (physical abuse of child)</td>
<td>29</td>
<td>33.0</td>
</tr>
<tr>
<td>V61.21- Parent-child relational problem (sexual abuse of child)</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>V61.8 - Sibling relational problem</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>V62.3 - Academic Problems</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>V62.81- Relational Problem, NOS</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>V62.82- Bereavement</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>V71.02- Child or Adolescent Antisocial Behavior</td>
<td>1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

N= 88

On all these disorders: anxiety, generalized anxiety, PTSD, bipolar, ADHD, mood disorder, substance abuse, oppositional defiant disorder and disruptive behavior disorder, victims of sexual abuse were compared to youths who had not been abused. Significant differences were found between the two groups on PTSD: \( \chi^2 = 8.98, \text{df} = 1, p < .01 \); no difference was found between these two groups on any of the other listed disorders. Further, sexual predators were compared to youths who did not commit any sexual
offense. Significant differences were found between the two groups on oppositional defiant disorder: \( \chi^2 = 4.71, \text{df} = 1, p < .05 \). On the other disorders, no differences were found between the two groups.

Based on information provided in the Youth and Parent versions of the OYPFS, particularly in the domain of satisfaction with behavioral health services, the evaluators reported data on the participants’ health. The results indicated that 39 (44.3%) youths had no reported visit to a hospital or an emergency room for a serious health problem, but medical and/or psychiatric care for physical or mental problems were provided to 49 (55.7%) offenders. The frequency of their visits to health care facilities varied from 1 to more than six times because 9 (10.2%) went to the hospital once; 19 (21.6%) twice; 6 (6.8%) 3 times; and 10 (11.4%) four times. The last 3 (3.4%) and 2 (2.3%) youths were respectively in a hospital 5 and 6 or more times. The general medical conditions of 49 (55.7%) offenders had been detailed in Table 21.
Table 21

DSM Axis III: General medical conditions

<table>
<thead>
<tr>
<th>Diagnosis types</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious and parasitic diseases</td>
<td>9</td>
<td>10.2</td>
</tr>
<tr>
<td>Endocrine, nutritional metabolic, immunity diseases</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Disease of the blood or blood forming organs</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Complications of pregnancy, childbirth, puerperium</td>
<td>5</td>
<td>5.7</td>
</tr>
<tr>
<td>Diseases of the skin and subcutaneous tissue/brain</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system/connective tissue</td>
<td>6</td>
<td>6.8</td>
</tr>
<tr>
<td>No diagnosis</td>
<td>39</td>
<td>44.3</td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
<td>100</td>
</tr>
</tbody>
</table>

The major diseases were related to the respiratory system experienced by 15 (17%) offenders and infectious and parasitic diseases diagnosed in 9 (10.2%) cases. Fetal alcohol syndrome (FAS) was indicated in 4 (4.5%) cases, and 9 (10.2%) participants were diagnosed with motor skills disorder. A combination of these two variables showed that among the 4 youths diagnosed with FAS, 3 had motor skills disorder. Among the 88 research participants, 4 (4.5%) were subject to seizure crises. Due to their needs for services, all of the subjects but 3 (3.4%) were involved with mental health professionals, psychiatrists, psychologists, medical doctors and/or counselors. Six (6.8%) youths
received counseling services only; 2 (2.3%) received medical services only; and 5 (5.7%) received psychiatric services only. Both counseling and medical services were provided to 4 (4.5%) participants; counseling and psychiatric services to 22 (25%); medical and psychiatric services were provided to 2 youths; and finally, forty-four (50%) received all three types of services.

The Global Assessment of Functioning scale had been used by the evaluators to assess the psychological, social, and occupational functioning of the offenders. The current level of functioning and the past year’s highest level were provided in the form of current and past scores. All the subjects whose scores had been provided were rated on a scale marked from 100 that indicates an individual who is functioning at the highest level in a wide range of activities and does not present any symptoms, to zero which describes a youth who is in persistent danger of severely hurting self or others, or who exhibits a persistent inability to maintain minimal hygiene or perpetuates serious suicidal acts with clear expectation of death as stated by Barker (1999). The current functioning scores of 83 participants had a mean of 47.8 ($SD = 7.38$), a median of 49 and a mode of 45; regarding the highest scores in the past year, no score was provided on 32 (36.4%) cases; for the other 56 (63.6%), the scores’ mean, median, and mode were respectively 53.7 ($SD = 5.61$), 55, and 55. Sixty adolescents (68.2%) had current scores of 50 or lower indicating, according to the DSM-IV, serious symptoms or impairment in social occupational or school functioning (Table 22).
Table 22

GAF scores: current and highest in the past year

<table>
<thead>
<tr>
<th>Score ranges</th>
<th>Current GAF scores</th>
<th>Past year GAF highest scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>11-20</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>21-30</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>31-40</td>
<td>12</td>
<td>13.6</td>
</tr>
<tr>
<td>41-50</td>
<td>45</td>
<td>51.1</td>
</tr>
<tr>
<td>51-60</td>
<td>21</td>
<td>23.9</td>
</tr>
<tr>
<td>61-70</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>NI</td>
<td>5</td>
<td>5.7</td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
<td>100</td>
</tr>
</tbody>
</table>

Based on the results of questions 2 and 3, a cross-tabulation of sex abuse victims, sex predators, and diagnoses (Axis I and V code) was performed. Results are presented in table 23. Disorders listed on table 16 but not appearing on table 23 have been deleted because neither sex abuse victims nor sex predators were diagnosed with those disorders.
Table: 23
Cross-tabulation disorders, problems, sex abuse victims and sex predators

<table>
<thead>
<tr>
<th>Axis I and V code diagnoses</th>
<th>n</th>
<th>Sex abuse victims (n = 28)</th>
<th>Sex predators (n = 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depressive disorder</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Major depressive, recurrent, prior history</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Bipolar I disorder</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Bipolar II disorder, Provisional</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Psychotic disorder NOS</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Anxiety disorder NOS</td>
<td>5</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Generalized Anxiety disorder</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dissociative disorder</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Obsessive compulsive</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>10</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Polysubstance abuse</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>15</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Substance abuse cannabis</td>
<td>18</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Cannabis abuse</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Eating disorder NOS</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Adjustment disorder/mixed</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PTSD chronic</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Depressive disorder NOS</td>
<td>13</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Conduct disorder adolescent onset severe</td>
<td>9</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Conduct disorder, childhood onset</td>
<td>18</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>moderate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Cases</td>
<td>New</td>
<td>Provisional</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------</td>
<td>-----</td>
<td>-------------</td>
</tr>
<tr>
<td>Conduct disorder adolescent onset</td>
<td>9</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Conduct disorder, Unspecified onset</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>24</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>ADHD hyperactive type</td>
<td>16</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>ADHD inattentive type</td>
<td>12</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Reading disorder provisional</td>
<td>10</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Learning disorder provisional</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mathematic disorder provisional</td>
<td>10</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Disorder of the written expression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisional</td>
<td>8</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Learning disorder NOS</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Parent-Child relational problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(physical abuse)</td>
<td>29</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Parent-Child relational problem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(sex abuse)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sibling relational problem</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Relational problem, NOS</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Sexual abuse of child (victim)</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Physical abuse of child (victim)</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Physical abuse, neglect of child (victim)</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Moderate MRDD 35-54</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mild MRDD 55-70</td>
<td>14</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Borderline 71-85</td>
<td>25</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

NB: Comments related to this table are on Appendix C.
The use of alcohol and other drugs is a characteristic of these youths (62; 70.5%). A t-test comparing subjects who use alcohol and other substances and those who were indicated as not using alcohol or other substances on the number of legal problem shows that there is no difference between these two groups (t = -1.53; df = 86; NS [users N = 62; M = 7.08 (SD 2.48); non users N = 26; M = 8.92 (SD =6.71)]. Among these substance users, diagnoses of polysubstance abuse (Axis I- 304.8), alcohol abuse (Axis I- 305), substance abuse cannabis in controlled environment (Axis I- 305.2), and cannabis abuse (Axis I- 305.6) were made on 42 youths (table 16). A cross-tabulation of these diagnoses, sex abuse victims and sex predators provided more information on these subjects’ diagnoses. Overall, among 28 victims of sex abuse, 6 are diagnosed with one or more of these disorders. Among the 6 youths, 1 is diagnosed with polysubstance abuse (Axis I-304.8); 1 with substance abuse cannabis in controlled environment (Axis I- 305.2); 1 with both alcohol abuse and cannabis abuse (Axis I- 305 and Axis I-305.6); 2 are diagnosed with both alcohol abuse and substance abuse cannabis in controlled environment (Axis I 305 and 305.2); and 1 is diagnosed with both alcohol abuse and cannabis abuse (Axis I-305 and 305.6). Among 11 sex predators, 5 are diagnosed with one or more of these disorders: 1 with substance abuse cannabis in controlled environment only; 1 with cannabis abuse only; 1 with alcohol abuse only; and 2 with both alcohol abuse and substance abuse cannabis in controlled environment. Four predators who are also victims of sex abuse are diagnosed with cannabis abuse (1), alcohol abuse and substance abuse cannabis in controlled environment (2); and alcohol abuse and cannabis abuse (1).
Question 4: What are the family functioning and structure of youthful offenders referred by the courts for mental health/behavioral disorders?

Based on information from the OYPFS worker’s version, and from the DIR, the evaluators reported data on the youths’ involvement with their families, parents and other relatives; offenders’ family health history, marital status, court involvement, and substance abuse of the parents were also described.

Forty (45.5%) of the youths had been removed from home; the reasons for their home removal varied from problems they were experiencing with both parents (19; 21.6%); with their mother (15; 17%); with their father/stepfather (2; 2.3%); problems the youths created themselves (2; 2.3%); and 2 youths were removed for other reasons not specified (Table 24).

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
</tr>
<tr>
<td>Mother and dad’s problems</td>
<td>19</td>
</tr>
<tr>
<td>Mother’s problems</td>
<td>15</td>
</tr>
<tr>
<td>Father/stepfather’s problems</td>
<td>2</td>
</tr>
<tr>
<td>Youth’s problems</td>
<td>2</td>
</tr>
<tr>
<td>Other reasons</td>
<td>2</td>
</tr>
<tr>
<td>Not removed</td>
<td>48</td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
</tr>
</tbody>
</table>
The assessments indicate that 21 (22.7%) youths had been placed in foster care. Age of placement for foster care youths ranged from birth to 9 years of age. The number of foster care placements for these 21 subjects ranged from 1 to 11 (M = .72; SD =1.8). An additional 19 youths had been removed from the home, but were not in foster care. A cross-tabulation of removed from home and age at foster home placement showed that among the 19 youths who were removed from the home, but were not placed in foster care, 5 (26.3%) had been placed for adoption, and the other 14 (73.7%) were living either with a relative or placed in a child care institution. Assessment information also indicates that the total number of adopted youths was 6 (6.8%). Cross-tabulation of three variables: age when assessed, adoption status, and age when first removed from home and placed in foster home shows that the additional youth adopted was not removed from home until 15 years of age when adopted.

