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Walden University
2022

Abstract

Mental Health Providers' Perspectives: The Link Between Childhood Trauma, Juvenile Delinquency and Long-Term Effects

by

Vanay Frederick-Ellis

MS, Walden University, 2012

BS, University of Phoenix, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

August 2022

Abstract

Juvenile delinquency is an ongoing problem in society and is detrimental as many delinquents have mental and behavioral health issues. Delinquency is costly to society, and it was found that many delinquents have a traumatic past or adverse childhood experiences. They include child abuse and neglect, loss, separation/divorce of parents, witnessing domestic violence, parents who struggle with mental health and/or drug and substance abuse, parents who have their own trauma, death of a loved one, natural disaster, or other tragedies that are linked to an increase in the likelihood of juvenile delinquency. In this study, the relationship between juvenile delinquency and trauma by the lived experiences of professionals who have worked with delinquents and at-risk youth was examined. The biopsychosocial model provided a theoretical framework for the study. Data were collected by interviewing 20 mental health professionals. The data were analyzed to determine common themes and patterns about professionals who work with at-risk youth. The 6 themes found during analysis were professionals' caseloads consisted of clients who have lived through trauma, vicarious trauma was common, professionals must adapt to the barriers that stem from working with the population, they faced many barriers working with at-risk youth, they wanted to be effective for their clients, they were interested in trainings to increase their effectiveness with clients, they found it was necessary for caregivers to be involved in treatment, and COVID-19 has impacted traumatized youth. This study can contribute to positive social change as professionals may be able to identify ways to intervene with at-risk youth to encourage normal social functioning.

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Dedication

I dedicate my hard work and success to my family who has supported me throughout this process and encouraged me to stay determined. They allowed me to pursue my goals without hesitation and were there to give me courage and strength to keep making forward progress. I would also like to thank the children I have worked with in the past to help me see my vision clearly and instrumentally gave me the idea to pursue this research in order for them to have more hope in their futures.

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Chapter 1: Introduction to the Study

Juvenile delinquency is a reoccurring issue worldwide. Sickmund and Puzzanchera (2014) found there has been a reduction in juvenile arrest rates, but the effects of delinquency continue to be detrimental and costly to society. According to Afterschool Alliance (2020), youth incarceration and confinement is costly to the United States and on average it costs between $8 billion and $21 billion each year. Lee et al. (2016) reported that for states, the annual cost of incarcerating youth is over 5 billion dollars and much of this money is spent on psychotropic medications due to at-risk youth with mental health diagnoses. That continues to have an impact on society because 70% to 80% of juveniles are rearrested within 2-3 years (Afterschool Alliance, 2020). The information is pertinent because it has been found that many juvenile delinquents have at least one adverse childhood experience (ACE) or traumatic experience (Baglivio et al., 2014; Finkelhor et al., 2015), which contributes to their struggles with mental health and delinquent behavior. Research has shown that many delinquents have at least one mental health diagnosis. According to Underwood and Washington (2016), juvenile delinquents meet the criteria for at least one mental health issue, even though many have comorbid diagnoses and are at risk for mental and physical health issues as adults. That information suggested the necessity of studying the relationship between ACEs or traumatic experiences and juvenile delinquency. The traumatic experiences leave lasting impressions on youth and can result in internalizing and/or externalizing behaviors (Fox et al., 2015). Furthermore, research has demonstrated that early childhood trauma has been linked to poor emotion regulation, lack of communication skills, poor academics,

mental health concerns, increased chronic illness, and premature death (Burke-Harris, 2018; Nurius, et al., 2015; Sevecke, et al., 2016). Each of these risk factors has an impact on the individual, their family, the community, and the world.

In this chapter, I will discuss the background of this study by summarizing research literature related to the topic and describe the gap in knowledge including how I addressed it during the study. I will present the problem statement and explain this study's significance to the field of forensic psychology. After the problem statement, I will discuss the purpose of the study, state the research question, and discuss the theoretical framework in detail. Next, I will explain the nature of the study, which was the rationale for the selected research method design and define key terms and definitions that informed my research. I will then address the major assumptions of this study, the study's limitations, and potential significance of the research. The last section will summarize the main points of the study and transitioned the research to Chapter 2, the literature review.