Of the 88 children, 31 (35.2%) had parents who had been divorced, 27 (30.7%) had parents who never married, 19 (21.6%) had their biological parents still married at the time of the assessment, and no information was provided on the marital status of 11 (12.5%) youths’ parents. The use of alcohol and drugs by the offenders’ parents as well as their involvement with the legal system were documented. The evaluators reported that 31 (35.2%) and 32 (36.4%) of the subjects’ fathers abused respectively alcohol and drugs; 26 (29.54%) children’s mothers abused alcohol and the same number of children had mothers abusing drugs. A cross-tabulation of parents’ alcohol use and parents’ drug use indicates that among the 31 youths’ fathers and 26 mothers respectively 16 (18.2%) and 12 (13.6%) were abusing alcohol only; among the 32 youths’ fathers and 26 participants’ mothers respectively 17 (19.3%) and 12 (13.6%) were abusing drugs only;
the other 15 (17%) subjects’ fathers and 14 (15.9%) subjects’ mothers were abusing both alcohol and drugs (Table 23). Combined, 48 fathers (54.6%) and 38 mothers (43.2%) were designated as abusing alcohol and/or drugs. Reports indicated that 30 (34.1%) subjects’ fathers and 19 (21.6%) mothers had been involved with the legal system; 25 (28.4%) fathers and 15 (17%) mothers had been in jail; in addition 5 (5.7%) fathers and 4 (4.5%) mothers were on probation.

Table 25:

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th>Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Father</td>
<td>31</td>
<td>57</td>
</tr>
<tr>
<td>Mother</td>
<td>26</td>
<td>62</td>
</tr>
</tbody>
</table>

How did these offenders perceive their family system? Who did they consider as members of their family? How extended was their family system? These questions reflect issues addressed in the survey and labeled as “Youth perception of the family system” (Table 26). A group of 25 (28.4%) offenders reported that they had a large family system composed of their mother, siblings, grandparents and some other relatives, while 16 (18.2%) other offenders considered as family their mother, siblings and stepfather.
### Table 26

Youth perception of the family system

<table>
<thead>
<tr>
<th>Perception of family system</th>
<th>% within gender</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>Mother and siblings</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td>12.7</td>
<td>5.9</td>
</tr>
<tr>
<td>Mother, father, siblings</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td>7.0</td>
<td>5.9</td>
</tr>
<tr>
<td>Mother, siblings, stepfather</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>%</td>
<td>18.3</td>
<td>17.6</td>
</tr>
<tr>
<td>Mother, grandparents, siblings</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>%</td>
<td>12.7</td>
<td>11.8</td>
</tr>
<tr>
<td>Mother, grandparents, siblings, others</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td>%</td>
<td>26.8</td>
<td>35.3</td>
</tr>
<tr>
<td>Grandparents</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>%</td>
<td>1.4</td>
<td>11.8</td>
</tr>
<tr>
<td>Adoptive foster parents and children</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td>8.5</td>
<td>5.9</td>
</tr>
<tr>
<td>Others</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td>12.7</td>
<td>5.9</td>
</tr>
<tr>
<td>Total</td>
<td>n</td>
<td></td>
</tr>
<tr>
<td></td>
<td>71</td>
<td>17</td>
</tr>
<tr>
<td>%</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>
Eleven (12.5%) of the respondents perceived their family system as composed of their mother, father, siblings and grandparents, while 6 (6.8%) others did not include their grandparents in the latter group. Ten (11.4%) youths perceived their family as composed of their mother and siblings only and 10 others reported no relative in what they perceived as family while 7 (8%) subjects considered their adoptive/foster parents and siblings as the only family members they had. Three (3.4%) respondents mentioned their grandparents as their only family members. This variable (perception of family system) was cross-tabulated with “gender”; the result provided information on the extent of the family system as seen by males and females (Table: 26). It was found that only 5 (7%) of the boys and one (5.9%) girl perceived their family system as composed of their biological parents (father and mother) and siblings; this finding, compared to the 10 youths (9 boys and 1 girl) who considered their family system composed of “others” shows how the concept of family was experienced by some offenders. For many subjects, 48 (67.7%) boys and 14 (82.4%) girls, the biological father did not appear as member of the family system; stepfathers, foster- adoptive fathers, and grandfathers appeared to play the role of male within the family; these adults held, in the youths’ life, the status of father-figure more than their biological fathers (Table: 26). The extent of the family could inform the researcher on the number of individuals the offenders considered as family members but could not provide information on which family members the youths were still in contact. This varied from one respondent to another. In effect, 6 (6.8%) subjects were in touch with 11 or more family members, 4 (4.5%) with 10 relatives, 1 (1.1%) with 9, and 7 (8%) with 8 kin. The larger groups 22 (25%), 15 (17%), 11 (12.5%) and 9 (10.2%) were in touch with respectively 5, 4, 6, and 7 relatives. Two other groups of 9
(10.2%) and 4 (4.5%) were in contact with respectively 3 and 2 relatives. Several of these youths experienced parenthood; a total of 9 (10.2%) offenders including 3 boys and 6 girls were teen parents as they had already one known child.

The individuals who most influenced the life of the largest group of subjects were their mother (33; 37.5%), grand-parents (16; 18.2%), father (10; 11.4%), siblings (8; 9.1%), both parents (6; 6.8%) or by their siblings and parents together (4; 4.5%). Individuals such as stepmothers, peers and “others” influenced respectively 1, 2, and 7 youths. One participant did not identify the person who most influenced him/her. A cross-tabulation of gender and “person who most influenced the youth” provided information on the persons whose actions or influence had most impact on male and female offenders’ behavior since they stood as role models in their lives. As shown in table 27, it was found that biological mothers had most influence on 24 (33.8%) of the boys and 9 (52.9%) of the girls; grandparents on 12 (16.9%) males and 4 (23.5%) females; and fathers on 10 (14.1%) boys; none of the girls has been most influenced by her father, stepmother, peers (Table: 27). A chi square test between “person who most influenced the youth and gang membership resulted in a non significant relationship. A cross-tabulation of birth order and person who most influenced the youth showed that among the 29 firstborns, 15 reported they had been most influenced by their mother; 5 by their grandparents; and 3 by their fathers. Among the secondborns 6 and 5 had been most influenced respectively by their fathers and grand parents; among the thirdborns 9 were most influenced by their mothers and 2 by their siblings.
Table 27:
Persons who influenced most the youths

<table>
<thead>
<tr>
<th>Persons who influenced most the youth</th>
<th>Gender</th>
<th></th>
<th></th>
<th>Total % *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings</td>
<td>7</td>
<td>1</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>9.9</td>
<td>5.9</td>
<td>9.09</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>24</td>
<td>9</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>33.8</td>
<td>52.9</td>
<td>37.5</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>14.1</td>
<td>0</td>
<td>11.36</td>
<td></td>
</tr>
<tr>
<td>Mother, and father</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>7</td>
<td>5.9</td>
<td>6.81</td>
<td></td>
</tr>
<tr>
<td>Grandparents</td>
<td>12</td>
<td>4</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>16.9</td>
<td>23.5</td>
<td>18.18</td>
<td></td>
</tr>
<tr>
<td>Mother, father, and siblings</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>4.2</td>
<td>5.9</td>
<td>4.54</td>
<td></td>
</tr>
<tr>
<td>Stepmother</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>1.4</td>
<td>0</td>
<td>1.13</td>
<td></td>
</tr>
<tr>
<td>Peers</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>2.4</td>
<td>0</td>
<td>2.27</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>8.5</td>
<td>5.9</td>
<td>7.95</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>----------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>No one</td>
<td>%</td>
<td>1.4</td>
<td>0</td>
<td>1.14</td>
</tr>
<tr>
<td>Total</td>
<td>n</td>
<td>71</td>
<td>17</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

% within group  %* sample
Chapter 5
Overview of the Findings

This research is a secondary analysis using data collected from full psychological evaluations of 88 youthful offenders who were being considered for entrance into a diversion/treatment program for violent offenders with mental health problems. Offenders referred to this program met the following criteria: being between age 11 and 17 years, having committed a violent offense, being identified as having a diagnosable mental disorder resulting in a significant mental impairment, and being viewed as progressing toward a commitment to ODYS “due to failure in less restrictive programs.” Final assessment evaluations were in the form of a written psychological report including test scores, diagnoses, historical information, and narrative and clinical conclusions.

The sample of 88 subjects were primarily male (N=71); the majority of the sample was Caucasian (60%), with African American and Hispanic youths comprising the remainder of the subjects (27% and 13% respectively). Ages ranged from 12-17 years, with a mean age of 15 years. Of the 88 children, 31 (35.2%) had parents who had been divorced, 27 (30.7%) had parents who had never been married, 19 (21.6%) had their biological parents still married at the time of the assessment, and no information was provided on the marital status of 11 (12.5%) youths’ parents.

The reports indicated that by five years of age almost one in three youths (29.5%) had started exhibiting behavior problems. Based on the Youth Level of Service/Case Management Inventory, approximately 66 percent of the sample was assessed as being high risk or very high risk for committing a future criminal act. DIR information
revealed that the mean number of previous incarcerations in this sample was 3.5 and the mean number of legal problems was 7.6.

The youths in this sample were highly impulsive and prone to injuring themselves and others. Approximately 88 percent of youths were noted as having impulsive behavior. Almost three in four juveniles (74%) had made a suicidal threat or gesture/act. Slightly over one in three (39%) were documented as having attempted suicide, including 8 of the 17 girls in the sample. A high percentage of juveniles (71%) were assessed as severely and extremely violent offenders, this means they were both verbally and physically aggressive and/or had committed crimes against persons during which they used a weapon (as specified in the DIR). One quarter of the youths had perpetrated violent acts on animals/pets such as dogs and cats by killing, mutilating or burning them. About 12 percent had committed at least one sexual offense and were adjudicated sexual predators. Over 40 percent of the sample (42%) had been noted as fire-setters. Almost three of four juveniles (72%) had perpetrated family violence. Finally, almost one-third of the subjects (32%) were victims of sexual abuse, with all females in the sample being victims of sexual and/or physical abuse.

Notably compromised intellectual functioning was indicated in almost half the sample. Three juveniles had full scale IQ scores in the moderate mental retardation range, 14 had full scale scores in the mild mental retardation range and 25 youths had scores in the borderline intellectual functioning range. Further, almost one in four youths had a provisional diagnosis related to a learning problem (i.e., reading disorder, mathematic disorder, learning disorder or written expression disorder). Among a total of 42 subjects whose IQ scores varied between 35 and 85 diagnosed with moderate, mild or
borderline mental retardation, there were two groups of 12 (13.6%) and 30 (34.1%) youths. The first group of 12 represented mentally retarded offenders who had been also diagnosed with at least one additional disability either in learning, math, reading disorder, or a disorder of the written expression; the other 30 youths were only mentally retarded or had only one disorder in math, reading, written expression or learning.

Over three in four juveniles were diagnosed with some type of conduct, oppositional, adjustment or disruptive behavior disorder, and mood disorders were diagnosed in over 1 in three adolescents. Similarly, attention deficit disorders were diagnosed in about one in three youths. Almost 30 percent of the sample was diagnosed with one or more substance use disorders, with youths being so diagnosed having significantly more incarcerations than youths without a substance use diagnosis. More than 45% (5/11) of the sexual predators had Axis I diagnosis of alcohol/substance abuse and more than 17% (5/28) of the sex abuse victims were given such a diagnosis. One sexually abused youth who was also sex predator was diagnosed with substance abuse cannabis.

About two in three adolescents had current scores of 50 or lower on the Global Assessment of Functioning Scale indicating serious symptoms or impairment in social occupational or school functioning. In addition, V code problems, codes that specify areas for clinical attention, were given for 43 youths, with the most common problem area being parent-child relations.

Parental abuse of alcohol/drug was noted in many records. Over half the fathers (55%) were cited as abusing alcohol and/or drugs. Approximately 43 percent of mothers were noted as alcohol/drug abusers. Parental histories of involvement in the legal system
were also noted in the reports. About one-third of the fathers and about one in five mothers had been incarcerated or on probation.

Juveniles indicated the following individuals as having the most influence on their lives: their mother (38%), a grand-parent (18%), their father (11%), and a sibling (9%). Peers were most influential for only 2 youths. Interestingly, the reports found relatively little gang affiliation, with records indicating only one in 10 youths having gang involvement. It was found that biological mothers had most influence on one in three boys and over half (53%) the girls of the boys and 9 (52.9%) of the girls. In no instance did a girl report being most influenced by her father.

Our findings, detailing personal, social, psychological and psychiatric characteristics of violent juvenile offenders with mental and behavior disorders as well as their family structure and functioning, have implications in the areas of professional practice, policy, and research as described below. Our data contribute to further identification and understanding of this particular population of youths whose special needs should to be taken into account when decisions are made during the process of indictment, conviction, incarceration, and treatment.
Discussion

The collected data provided information on the personal, social, psychological, and psycho-affective/cognitive characteristics of this category of youth offenders. In addition, other findings related to the structures and functioning of the youths’ families were presented. The use of pluralistic interlocking theoretical perspectives that incorporate systems and social learning perspectives enables combinations of constructs, and principles deriving from these two theories to be instrumental for the interpretation of this study’s findings.

This study’s sample was mostly Caucasians aged 12 to 17 years. The racial composition of this sample does not reflect the composition of the United States general population. In this sample of violent juvenile offenders, minorities, African Americans (27.3%) and Hispanics (12.5%), in comparison with Caucasians (60.2%), are disproportionately represented. This phenomenon is more noticeable with African Americans who represent only 12% of the current U.S population (Population Resource Center, 2000). A similar disproportion for African Americans is confirmed by OJJDP researchers, Snyder and Sickmund (2006) who reported that in 2003, African Americans represented 27% of the total juvenile arrests. For Caucasians, the sample proportion of this study is lower than the 71% reported in the 2003 study, but for Hispanics the rate is higher than the 3% the OJJDP estimated for 2003. First, it should be noted that this is a clinical sample; it does not represent the overall population of juvenile offenders in the state; it is a sample of seriously troubled youths in the ODYS and Juvenile Justice systems. Second, it is important to emphasize that this was a group of violent youths with mental health problems who were being considered for a diversion program as an
alternative to incarceration (some of these youths were in a detention facility or had recently been in detention and were being considered for alternative treatment, i.e., diversion to a mental health treatment program).

Although the mean age of this sample was approximately 15 years, the findings demonstrate that this group is characterized by an early onset of behavior problems and instability in living environment. Findings show that the exhibition of behavior problems early in life is among the characteristics of these youths, many of whom by the age of five had already demonstrated acting out behaviors that raised parents’ and professionals’ concerns although, Moffitt (in press) notes that previous research suggests that one half of conduct-problem boys do not grow up to have antisocial personalities since “early conduct problems are fully malleable and need not be a cause for pessimism” (p.13). Findings also illustrate a significant instability of home environment evidenced by numerous subjects having histories of being removed from their biological parents’ homes to be sent to foster homes (for some, as many as 10 or more). More specifically, by age five, slightly less than one in three youths had already exhibited behavior problems, and 17% had been removed from their home and placed in foster care. By age ten, two in three youths had exhibited acting out problems, and almost one in four had been removed from home.

In this sample, all the youths placed in foster care were younger than 10 years at time of placement, and represented 22.7% of the sample. Knowing that, in 2002, among the general population of children entering foster care, 60% were less than 10 years old, (Snyder & Sickmund, 2006), it appears that youths in the general population are more likely to enter foster care than those in this sample. Further, the rate of adopted youths in
this sample (6.8%) is very low when compared to the 18% of the population of exiting foster care youths who were adopted in 2002. Consequently, both observations lead to the conclusion that these research participants are less likely to be accepted in foster homes or to be adopted than children in the general population. This phenomenon may be due to their mental health status and to the nature of their personal, psycho-social, psychiatric, and familial problems.

The birth order variable (rank among siblings) was studied in relation with others variables such as “gang membership”, “person who most influenced the youth” and “IQ scores”. Clayton (2006) reported previous research findings suggesting that firstborns hold memberships in more organizations than laterborns. Considering gangs as organizations, this researcher checked the birth order of the gang members; it was found that among 9 gang members 3 were firstborns, 2 were secondborns, 1 was fourthborn, and 2 were seventhborns; the rank of 1 youth was not provided. This result is aligned with Nelson and Harris’ findings. On the issue of influence by someone, among 29 firstborns, 23 were most influenced by their kins: 15 by their mothers, 5 by their grandparents, 3 by their fathers. On this variable, a chi-square test comparing firstborns and the other 59 youths resulted in a significant difference between the two groups ($\chi^2 = 63.57$, df = 54 p < .05). This is supported by previous findings (Salmon & Daly, 1998) which suggest that firstborns were more likely to nominate their mothers as the person that most influenced them. Two of the 3 lastborns were most influenced by other people with whom no kinship was shared. On the IQ score variable, Sulloway (2001) found that firstborns tended to have higher IQs than their younger siblings. Our findings support this as the total IQ scores of firstborns were significantly higher than later born children.
In this study, the number of subjects who attempted suicide (34; 38.6%) is equal to the number of attempted suicides because none of the youths recidivated after surviving the first experience. The rate of suicide attempts among females in this sample (47.1%) is higher than the males’ rate (36.6%). These findings support statistics provided in the Oregon Vital Statistics (2003) which reports that in 2003 about three fourths (77.5%) of all reported suicide attempts were committed by girls; this result confirms a trend showing that girls have consistently been more likely to attempt suicide than boys. Comparing this research findings of 38.6% suicide attempts, and 56.8% of youths who exhibited suicidal ideations to the 17.6% and 16.9% of a previous study of 271 male delinquents diagnosed with conduct disorder (CD) (Rushkin, Schawab-Stone, Koposov, Vermeiren, & King, 2003), it is noticeable that the prevalence of the two phenomena is higher among youths in the current sample. This variation may stem from the composition of this sample, which includes males and females, 12 to 17 years old, when the previous includes males only, 14 to 19 year old. Further, all the youths in this sample have mental and behavioral disorders while in the other one, a diagnosis of mental or behavioral disorder was not a criterion for selection, although the participants used self report scales of psychopathology to present internalizing and externalizing symptomatology that resulted in psychiatric diagnoses such as separation anxiety, anxiety disorder, and PTSD. Both samples share the latter diagnoses but with the current one, no significant association was found between any of these diagnoses and suicide attempts or suicidal ideation.

Other results of this study show that many of these subjects (42%) are inclined to hurt themselves. This tendency of self mutilation (by cutting or other means) is another
characteristic of the subjects. In general, self mutilation is viewed as a means for certain people to call for attention, to manipulate others, or to request help. Meanwhile, psychiatrists in particular consider this practice as symptoms of internal disturbances with various manifestations (Matsumoto et al., 2004; Matsumoto et al., 2005). Self mutilation may take various forms such as self-cutting, and self burning as reported by Matsumoto et al. (2004) who found that subjects who cut/burn themselves experienced traumatic events such as separation from parents, bullying in school, physical and sexual abuse; they used illicit psychoactive drugs, attempted suicide or had suicidal ideation. These authors’ findings are supported by this study as among the 34 youths who attempted suicide, 21 cut themselves; among 28 sex abuse victims, 16 are self mutilators; and among the 60 physically abused youths, 26 have inflicted injuries to themselves.

Early involvement with the juvenile system is another characteristic of these subjects. Snyder and Sickmund found that in 2002, among the general population of delinquents, 36% were aged 14 or younger. This 2002 rate is low compared to this study’s 86.4% youths who have already been in contact with the juvenile system by the age of fourteen. This distortion may reside in the distinctiveness of this sample as all the subjects have mental health problems. No significant association was found between “age at first contact with the juvenile system” and “number of incarcerations”. This finding does not support previous research results (Katsiyannis & Archwamety, 1997) contending that “recidivism” was associated with “age at first offense”. Two factors may explain this difference. The first one relates to the sampling; Katsiyannis and Archwamety’s sample is only composed of male offenders already committed to a correctional facility while this study sample includes males and females; moreover, some
of them (3.4%) have not yet been committed to an institution and 19.3% have been incarcerated only once. The second factor resides in Katsiyannis and Archwamety’s definition of recidivism; they defined a recidivist as an offender whose second committed date was less than three years after the first one and they excluded parole violators for status offenses. In the current study, all offenders who have been incarcerated for a second time at least, are considered as recidivists. Despite these differences, the two studies are aligned as Katsiyannis and Archwamety acknowledge that family interventions, early intervention, prevention and a variety of treatment approaches are important factors in reducing recidivism, addressing the mental health needs of delinquent youths, and providing educational remediation for a successful rehabilitation of delinquents. These authors’ findings and suggestions reinforce the firm belief of the judges who participated in this program and supported the psychological assessments used for the current research; they are convinced that it is in the best interest of the eligible offenders to be sent to diversion programs instead of jail and to address their mental health needs within their community and family; in doing so, juvenile court’s philosophy is upheld and recidivism rates are expected to be positively impacted.

A significant negative correlation ($r = -.38; p < .01$) was found between “age at first contact with the juvenile system” and “number of legal problems”, which means that the older the subjects are at the time they commit their first offense and come into the system, the lower the “number of legal problems” in which they are involved. One explanation of this finding resides in the fact that the older offenders who come late into the system are closer to the age of 18 and therefore, have a shorter interval of time during which their number of offenses is evaluated and consequently the count may be lower.
Another explanation would emphasize the skills and ability the older youths develop to avoid getting back into the system. In effect, more experienced or older subjects would take advantage of younger children by convincing or instructing them to get involved in illegal activities while they stay away from the scene so they would not be caught; for example, older youths involving their young brothers or friends in drug trafficking.

These subjects exhibit various levels of aggressive behaviors in their interactions with their siblings and peers. This phenomenon illustrates the power of social learning theory in explaining the process by which children learn, integrate, and imitate aggressive behaviors acted out during encounters with siblings as well as peers. This study demonstrates the range of aggressiveness of the subjects who tend to be either both verbally and physically aggressive, physically aggressive only or verbally aggressive only with siblings and peers. With their aggressive tendencies, they aim at hurting not only individuals but also animal pets, dogs, and cats, and for these actions, some of them faced domestic violence or animal cruelty charges, which affected their level of risk for future criminal activity. Based on their scores on this scale, three groups have been determined. The scores in the largest group vary between 23 and 35; this is a very high level of potential for future involvement in crime compared to the moderate (13-22) and low (0-12) risk levels for future criminal activity; this variable is significantly associated with the number of incarcerations (r = .29; p< .01), with the number of legal problems a youth is involved in (r = .32; p < .01), and with alcohol abuse (r = .27; p< .05). These findings suggest that the offenders, who have a high number of incarcerations, high number of legal problems, and/or who abuse alcohol, are more likely to get involved in criminal activity in the future.
Any intervention to deter this trend needs to take into account all risk factors contributing to the future criminal activities of the youths. In effect, this study reveals that there are risk factors intrinsic to education/learning problems, family circumstances, lack of positive leisure/recreational activities, peer relations, personality, substance abuse and other unspecified issues. In all the cases but two, the contributing factors were determined and turned out to have a combined influence on the youths. For example, seven risk factors concomitantly influenced the life of 29 subjects; a combination of five factors influenced the second group of 24, and a group of 3 participants had only two risk factors that contributed to their risk for future criminal activity.

Besides these risk factors, this study reveals the nature of some events that precipitated the youths’ incarcerations. A particularly potent one is the combination of two events: the “incarceration of a relative/separation” and “lack of supervision”. These two events, occurring concurrently, preceded the incarcerations of 28 offenders and may even have motivated the commission of the offense that led them to be involved with the juvenile justice system; these youths did not have any control over the occurrence of these events and their traumatic effects, which are in many cases anxiety and tension producing for children.

Another finding of this study relates to the social problems experienced by these violent offenders. The high rate of runaway cases (39; 44.3%) is an important characteristic of this sample. Among the 71 boys in this study, 29 (41%) had run away from home; among the 17 girls, 10 (59%) had run away. This result does not reflect Mitchell’s (2003) findings that equal numbers of runaway males and females contacted the Message Home helpline aimed at providing support to youths who have run away.
Mitchell found that conflict with parents was the most common reason (35%) for children to runaway from home; the second common reason was abuse by a family member, usually a parent (24%). This author stated that some young people readily admitted that their own behavior had been difficult but also invoked sex abuse among the reasons of their running away. Other researchers stressed that some runaway youths unwillingly participated in sexual acts and suffered from them as victims, but reported that, in contrast, in order to meet subsistence needs, some other runaway and homeless youths got involved in “survival sex” (Greene et al., 1999). Greene et al. argued that their subjects were compelled to get involved in this practice which refers to the selling of sex to get money, food, or a place to stay. Although the criminal history and mental health status of the youths involved in Mitchell’s and Greene et al.’s research are different from those in this study, there are some similarities in the reasons invoked by these youths for their running away and removal from home. Greene et al.’s sample reflects more closely this study’s participants as 41% of their sample of youths had been placed in a psychiatric hospital at least once.

This study’s findings also contribute to our understanding of this population’s educational/learning deficits. Almost 25% of the sample had a provisional diagnosis related to a learning disorder. Svensson, Lundberg, and Jacobson (2003) reported that reading disorder was prevalent among inmates in juvenile institutions because almost 50% of inmates in Swedish institutions showed some kind of reading difficulty; but they found that only 10% had pronounced phonological difficulties that meet a dyslexic criterion. Even though Svenson et al. acknowledged that “Dyslexia is assumed to be frequent among inmates in prisons and in juvenile institutions” (p. 667), their findings
show that their model suggests that manifest reading problems have a multitude of possible causes among which limited opportunity to learn, change of teachers, truancy and exclusion from school due to conduct problems. These authors’ thorough investigation showed that dyslexia affects children’s skills in math, writing, spelling and even speaking.

In the present study, despite the fact that many subjects were provisionally diagnosed with reading, mathematics, and disorder of written expression, none of them were given a formal evaluation for dyslexia due to the additional time/expense of such further evaluation. However, further assessment and evaluation of learning difficulties is warranted.

Researchers have stressed out the overrepresentation of offenders diagnosed with learning disability and mental retardation in juvenile correction (Casey and Keilitz, and Bullock and McArthur, as cited in Quinn, Rutherford, & Leone, 2001). For example, Bullock and McArthur noted that mentally retarded and learning disabled youths represented respectively 35.6% and 12.6% of incarcerated offenders. These findings are supported by the current study results showing that 48% (N=42) of youths had low IQ varying from borderline (71-85), to mild (55-70), and moderate mental retardation (35-54) and that provisional learning disability in math, reading and written expression was experienced by 20 (22.7%) of the subjects. Almost one in four youths in this sample had a provisional diagnosis related to a learning problem.

Katsiyannis and Archwamety (1997) reported that deficits in math, reading, and enrollment in special education are associated with recidivism. The current study has investigated the impact of students’ deficits in reading, math and learning on the number
of incarcerations but no significant difference was found between subjects diagnosed with a learning disorder and those with no learning disorder on the number of incarcerations. However, it was found that 52% of the offenders had problems related to truancy, and 87.5% with disrupting school. On these two variables (“truancy”, and “disruptive in school”), no difference was found between the subjects with low IQ and learning disorders and those with high IQ scores and not diagnosed with the latter disabilities. This result suggests that subjects diagnosed with low IQ and learning disability and their peers with no learning disabilities are likely to experience the same problems related to school attendance, and disruption. This finding does not support Winters’ (1997) conclusion that failure in school is a result of poor attendance for many students particularly for learning disabled.

In this study a relatively low number of children (9) were found to have a gang affiliation. No significant difference was found between the IQ’s of gang affiliates and other subjects. Additionally, one gang affiliate had a provisional learning disorder.

This study found no differences between offenders with provisional learning disorder (LD) diagnoses and those with no provisional diagnoses of LD on the number of legal problems and on the number of incarcerations. This result is aligned with Winters’ report that no causal relationship was found between LD and delinquency even though Permutter (as cited in Winters, 1997), had found a link between LD and adjudicated adolescents. It may be stressed that the high number of incarcerations may also translate into low regular school attendance and therefore disruption of their education with consequences on their reading as well as mathematics skills. Other factors such as the
subjects’ parental level of education, and attitude toward school could impact their children’s educational level and school problems.

Findings from this study provide detailed information on the mental health diagnoses of a sample of violent delinquents with emotional/mental problems being considered for diversion and treatment. Most youths in this sample were diagnosed with some type of behavioral/conduct disorder and almost one in three youths were diagnosed with a substance use disorder. While behavioral, mood and substance disorders were quite common there were no diagnoses of schizophrenia and only one diagnosed psychotic disorder.

The frequency of emergency room admissions or hospitalizations, the large number of youths receiving counseling, medical, and psychiatric services, and the variety of psychotropic medications prescribed to them illustrate the extent of their mental health problems and needs. After detailing mental health problems experienced by the youths, the evaluators described the types of services provided to them. These services included counseling, medical, and psychiatric interventions with various combinations of two to three types of services. This study documents the variety of medical services needed to address their health conditions. Among the youths diagnosed with medical conditions the largest group (17%) experienced diseases of the respiratory system; some others were diagnosed with infectious and parasitic diseases (10%), followed by complications of pregnancy, childbirth, puerperium (6%).

The use of prescribed psychotropic medications is another indication of the mental health disorders these offenders experience. Sixty-seven youths were taking 1 to nine medications. An additional three outliers had been prescribed 12, 13, and 17
medications. The high percentages of self mutilators (42%), suicidal gestures (57%),
fire-setters (42%) as well as the youths’ violent behaviors could also be considered as
indications of significant mental health problems. Previous studies show that due to
medication side effects and youths’ non compliance to medication taking schedule, some
children have been prescribed a series of medications at various points of their lives
is a major problem area with offenders who have mental health problems in the juvenile
justice system because of issues such as noncompliance with treatment in general and
with medication taking in particular. The high degree of impulsivity, family
disorganization/instability, cognitive and learning difficulties, and poor school
compliance make this study’s population at high risk for medication compliance
problems. Terneus and Wheeler (2005) raised problems inherent to side effects, prices of
medication, difficulties in administering medication, and possible addiction to drug.
Continuity in administering medicines after the offenders’ release from detention
institutions is another poignant issue that concerns the juvenile justice system. In fact, a
short time following their release, some youths could be readmitted in an institution with
health conditions worse than when they were leaving because, while at home, either they
could not afford buying their own medications, did not comply with the dosage, or did
not take them on a regular basis as prescribed.

Global Assessment of Functioning (GAF) scores were low, with almost two in three
(62.5%) scoring in the 40-50 range in the year of the assessment. According to the GAF
scale in DSM IV, youths whose scores are included in the range of 40 to 50 experience
some impairment in reality testing or communication (e.g., speech is at times illogical,
obscure, or irrelevant) or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., frequently beating up younger children, defiant at home, and failing at school). They also exhibit serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job). Since the GAF score is mostly used for assessing impairment among patients with psychiatric or substance use disorders or patients experiencing both problems, there is an assumption of association between the GAF scores and the use of health care facilities and allocation of services needs. The current research found no association between the offenders’ GAF current scores and number of hospitalizations, and the number of services provided to study participants. These results support Bogenschutz and Siegfried (as cited in Moos, Nichol, & Moos, 2002) who found no relationship between GAF scores and the use of outpatient mental health services.

Offenders’ family structure and functioning were also examined. This study addressed the influence of family and non-family members on these violent juvenile offenders. Findings show that the influence of the parents particularly that of the mother, siblings and grand parents on the offenders is more pronounced than the influence of the peers. This finding is an indication that the participants were more attached to members of their own family than to their peers some of whom are involved in gang activities. The chi square result that revealed a non-significant relationship between “person who most influenced the youth” and “gang membership” may explain the youths’ rather low involvement in gangs as only 10.2% of the sample self reported gang membership. In interpreting this finding, a compelling need for caution is necessary because gang
members are usually required to refrain from openly talking about their belonging to such
groups even though they may be identified through their clothing and other external
signs.

Welte et al. found a relationship between drug use and criminal behavior among
juveniles. Our data have demonstrated a link between a diagnosis of substance
abuse/dependence and an increased number of incarcerations. Other findings (Oregon,
2003) show that drugs were used in two of every three suicide attempts. However results
of the current study demonstrated no difference between those diagnosed with a
substance abuse disorder and those not so diagnosed in relation to the number of legal
problems or charges, and to the number of suicides attempted. Many of these offenders
as well as their parents were involved with alcohol, drugs, and the legal system. A t-test
between alcohol abuse and number of legal problem revealed that there is no difference
between youths diagnosed with alcohol abuse and those with no diagnosis of alcohol
abuse on the number of legal problems they were involved in.

As previously stated, most of the participants (56%) interacted more with their
mothers or grand parents than with other relatives or individuals and reported that they
were more influenced by their mothers (38%) or grand parents (18%). They also
perceived their family system as composed primarily by the “mother, siblings, grand
parents and others” (28%) or by the “mother, stepfather, and siblings (18%). These
findings revealed the relatively low influence of the biological father. Only 10 youths
reported being most influenced by their fathers. Consequently, various other individuals
may incarnate the role of father figure. Snyder and Sickmund (2006) reported that, in
2002, three of every five youths living in households headed by other relatives, were
living with a grand parent. This is a trend illustrated in this sample as 3.4% were living with their grand parents but this rate does not reflect that of the general population as reported by Snyder and Sickmund.

The sexual behavior of subjects in this study is a cause for concern. Eleven youths were adjudicated sexual offenders. Nine of them were documented as having problems with public masturbation, but the reasons for perpetrating sexual offenses have not been studied and therefore are not specified in this research; however, a significant chi square result between “public masturbation” and “sex offense perpetration” was found. A cross-tabulation of these variables shows that 5 of the 9 youths who masturbate publicly, have perpetrated a sexual offense. Farmer and Pollock (2003) reported that young sexually abused victims experience confusing feelings of sexual arousal and a sense of insecurity and safety. They suggested that the acts of sexual abuse the youths underwent had many consequences including a heightened sense of arousal that makes the abused child experience compulsive masturbation. The present research supports this association between masturbation and sexual offending behaviors.

Previous research (Ackerman et al., 1998) found that there is a prevalence of PTSD and other psychiatric diagnoses in children victims of sexual, physical or both types of abuse. These researchers emphasized that the latter group (victims of both sexual and physical abuse) appeared to be at highest risk of psychiatric disturbance. The current study shows that among the participants 4 (4.5%) have been diagnosed with PTSD. Depressive disorders were diagnosed in 15 (17%) youths, a high percentage as reflected in Messier and Ward’s study (1998) prompting these researchers to suggest mandatory screening for this disorder for all incarcerated delinquent children; they found that 15 to
18% of incarcerated juveniles show symptoms of depression. The results of the current study support Messier and Ward’s finding; a highly similar rate of participants have been diagnosed with depressive disorder.

Sexually abused subjects as well as sex predators in this sample have been compared to the other subjects with respect to substance abuse disorders, anxiety, PTSD, bipolar I and II, and mood disorder, disruptive behavior, oppositional defiant disorder, and borderline intellectual disorder for example. Chi-square results show a significant difference between sex abuse victims and the youths who have not been abused sexually on PTSD chronic and disruptive behavior disorders NOS; in other words, sex abuse victims are more likely to experience PTSD and exhibit more disruptive behavior disorder than the other group. Sex offenders in this sample are more likely to show oppositional defiant disorder than non-sex offenders; further they exhibit more symptoms of borderline intellectual functioning as chi-square results show. No significant difference was found on variables such as depressive disorder, bipolar, mood, anxiety, substance abuse, learning and conduct disorders. Due to the size of the sample, and the low number of sex abused victims as well as sex offenders, these tests may not reflect previous research findings on conduct and learning disorders (Ackerman et al., 1998; Farmer & Pollock, 2003). Among the 11 sexual predators, 5 (45.5%) including 1 female had been sexually abused. The total number of sexually abused being 28, the sexual predators represent 39.3% of the victims. This study’s rate of sex predators who have been victim of sex abuse reflects previous research findings (Farmer & Pollock, 2003) even though it is lower than the half reported by Farmer and Pollock.
The current study also shows high rates of sex predators and victims of sexual abuse diagnosed with alcohol/substance abuse. Results indicate that 5 (45.5%) of the 11 sex predators, and 5 (17.9%) of the 28 victims of sex offenses had been diagnosed with alcohol and substance abuse; the only offender who was both sexually abused victim and sexual predator was diagnosed with substance abuse cannabis. These findings are of importance as they indicate that sexual concerns should be assessed and even addressed when treating these youths.

The characteristics found within this sample are shared with a larger population of juveniles incarcerated in institutions, whose needs for services are not met, and who are considered as over represented among the general population of incarcerated offenders. Previous research using different samples have investigated some of the characteristics and even clustered them into distal and proximal factors of delinquency. The particularity of these characteristics requires specific practice methods, new policy and more research.
Implications for practice

The high degree of pathology found in this sample of delinquents is noteworthy and includes serious acts of violence, sexual offenses, fire-setting, animal cruelty, mental and substance disorders, suicide threats/attempts and extensive histories of legal problems. The contextual background of these youths includes high rates of parental incarceration, parental substance abuse, family instability, compromised intellectual functioning, learning problems, early documentation of behavioral problems (i.e. by age 5), and sexual/physical abuse as victims or perpetrators. Clearly this population of youths requires an array of interventions capable of addressing a cluster of problematic and disturbing behaviors that are anchored by mental and drug use disorders and compromised intellectual functioning.

Early identification of the above problems is the cornerstone of good treatment. The earlier these youths can be identified and treated, the more likely the treatment will be successful. In this study, one in three youths was identified as having a behavior problem by the age of five. Research has demonstrated that when such children and their families can be given appropriate clinical interventions at this early age/stage, treatment is often successful even though, the long term effectiveness of prevention and treatment programs is limited (Hill, 2003). Therefore, the most cost effective and efficacious approach to addressing the problems experienced by this sample of youths is early identification and treatment.

Training and screening by preschools, elementary schools, foster-care agencies, county social service agencies and other child serving organizations should be common practice. Research has consistently demonstrated that the early emergence of behavior
problems (i.e., age 5 or younger) is predictive of later, more severe problems; however, when early identified problems are addressed, the future outcome is enhanced (Hill, 2003); and preventing life-course persistent offending lifestyles requires early childhood interventions in the family (Moffitt, in press). While such early identification and intervention are the ideal options, identification during later stages of development is also important. When children first encounter the juvenile justice system, attention should be given to their psychosocial needs and statuses. Screening and assessment for mental health should be a required step in the admission process of youth offenders in juvenile court, probation and institutional settings. The outcome of this mental health assessment along with other factors such as the type and violence level of the offense committed and the cognitive and intellectual potentials of the youths would provide valuable information toward managing these offenders and making appropriate decisions for possible diversion options.

In detention settings offenders diagnosed with mental health disorders should receive appropriate treatment and medication when indicated. This service would require an on-site psychiatrist who could prescribe the proper medications and treatment; further, on-site mental health professionals (i.e., social workers, counselors) should be available to institutions on a twenty-four hour basis. Caseloads for these professionals should reflect the degree of their clients’ illnesses; thus, the high degree of disturbance found in the current study’s population should be reflected by a lower caseload. Lower caseload adjustments should also be made for this population of delinquents in non-residential juvenile justice settings such as probation and parole; in residential settings, they should not be assigned to overcrowded units.
An important additional approach is education of key personnel in the juvenile justice system. Juvenile justice professionals, judges, lawyers, social workers, correctional and probation officers as well as police officers should attend mandatory initial training courses and refresher training courses aiming at providing them with an in-depth understanding and knowledge in child development, mental health disorders, learning disabilities, special education, and Individuals with Disabilities Education Act (IDEA) rules. This knowledge would enable them to ensure that proper actions are taken through court proceedings, placements, and supervision. These workshops would enhance their skills in the identification of mental health disorders and learning disabilities, as well as policies regarding provision of special education services to juvenile offenders with mental health, learning and behavior disorders. For example, some misunderstandings between incarcerated children and detention officers would likely be overcome because the latter would be more aware of the cognitive level of the youths and therefore would make sure that their instructions were communicated clearly before expecting the offenders to follow through. Additionally, juvenile justice professionals would learn to develop their skills in networking with experts specialized in education, mental health, behavior management, and medical settings; further, they would learn to recognize potential problems that could arise when working with youths affected by multiple disabilities.

Professionals in the juvenile courts should be more knowledgeable in understanding and assessing the impact of disabilities on the youths’ behaviors; for example they should know that youths with attention deficit disorder “commonly act impulsively, fail to anticipate consequences, engage in dangerous activities, have
difficulty with delayed gratification, have a low frustration threshold, and have
difficulties listening to or following instructions” (J.J.B, 2000, p. 6) and that “Among the
most important personality dimensions that predict violence are hyperactivity,
impulsiveness, poor behavioral control, and attention problems” (Farrington, 2005,
p. 11). They would also know that sexual predators and sexually abused offenders
diagnosed with alcohol and/or substance abuse disorders need to be involved in treatment
programs that address both the substance abuse disorders and sexual deviance. Court
sanctions could then take such factors into consideration resulting in more therapeutically
appropriate sentences. These workshops would enhance juvenile justice professionals’
knowledge in many domains such as the monitoring of special education programs, the
processing of the mandatory and necessary release of information form that is to be
signed by the youths’ parents authorizing school administrators to transmit information to
the court, the implementation of IDEA, as well as the accreditation of correctional
facilities.

Programmatically, the high percentage of juveniles in this sample with cognitive
and/or learning deficits requires significant attention. Throughout the juvenile court and
treatment processes, such deficits must be considered to help youths more fully
understand the court proceedings and to understand and participate more fully in
treatment. Special education teachers should be specially trained (initial or in service
training) to work with multiply compromised juvenile offenders after their hiring by the
juvenile justice administration. These teachers would need to learn more about the
specific subculture of youth offenders which is not the same as that of public schools
students. Social workers practicing in juvenile institutions, family and youth services,
including detention centers, jails, group homes, and treatment centers should be prepared to help these youths enhance their social and coping skills, grieving methods, self esteem, and behavior management abilities. They should be able to contribute to the development of the youths’ skills in decision making, and in interacting with others: siblings and peers. In order to succeed in those tasks, these professionals would need training and tools to organize specific activities aiming at strengthening their clients’ ability to cope with divorce, loss of or separation from parents, close relatives, or peers; they should help them develop strengths enabling them to manage their anger, identify and express their feelings, anticipate the consequences of their actions, and acknowledge their responsibility in those behavior outcome. These professionals should be able to provide services that would enable their clients, despite their cognitive/learning deficits, to resolve conflicts they are involved in or involving their friends and others, stand up against and even conquer bullies, and develop a positive self esteem/self concept by raising their awareness of their specific deficits/problems. They should be prepared to contribute to the strengthening of their clients’ abilities to identify their own needs, and to seek help, when necessary, from others, or develop strategies to fulfill their goals.

The complexity of clinical issues present in this sample’s population requires a wide array of practice capabilities and most likely, interagency collaborations. On the local level, perhaps the existing clinical services that most approximate the needs of these youths are adolescent dual disorders programs. These programs providing both mental health and substance use evaluations/interventions are often aware of histories of sexual/physical abuse and some possible learning problems such as attention deficit/hyperactivity disorder. However, even these programs are typically not
configured with services that can address additional issues seen in this sample such as compromised cognitive abilities, sexual predation, and fire-setting. For example sexual predators diagnosed with alcohol/substance abuse should be involved in treatment programs that address both their sexual deviance and substance abuse disorders. Indeed, such client characteristics may prevent a youth from being served by a dual disorders agency.
Implication for Policy

The complexity and depth of problems experienced by this study’s population of youths require collaboration not only at the service level, but also at the state agency level. In Ohio, agencies such as the Departments of Mental Health, Alcohol and Drug Addictions Services, Mental Retardation and Developmental Disabilities, Rehabilitation Services, Education, and Youth Services all have important roles in serving these youths. Interagency coordination of funding for both services and research is essential to develop and sustain appropriate treatment models/services for this population of severely compromised juveniles. Collaborative strategies should be developed through interagency team meetings. Regular meetings and formal communications would promote more understanding of the goals of each department with respect to this population of youths and enable them to assist each other in meeting a common objective: the welfare, safety and security of children in their care.

Effective and efficient intervention with these children requires that numerous systems be involved in their identification and care. Therefore, authorities at the county level should plan for the creation of more specialized courts whose mission is aligned with that of regular juvenile courts but with a focus on offenders diagnosed with mental health and behavior disorders; authorities could also adopt another alternative by setting forth a type of multidisciplinary task force involving representatives of the Juvenile Justice, the Mental Health Board, the Department of Youth Services, the Department of Jobs and Family Services, the Department of Health, and any other organization whose involvement is deemed necessary. This task force would meet regularly once every three months and may be called for emergency meetings once between two regular
meetings in order to alleviate the case load. Members would hear reports on cases referred to them by judges, and agency professionals so they would make recommendations for placements, treatment, funding and policy, evaluate program performance for adequate placements, and follow up on recommendations. In addition, for more effectiveness, the task force should have a workshop agenda to provide professional support and education to all agents such as social workers, teachers, detention officers, and the police who in their daily intervention are involved with children experiencing mental health disorders with co-occurring problems such as substance abuse, and other disorders.

Professionals and researchers (EDJJ, 2000) acknowledge that efforts have been made to improve corrections education by implementing a national policy for corrections education and developing standards for administration; meanwhile, they recognize that there is no formalized process for measuring compliance with the standards or for using measures as the basis for certification or accreditation of corrections schools or school systems. Therefore, there is an urgent need for formalizing the process, measuring compliance with standards, and using measures as the basis for certification or accreditation of corrections schools. All teachers working in a juvenile detention facility should be certified in special education and trained in offenders’ subculture awareness. The curriculum should encompass conflict resolution, the cycle of behavior (ABC of behavior) stressing the various stages in the process of feeling-reasoning-acting out, adaptive behavior, goal setting, and thinking ahead; vocational skills such as computer use should also be in the program. The individualized education program (IEP) of the youths should be based on cognitive behavioral and social learning approaches. These
themes should be reinforced by social workers during mandatory group intervention attended by offenders.

For their education, these youths would be assigned to the appropriate classrooms so their special education needs would be met. While in detention, a screening for learning disorders and an IQ test should be implemented within 72 hours of admission in a detention facility if the youths have not been previously assessed or if the child’s school record is not accessible. The IDEA requires the identification, location, and evaluation of all children with disabilities residing in any state; therefore any child with disability entering the juvenile system should have been identified and evaluated; their records should be available to the justice system. This approach would help determine the number of youths with a diagnosis of learning disorder and plan for service provision. It would help judges in the sentencing and placement of the youths.

A less stressful and safer management of jails depends on many factors but particularly on an effective treatment of offenders with mental health disorders. Detention officers should be required to report incarcerated youths’ compliance with medication taken in the presence of the institution’s nurses who hand out prescribed medications to the youths. Probation officers’ job description should include mandatory supervision of the youths’ compliance to treatment and monitoring their keeping appointments with mental health agencies after their release. A mental health department or at least an on-site mental health office within the facility would contribute to the accessibility and availability of mental health professionals; they should be available around the clock as they would be on call after work hours. The provision of adequate services would require a specific budget for the mental health department in order to meet related expenses.
Another alternative would be to include this budget in the one attributed to the medical department; this initiative would foster more effective interventions as the two departments would have to collaborate to develop a more efficient evidence based intervention approach and to take into account the general medical conditions of this population of offenders. Research (Ohio SAMI-CCOE, 2003) has shown that collaborative efforts between mental health professionals, medical staff, and social workers have led to evidence based intervention strategies such as the Integrated Dual Disorder Treatment (IDDT) developed by multi-disciplinary teams for dual diagnosed clients experiencing co-occurring mental health disorders and other illnesses, particularly alcohol abuse and other substance use.

The option to consider these youths’ placement in diversion programs could be worthy of experimentation as it could eliminate inappropriate and unnecessary incarcerations, alleviate juvenile courts’ financial burden of expensive operations and maintenance of detention facilities, and also provide the youths with more opportunities to engage in productive activities and take advantage of the actions and skills of experienced professionals in less restrictive environments.
Implications for research

Limits of this study

This study is exploratory and thus no causal inferences can be drawn. Further, the small sample size and non-random selection of subjects suggests caution in applying the findings to the larger universe of violent delinquents with mental/behavioral disorders. Another limit is the manner in which some variables were operationalized due to the restrictions posed by secondary data analysis. For example, some variables such as the number of incarcerations and the number of offenses would be of more value if each offense committed by the youths was attributed a value. This approach would contribute to rank ordering the offenders according to the score they achieved. The variable “Number of offenses” would also be used in a more meaningful way if the different offenses were specified. For example, if the number of aggravated assaults, aggravated domestic assaults, robberies, thefts, and burglaries committed by each youth were known, a differentiation or comparison of the groups deriving from this classification would be possible. In addition, the socio-economic status of the offenders and their families had not been assessed. If this variable was investigated, it would provide more details on the offenders’ environment, living conditions, and community.

Future Research

This exploratory research aimed at determining important characteristics of violent youth offenders with mental and behavioral problems. Further research is needed to ascertain whether a causal relationship exists between violent offending behavior and many of these youths’ characteristics. Future research should explore the underlying mechanisms of key associations between many of these variables. In doing so,
researchers would contribute to the development of new policies and treatments regarding juvenile offenders with mental and behavioral disorders in particular and perhaps youth offenders in general.

Research aiming at determining offense trajectories could be initiated and findings would contribute to further research on subgroups such as “persisters” and “desisters”, among these violent offenders with mental and behavioral problems. Follow up studies of similar subjects should be initiated into adulthood to explore the degree and nature of subjects’ involvement with the criminal justice, mental health and substance abuse systems. One objective of such a longitudinal study would be to investigate the factors that have contributed to the youths’ violent offending behaviors. Further, researchers would be able to evaluate the accuracy of the “risk for future criminal activity score” provided by the evaluators; they would have to assess the persistence of the offending behavior, and the recidivism rate in adulthood. They could also aim at determining which of the risk factors assessed in this study has effectively contributed to the subjects’ offending behaviors.

Future research could also be prompted by the high percentage of youths who attempted suicide and those who expressed suicidal thoughts. Such studies could compare this population to other populations of offenders in regard to specific youth characteristics related to persistent suicidal ideation, attempts and completions. Identifying important contributing factors would help professionals and parents in planning prevention, intervention and rehabilitation services that would facilitate the decline of this trend among this group of youths.
Conclusion

This research was designed to explore the psychosocial characteristics and functioning of violent youthful offenders with presumed mental health/behavioral problems who were referred for psychological assessment. As exploratory research, its findings are descriptive and present specific characteristics shared by the participants, providing detailed information that could contribute to a better understanding of these youths, based on their personal characteristics, an analysis of their social, emotional, intellectual, and situational problems, and the functioning as well as the structure of their family systems. Previous studies have investigated some of these characteristics and delinquency factors. The current study, however, provides an analysis of in-depth psychosocial testing across a broad spectrum of potential problems/difficulties. The results of this study provide information on a population that has a great deal of needs and requires multiple services among youth-serving agencies. Finding from this study may be useful to inform much needed longitudinal studies of this population of delinquents. The current findings may also be useful in informing current practice and policy to serve better violent juvenile offenders with mental/behavioral problems.
APPENDIX A

Definitions and recording of the variables

In this appendix, the concepts Researcher and Evaluators refer respectively to the doctoral student, author of this thesis and the professional psychologists who assessed the youthful offenders. The results of the evaluations were presented in individual reports used to complete the database. The researcher’s data collection process consisted of reading the evaluators’ reports and recording their findings. If there were missing data from the reports, the researcher would consult the youths’ files in order to complete the data collection. In the following list, there are two sets of variables. In the first one (set1), there are 91 variables listed in alphabetical order according to their labels’ spelling; each one has a label with a maximum of eight letters as required for data-entry in the Statistical Package for Social Sciences (SPSS), which is the statistical program used for data analysis. For example variables such as “academic problems” and “animal cruelty” are respectively labeled “acadpbl” and “acruelty”. The second set (set2) is composed of 56 variables representing DSM IV diagnoses on AXIS I and AXIS II, labeled with their classification numbers. The total number of variables used in this study is 147.

In this list, the numbers in parentheses are the values attributed to the variables on a Likert scale; for statistical reasons all nominal variables have been transformed into ordinal variables.
Set 1

1- Abandoned by parents (abandond): the researcher has recorded the evaluators’ reports of youths who were voluntarily given up by their biological parents and who, during a certain period of their life, had no contact with one or both biological parents.

2- Academic problems (acadpbl): this variable refers to information provided on the youths’ grades, and school performance. The youths have academic problems for example if they had been making passing grades and then declining or failing grades; they may also complete unsatisfactory work and attend grades that do not correspond to their age.

3-Animal cruelty (acruelty): this variable is related to the youths’ treatment of animals. The evaluators may have explicitly reported that the offenders were cruel to animals; they may also note that the youths attacked, killed or mutilated dogs, cats and other pets; therefore the researcher infers that there is animal cruelty.

4- Adoption status (adopted): the researcher records the evaluators’ report that the youths have been taken permanently by other families into their homes.

5- Age of youths when assessed (age): the researcher records the age the youths had at the time of the evaluation by the psychologists.

6- Age when first behavior problem occurred (ag1bhpb): the researcher records the age the youths had when they started acting out negative and aggressive behavior.

7- Age when first contact with juvenile system occurred (ag1lglpb): the researcher records the age the youths had when they were brought to juvenile court for the first time by law enforcement officers after being picked up for allegedly committing an offense or a crime.
8- Age when first removed from home and placed in foster home (ag1fost): the researcher records the age the youths had when they were first removed from their biological parents’ homes and placed in foster homes.

9- Age first sex offense was perpetrated if sex offender (ag1sexpp): the researcher records the age the youths had when they were brought to justice for the first time after they allegedly perpetrated a sex related offense.

10- Aggressive behavior (aggresbh): all these youths have committed violent acts but due to the level of violence of the crime they committed, they were ranked as violent (1) extremely violent (2) or severely and extremely violent (3). For example the youths who committed crimes against property, made threat to people but did not physically harm them were considered violent; those who committed offenses or crimes against people and physically harming themselves or others are recognized as extremely violent; the third group the “severely and extremely violent” youths are those who have committed both crime against property and persons such as forcible rape and aggravated assault.

11- Alcohol or drug abuse problem (alcsubah): the researcher distinguishes 3 categories of substance abusers: the youths who only drink alcohol (1), those who only use drugs (2) and those who drink alcohol and also use drugs (3). The offenders who neither drink nor use drugs represent a fourth category (0).

12- Attention seeking behaviors (attnseek): the researcher records the evaluators’ report of attention seeking behaviors observed. For example when the evaluators report that the youths often draw other people’s attention by acting out or intentionally
simulating being hurt, or sick at specific periods, the researcher infers that the youths exhibit attention seeking behaviors.

13-Compulsive behavior, tic disorder (compulbh): the researcher records the evaluators’ report of compulsive behaviors, tics or gestures instinctively repeated by the youths.

14-Coping skills in dealing with negative actions and thoughts (copgsk): the researcher records the evaluators’ report that the youths were or were not able to adopt effective behavior aiming to avoid getting in trouble. Referring to the youths’ score on the coping skills item in the YLS/CMI, the evaluators may report that the youths have no coping skills (0), deficit in coping skills (1), or appropriate coping skills (2). For example when they state that the youths need to develop more coping and socialization skills, the researcher infers that the youths have a deficit in coping skills.

15- Cult member (cultmbr): the researcher records the evaluators’ report that the youths belong to groups of individuals, sects or religious groups that practices certain rites or ceremonies.

16- Father's alcohol use problem (dadalcpb): the researcher records the evaluators’ reports that a youth’s father drinks alcohol at a point he has currently (or in the past) alcohol problems.

17- Father's drug use problem/involvement (daddgpb): the researcher records the evaluators’ report that a youth’s father uses drugs or is currently (or in the past) involved with drug trafficking.

18 - Father's legal problems (dadlglpb): the researcher records the evaluators’ reports that a youth’s father is currently (or in the past) involved with the justice system
and consequently is on probation (1), jailed (2). It is possible that he has never been involved with the justice system for breaking the law (0).

19- Defiance to authority figure, Oppositional Defiant Disorder (defyauth): the researcher records the evaluators’ report of a youth’s diagnosis of Oppositional Defiant Disorder. He may also infer “defiance to authority figures” from the evaluators’ description of the youths’ attitudes toward directives given by authority figures, their failing to comply with rules established in settings such as classrooms, schools, and homes.

20- Destruction of property (destrucp): the researcher records the evaluators’ report that the youths have being charged for destructing property. He may also infer from the evaluators’ description of various acts committed by the youths, their tendency to destroy others belongings when upset or when their needs were not met. For example, after an argument with a neighbor or a relative, a youth smashes that person’s belongings, car or house.

21- DSM diagnostic Axis III: General medical conditions (diagax3): the researcher records the evaluators’ report of a health condition listed in DSM IV, Axis III such as infectious and parasitic diseases, diseases of the respiratory system, and Diseases of the digestive system.

22- DSM diagnostic Axis V: GAF current score (diagax5a): the researcher records the youths’ current scores on the GAF scale providing the relative degree to which the youths currently function psychologically, socially, and occupationally.

23- DSM diagnostic Axis V: GAF highest in past year (diagax5b): the researcher records the youths’ highest score in the past year on the GAF scale.
24- Conduct Disorder 312.8 (diagcd): the researcher records the evaluators’ report of a diagnosis of Conduct Disorder.

25 - Mathematics disorder 315.1 (diagmath): the researcher records the evaluators’ report of a diagnosis of Mathematic Disorder.

26- Diagnostic of Posttraumatic Stress Disorder (DSM: PTSD 309.81 diagptsd): the researcher records the evaluators’ report of a diagnosis of PTSD.

27- Reading disorder 315.00 (diagread): the researcher records the evaluators’ report of a diagnosis of Reading Disorder.

28- Disruptive in school (disrptsc): the researcher records the evaluators’ report that the youth act out in school and disrupt classes.

29- Domestic violence between parents (domviolp): the researcher records the evaluators’ report of the extensive fighting, and violence between the youths’ parents. One parent may have intentionally endangered or harmed the other and charged with domestic violence.

30- Domestic violence by youths (domvioly): the researcher records the evaluators’ report of the youths’ aggressions on their parents, siblings or relatives, even if not reported to the police for prosecution. The youths may have intentionally endangered or harmed other family members and charged with domestic violence.

31- Depression (dpressed): the researcher records the evaluators’ report of a diagnosis of Depression.

32- Eating disorder (eatgpb): the researcher records the evaluators’ report of a diagnosis of Eating Disorder; he may infer “eating disorder” such as anorexia, bulimia, and pica, from the evaluators’ description of symptoms of eating disorders. For example,
the evaluators may report that the youths force themselves to vomit, go on eating binges, or have poor appetite.

33- Fetal alcohol syndrome Axis III (fetalcsy): the researcher records the evaluators’ report of a Fetal Alcohol Syndrome diagnosis. The evaluators may have found that a youth’s mother have been drinking so heavily while pregnant that doctors stated that the fetus was damaged resulting in the youths’ slow growth, developmental delay, or mental retardation for example.

34- Fire setting (firesetg): the researcher records the evaluators’ report of fire setting by the youths. He may also infer from the evaluators’ description of facts showing the youths’ compulsion to start destructive fires.

35- Gang member (gangmbr): the researcher records the evaluators’ report that the youths belong to organized groups of peers involved in crimes, sharing values and maintaining mutual bonding they may not share with their own family members.

36- Gender (gender): the researcher records the evaluators’ report of sex of the youths which is either male or female.

37- Already parent (haschild): the researcher records the evaluators’ report of the youths’ status as parents. This variable shows whether the youths have children (1) or do not (0).

38- Hyperactive disorder (hyperact): the researcher records the evaluators’ report of a diagnosis of hyperactive disorder.

39- Impulsive behavior (implsvbh): the researcher records the evaluators’ report that a youth has an impulsive or explosive attitude when facing certain circumstances.
40- Incontinence (incontnc): the researcher records the evaluators’ report that the youths wet their beds or urinate in bed.

41- WIAT-screener achievement score (intelach): the researcher records the youths’ achievement score on the WIAT as reported by the evaluators.

42- Intelligence quotient score (IQ full) (intelgnc): the researcher records the youths’ intelligence quotient (full IQ score) as reported by the evaluators.

43- Performance IQ score (intelper): the researcher records the youths’ performance score as reported by the evaluators.

44- Verbal IQ score (intelvbl): the researcher records the youths’ verbal IQ score as reported by the evaluators.

45- Interaction with peers (intrpeer): the researcher records the evaluators’ report regarding various types of interactions or relationships the youths have with their peers. They may have close relationship (0) or be isolated from them (1). They may be verbally (2), physically (3) or both verbally and physically abusive toward them (4). For example, the researcher may infer the type of relationship the youths experience with their peers from the evaluators’ report that the youths are teased or bullied by their peers.

46- Interaction with siblings (Types) (intrsibl): the researcher records the evaluators’ report regarding the various types of interactions or relationships the youths have with their siblings. They may have close relationship with them (0) or be isolated from them (1). They may be verbally (2), physically (3) or both verbally and physically abusive toward them (4). The researcher may also infer the type of relationship the youth experience with their siblings from the evaluators’ report; for example, it may be reported that they get along well with their siblings or committed aggression toward them.
47- Legal status (lgstatus): this variable tells the status of the youth at the time of the assessment. The researcher records the information provided by the evaluators regarding the court’s decision to keep the youths off probation (0), on probation (1) or in a detention center or jail to serve time for the offense committed (2).

48- Lying problem (lyingpb): the researcher records that the youths have a lying problem as explicitly mentioned in the report, or he infers that the youths have a lying problem from the evaluators’ reports of contradictory statements they made; for example, the evaluators may report that the youths have denial tendencies.

49- Number of psychotropic medications prescribed (medicatn): the researcher makes a count of the psychotropic medications prescribed to the youths as reported by the evaluators.

50- Mental retardation Axis II- 317, 318, 319 (mentreta): the researcher records the evaluators’ report of a diagnosis of Mental retardation (MR). The youth may be diagnosed with mild MR (IQ = 50-55 to 70) (1); moderate MR (IQ = 35-40 to 50-55) (2); severe MR (IQ = 20-25 to 35-40) (3); profound MR (IQ = below 20 or 25) (4); and severity unspecified (5).

51- Mother's use of alcohol (momalcpb): the researcher records the evaluators’ reports that a youth’s mother drinks alcohol at a point she has currently (or in the past) alcohol problems.

52- Mother's use of drug/ involvement (momdgpb) the researcher records the evaluators’ reports that a youth’s mother uses drugs or is currently (or in the past) involved with drug trafficking.
53- Mother's legal problems (momlegpb): the researcher records the evaluators’ reports that a youth’s mother is currently (or in the past) involved with the justice system and consequently is on probation (1), jailed (2). It is possible that she has never been involved with the justice system for breaking the law (0).

54- Mood disorders (moodpb): the researcher records the evaluators’ report of a diagnosis of Mood Disorder such as bipolar disorder (1), depressive disorders (2), mood disorders due to general medical condition (3), or mood disorder due to substance use (4).

55- Person that most influenced the youth (mostinfl): the researcher records the evaluators’ description of individuals whose actions have impacted the youths’ lives leading them to adopt a certain lifestyle, a way of dealing with others, and a vision of their future. These individuals could be: no one (0), mother (1), father (2), both parents (3), grand parents (4), step father (5), step mother (6), mother and grand parents (7), others (8), siblings (9) and peers (10).

56- Sensorimotor, motor skills disorder (DSM 315.4) (motorpb): the researcher records the evaluators’ report of a diagnosis of sensorimotor, motor skills disorder or from the evaluators’ description of the symptoms experienced by the youths, he infers motor skills disorder.

57- Number of family members in touch (nbfammb): the researcher makes a count of all the family members reported to be in touch with the youths, or living with them.

58- Number of foster home placements (nbfosth): the researcher makes a count of the foster homes where the youths have been placed or where they stayed.
59- Number of hospitalizations (nbhospta): the researcher makes a count of the health care facilities where the youths stayed or the number of times they stayed in each one or emergency rooms.

60- Number of incarcerations (nbjailed): the researcher makes a count of the detention facilities the youths stayed in (jails, detention centers or other holding institutions) and the number of times they stayed in each one.

61- Number of legal problems (nblgpb): the researcher makes a count of the youths’ charges, and offenses committed as described in the reports.

62- Number of siblings (nbsiblg): the researcher makes a count of the youths’ siblings mentioned in the reports.

63- Neglected by parents (neglect): the researcher records the evaluators’ report of neglect of the youths by their biological parents or by people who have legal custody of the youths. The researcher also recorded the evaluators’ report that the youths expressed the feelings of being neglected or unwanted by their biological parents.

64- Victim of physical abuse (physabus): the researcher records the evaluators’ reports that a youth was victim of physical abused by his/her parents, relatives or others. He may also infer that a youth was physically abused from the evaluators’ description of the offender’s physical treatment by other family or non family members.

65- Marital status of the youths’ biological parents (pmaritus): the researcher records the current marital status of the biological parents. They may be still married at the time of the evaluation (0); currently divorced (1); or never married (2). The evaluators may report that the parents were in a marital relationship or staying with another person; they
may provide no information on the parents’ relationship; therefore in both cases this variable’s value is 3.

66-Event that precipitated the youth incarceration or change (precpevt): the researcher records the type of events that occurred and precipitated a major change in the youths’ lives: incarceration, or behavioral change. These events may be the death of a close relative (1); incarceration of a relative or separation from a relative who was an influential person in their lives (2); lack of supervision (3); any combination of these events; or personal conditions (8).

67- Race or ethnic background (race): the researcher records the ethnic background of the youths as mentioned in the individual reports; if it is not explicitly mentioned in the report, the researcher refers to other documents such as the Disposition Investigation Report or the Ohio Youth Problem Form. Three ethnic backgrounds have been mentioned: African American or bi-racial (0), Caucasian (1), and Hispanic (2). For statistical reasons the researcher has decided that whenever a youth is reported to have one African American parent and another from any other race, his/her ethnic background is considered African American.

68- Rank of the youths among siblings (ranksibl): after counting the number of siblings and noting the age of each one, the researcher figures out the rank of the offender among his/her siblings.

69- Areas that most contribute to the risks of future criminal activities (riskfact): this variable provides information on various domains in which the youths experience problems; these are also conditions that do not provide enough support to the youths, and do not protect them from getting involved with crime. These factors are: family
circumstances, substance use (1); peer relations, personality (2); educational problems (3); lack of positive leisure/recreation activities (4); or any combination of factors.

70- Risk for future criminal activity (riskfca): this variable provides information on the likelihood of the youths’ involvement in criminal activities in the future; it represents the sum of various scores made by the youths on all the items composing the Disposition Investigation Report. The researcher records the youths’ scores as reported by the evaluators.

71- Runaway from home (runaway): the researcher records the evaluators’ reports that the youths left home without permission, repeatedly did not return home in a timely manner, or stayed away from their homes until they were found and sent back by the police.

72- Experience of seizure crises (seizure) the researcher records the evaluators’ reports that the youth experience breakdown or convulsions at certain periods.

73- Youth victim of sexual abuse (sexabvic): the researcher records the evaluators’ reports that a youth has been victim of sexual exploitation by his/her parents, relatives or others. He may also infer that the youth has been sexually exploited from the evaluators’ description of the youth’s sexual treatment by other family or non family members.

74- Sexual gestures (sexlgest): the researcher records the evaluators’ reports that the youths have exposed their body to other people, have been cross-dressing, touching breasts or sexual parts of other individuals, and have been sexually active.

75- Perpetration of sexual offenses (sexpreda): the researcher records the evaluators’ reports that the youths have been adjudicated delinquent for committing sex offenses such as rape, sodomy, sex penetrating, and fondling.
76- Masturbation (sexself): the researcher records the evaluators’ reports that the youth has sought sexual pleasure by trimming on his/her own sexual organs, or any other private parts.

77- Self care, hygiene (sfcarepb): the researcher records the evaluators’ reports that the youth take care of themselves by maintaining a proper hygiene, combing their hair and wearing clean clothes.

78- Level of self esteem (sfesteem): the researcher records the evaluators’ reports that a youth has a low or high sense of personal worth.

79- Self mutilation/harm (sfmutila): the researcher records the evaluators’ reports that the youths have a tendency to harm themselves with self inflicted wounds.

80- Social skills (socialsk): the researcher records the evaluators’ reports that the youths had appropriate social skills (0), or have a deficit in positive social skills (1).

81- Stealing problems (stealing): the researcher records the evaluators’ reports that the youths had a propensity to take other people’s belongings; he also may infer that the youths are thieves from the offenses they were charged for.

82- Number of suicide attempts (suicidat): the researcher makes a count of the youths’ suicide attempts described by the evaluators in the report.

83- Suicidal gestures (suicidgs): the researcher records any type of suicidal gestures reported by the evaluators. For example, the evaluators may report that the youths have committed acts or made statements that could prompt someone else to attack them or attempt to hurt or kill them.

84- Suicide threats (suicidth): the researcher records any verbal statement or threats made by the youths to kill themselves as reported by the evaluators.
85- Services provided to youth (svcrcvd): the researcher records the evaluators’ reports of services received by the youths from professionals such as psychiatrists, psychologists, medical doctors, counselors, and social workers. It could be counseling only (1), medical only (2), psychiatric only (3), or a combination of counseling and medical services (4), counseling and psychiatric (5), or counseling, medical, and psychiatric services (6) medical and psychiatric services (7).

86- Threats to kill or harm others (threatkh): the researcher records the evaluators’ reports of threats to harm or kill others made by the youths.

87- Truancy (truan1): the researcher records the evaluators’ reports that the youths are truant, do not stay in school when they are expected to, or get suspended very often for long periods (1); when the youths are not truant, attend school regularly and do not get suspended, this variable is valued 0.

88- Vandalism perpetrated by youths (vandalism): the researcher records the evaluators’ reports that the youths have been charged with intentionally destroying public or private property, or criminal damaging; the researcher may also infer vandalism from the reports of acts committed by the youths for example flooding a room by stuffing the toilet with toilet paper or destructing things in a locker room.

89- Vehicle theft (vehtheft): the researcher records the evaluators’ reports that the youths have been charged for car, or motor bike theft; the researcher may also infer from the evaluators’ report that the youths have been involved in car or motor bike thefts but have not been charged for these offenses.

90- Reason for home removal (wyhmrmvl): the researcher records the evaluators’ reports that the youths have been removed from their parents’ homes due to the youths’
problem behavior (1), mother (2), dad (3), or both parents’ problems (4). These problems could be alcohol or drug use, incarceration, violent aggressions, and divorce. The removal may also be due to other reasons (5). If the youths have not been removed from their homes, this variable’s value is 0.

91- Youth perception of the family system (ypfamsys): the researcher records the evaluators’ report of individuals who the youths consider as members of their family.

SET 2

Diagnoses on Axis I and Axis II of DSM IV made by the evaluators and documented in the reports are also included in the data base. The numbers representing the disorders’ labels in the data base are structured as follows: Axis I or Axis II followed by a number: for example Axis I 1, Axis I 2, and Axis I 3 or Axis II 1, Axis II 2 and Axis II 3. Listed are 53 diagnoses on Axis I including 8 V code disorders, and 3 on Axis II.

Axis I 1 - 295.7-- Schizoaffective Disorder, Depressive Type, Provisional
Axis I 2- 296.22-- Major Depressive Disorder, Single Episode
Axis I 3- 296.3-- Major Depression, recurrent, prior history
Axis I 4- 296.32-- Major Depressive Disorder, Recurrent Moderate
Axis I 5- 296.4--Bipolar I Disorder, Childhood onset type
Axis I 6- 296.62-- Bipolar I Disorder, Mixed episodes, Moderate
Axis I 7- 296.7-- Bipolar I Disorder, provisional
Axis I 8- 296.89-- Bipolar II Disorder provisional
Axis I 9- 296.9-- Mood Disorder, NOS
Axis I 10- 298.9-- Psychotic Disorder NOS
Axis I 11- 299.8-- Pervasive Developmental Disorder NOS
Axis I 12- 300-- Anxiety Disorder NOS
Axis I 13- 300.02-- Generalized Anxiety Disorder
Axis I 14- 300.15-- Dissociative Disorder NOS
Axis I 15- 300.3-- Obsessive Compulsive Disorder
Axis I 16- 300.4-- Dysthymia
Axis I 17- 304.3-- Cannabis Dependence, in controlled Environment
Axis I 18- 304.8-- Polysubstance Abuse
Axis I 19- 305-- Alcohol Abuse
Axis I 20- 305.2-- Substance Abuse Cannabis (in controlled environment)
Axis I 21- 305.6-- Cannabis Abuse
Axis I 22- 307.23-- Tourette's Disorder, provisional
Axis I 23- 307.5-- Eating Disorder NOS
Axis I 24- 309.3-- Adjustment Disorder with Disturbance of Conduct, chronic
Axis I 25- 309.4-Adjustment Disorder with mixed disturbance emotions/conduct chronic
Axis I 26- 309.81-- PTSD chronic
Axis I 27- 311-- Depressive Disorder NOS
Axis I 28- 312.8-- Conduct Disorder, Adolescent onset, Severe
Axis I 29- 312.81-- Conduct Disorder Childhood onset, Moderate
Axis I 30- 312.82-- Conduct Disorder Adolescent onset
Axis I 31- 312.89-- Conduct Disorder, Unspecified onset
Axis I 32- 312.9-- Disruptive Behavior Disorder, NOS
Axis I 33- 313.81-- Oppositional Defiant Disorder
Axis I 34- 313.82-- Conduct Disorder Adolescent onset, Moderate/Identity problem
Axis I 35- 314.01-- ADHD hyperactive type
Axis I 36- 314.02-- ADHD inattentive type
Axis I 37- 315-- Reading Disorder, Provisional
Axis I 38- 315.09-- Learning Disorder, Provisional NOS
Axis I 39- 315.1-- Mathematic Disorder Provisional
Axis I 40- 315.2-- Disorder of Written Expression Provisional
Axis I 41- 315.9-- Learning Disorder NOS
Axis I 42- 396.22-- Major Depressive Episode, Single Episode, Moderate
Axis I 43- 995.53-- Sexual Abuse of Child (victim)
Axis I 44- 995.54-- Physical Abuse of Child (victim)
Axis I 45- 999.5-- Physical Abuse, Neglect of Child (victim)
Axis I 46- V 15.81-- Noncompliance with treatment
Axis I 47- V61.20-- Par/child relational problem (physical abuse of child)
Axis I 48- V61.21-- Par/child relational problem (sexual abuse a child)
Axis I 49- V61.8-- Sibling Relational problem
Axis I 50- V62.3-- Academic Problems
Axis I 51- V62.81-- Relational Problem, NOS
Axis I 52- V62.82-- Bereavement
Axis I 53- V71.02-- Child or Adolescent Antisocial Behavior
Axis II 1- 317-- Mild Mental Retardation
Axis II 2- 318-- Moderate Mental Retardation
Axis II 3- V62.89-- Borderline Intellectual Functioning
APPENDIX B

List of instruments used by psychological evaluators who completed the offenders’ reports the researcher read in order to collect data on each youth.

1) Clinical Interview with client

2) Disposition Investigation Report (DIR).

3) Family Clinical Records

4) Family System Test (FAST)

5) Juvenile Record Review,

6) Millon Adolescent Clinical Inventory (MACI)

7) Ohio Youth Problem, Functioning, and Satisfaction Scales: Youth, Parent, and Worker’s Forms (OYPFS)

8) Personal Experience Screening Questionnaire (PESQ)

9) Wechsler Individual Achievement Test-Screener (WIAT)

10) Wechsler Intelligence Scale for Children, 3rd edition-Short Form (WISC-III)

11) Youth Level of Service/Case Management Inventory (YLS/CMI)
Appendix C
Comments on results of cross-tabulation of disorders (Axis I and V code problems), sex abuse victims, and sexual predators.

NB: all disorders not listed in the table have been deleted because no sex abuse victim nor sex predator was diagnosed with those disorders.

- Dysthymia: among the 10 youths diagnosed with this disorder, 6 are sex abuse victims (among them 1 is also sex predator); the sex predator shown has a history of sex abuse victimization.

- Alcohol abuse: Among 15 youths diagnosed with this disorder, 3 are sex abuse victims only; among the 3 sex predators, no one has a history of sex abuse victimization.

- Substance abuse cannabis: Among 18 youths diagnosed with this disorder, 4 are sex abuse victims (among them 1 is also sex predator); among the 3 sex predators, 2 have no history of sex abuse victimization.

- PTSD: All 4 youths diagnosed with PTSD, are victims of sexual abuse; among them 2 are sex predators.

- Depressive disorder NOS: Among the 13 youths diagnosed with this disorder, 4 are sex abuse victims (1 of them is not only a victim but also a sex predator); among the 2 sex predators, 1 has not been sexually abused.

- Conduct disorder adolescent onset severe: Among 9 youths diagnosed with this disorder, 2 are sex abuse victims (among them 1 is also sex predator).

- Conduct disorder childhood onset moderate: Among the 18 youths diagnosed with this disorder, 8 are sex abuse victims (2 of them are not only victims but also sex predators); among the 5 sex predators, two have a history of sex abuse victimization.
• Conduct disorder adolescent onset: Among the 9 youths diagnosed with this disorder, 1 are sex abuse victims; among the 2 sex predators, no one has a history of sexually abuse victimization.

• Oppositional Defiant Disorder: Among the 24 youths diagnosed with this disorder, 10 are sex abuse victims; none a sex predator.

• ADHD hyperactive type: Among the 16 youths diagnosed with this disorder, 3 are sex abuse victims, and 2 others are sex predators.

• ADHD inattentive type: Among the 12 youths diagnosed with this disorder, 3 are sex abuse victims; the sex predator has no history of sex abuse victimization.

• Reading disorder provisional: Among the 10 youths diagnosed with this disorder, 3 are sex abuse victims (2 of them are not only a victim but also a sex predators); among the 3 sex predators, 1 has no history sexually abused victimization.

• Mathematic disorder provisional: Among the 10 youths diagnosed with this disorder, 2 are sex abuse victims and both of them are sex predators); among the 3 sex predators, 1 has no history of sex abuse victimization.

• Disorder of the written expression provisional: Among the 8 youths diagnosed with this disorder, there is 1 sex abuse victim who is also a sex predator; among the 2 sex predators, 1 has no history of sex abuse victimization.

• Parent child relational problem (physical abuse): Among the 29 youths diagnosed with this problem, there are 10 sex abuse victims (1 of them is also a sex predator); among the 3 sex predators, 1 has a history of sex abuse victimization.

• For the remaining disorders, results show that no sex predator was diagnosed with one of them. NB:
• Among the 3 youths who are diagnosed with alcohol abuse (Axis I- 305), one is also diagnosed with substance abuse cannabis (Axis I-305.2).

• Among the 3 youths who are diagnosed with substance abuse cannabis (Axis I- 305.2), one is also diagnosed with alcohol abuse; the other two with substance abuse cannabis only.

• Both youths diagnosed with cannabis abuse (Axis I- 305.6) are also diagnosed with alcohol abuse (Axis I- 305).
Appendix D

Program Overview

Lorain County

Juvenile Court
- Identify youth who meet criteria:
  - Violent charge
  - Serious mental health problem
  - Age 12-17
- Conducts initial assessment:
  - DSR
  - LSI
  - Ohio Scales

Bellefaire
- Additional assessment:
  - Psychological evaluation

DYS

Juvenile Court

Bellefaire JOP Residential

Bellefaire JOP Wrap

Community Programs

Alternative Program
REFERENCES


http://www.ncjrs.org/txtfiles/fs9882.txt


www.ship.edu/~cgboeree/bandura.html


http://www.buildingblocksforyouth.org/issues/mentalhealth/factsheet.html


pp.83-93.

Canada, Justice. (2003). *Youth Level of Service/Case Management Inventory-Screening Version*. Retrieved on 7/20/04, from:


http://www.cdc.gov/ncipc/factsheets/suifacts.htm


http://clearinghouse.missouriwestern.edu/manuscripts/17.asp


ODMH, ODYS, ODJFS, and OCJS.


Flores, A. W., Travis, L. F., & Latessa, E. J. (2004). Case Classification for Juvenile Corrections: An Assessment of the Youth Level of Service/Case Management Inventory (YLS/CMI), Executive summary. Retrieved on 2/10/07, from: 

[www.ncjrs.gov/pdffiles1/ncj/grants/204005](http://www.ncjrs.gov/pdffiles1/ncj/grants/204005)


http://aolsearch.aol.com/aol/search?innovationType=wscreen-searchboxhtml&query=ogles%2c
Ohio Substance Abuse and Mental Illness Coordinating Center of Excellence (2003): Integrated Dual Disorder Treatment: An overview of the model. Retrieved on 12-20-05 from:  
www.dhs.state.or.us/dhs/ph/chs/data/arpt/03v2/chapter8/chapter8-nar.pdf
www.prcdc.org/summaries/changinnation/changingnation.html


www.findarticles.com/p/articles/mi_m2248/is_n126_v32/ai_19619426/pg_8