Background

The literature related to this study identified a broad spectrum of correlations between childhood trauma and juvenile delinquency. Much research has found a significant relationship between childhood adverse experiences and lasting impacts throughout an individual's life (e.g., Child Welfare Information Gateway, 2013; Fox et al., 2015 Johnson et al., 2020; Kerig, 2014). The National Survey of Children's Exposure to Violence II (2015) reported that, over a lifetime, 39.2% of youth have witnessed violence and, over a lifetime, 25.6% of youth have experienced maltreatment and

suggested that research should focus on the impacts of this trauma on youth (Finkelhor et al., 2015). The Child Welfare Information Gateway (2013) found similar evidence noting that child abuse and neglect have psychological, physical, behavioral, and societal impacts on the children who have witnessed or experienced such abuse. Abuse is not the only form of trauma on children and adolescents. It has also been noted that parental separation/divorce, living in a household with domestic violence, living with a mentally ill individual, and/or living with someone who has drug/substance use and abuse also has adverse effects on minors (Bielas et al., 2016).

Understanding the severity of adverse experience on minors has encouraged further research to seek alternatives for better prevention and treatment. Baglivio et al. (2014) argued that ACEs not only increase the likelihood of juvenile delinquency but also increase the risk of life-threatening illnesses and premature death in adulthood. In relation to juvenile delinquency, it was noted that juveniles commit about 25% of violent crimes in the United States (Fox et al., 2015) and that the offender rates can be attributed to their own victimization during childhood (Cuevas et al., 2013). This again links juvenile delinquency to childhood trauma and demonstrates the need for more research on this topic as it continues to be an issue today.

Trauma also impacts youth within the juvenile justice system. Dierkhising et al. (2013) stated that many of the youth in the juvenile justice system meet the criteria for posttraumatic stress disorder (PTSD) or have PTSD symptoms, have comorbid mental health diagnoses, and have issues with regulating emotions, academics, and building peer relationships. Underscoring the role of mental health, Underwood and Washington (2016)

found that at least half of the youth in the juvenile justice system have at least one mental health disorder. Aside from mental health diagnoses and struggles in normal daily functioning, juveniles that were exposed to early childhood trauma are at-risk of exhibiting aggressive and violent behaviors, impulsivity, and psychopathy in adulthood (Sevecke et al., 2016). Additionally, childhood trauma and adversity impacts brain development, which is the reason at-risk youth struggle with normal cognitive functioning increasing their lack of ability to succeed academically and regulate their emotions (Burke-Harris, 2018; Sapolsky, 2017).

Toxic stress produced from childhood trauma and adversity affects brain development and is seen in children with mental health diagnoses (Burke-Harris, 2018). These diagnoses include attention-deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD; Carliner et al., 2017), which are commonly characterized by poor impulse control, poor social functioning, poor focus, poor compliance, and poor academic achievement. The research implied that juvenile delinquency may be a result of ineffective brain functioning since effective brain functioning allows individuals to think logically and control their emotions as well as behaviors. Additionally, if children are unable to function normally due to adversity, it can be assumed they will not have the ability to function normally when they become adults. Johnson et al. (2020) noted that the effects of toxic stress often put adults at risk for chronic illnesses, which include diabetes, cardiovascular diseases, obesity, and inflammatory disease. The long-term consequences of childhood adversity also increase

the likelihood of depression, substance use/abuse, drug use/abuse, and suicide (Merrick et al., 2017).

Other emerging research that supported the current research topic was the study of epigenetics. Epigenetics study how our environment influences genetic expression and how individuals exhibit behavior based on how their genes are altered by environmental influence (Kiyimba, 2016). Palumbo et al. (2018), explained that adversity can alter genetic makeup increasing the likelihood of aggression in childhood and adolescence. This implied that adverse experiences are expanded to include growth and development throughout the prenatal period. Furthermore, Raine (2015) discussed the anatomy of violent behavior arguing that some individuals are more likely to exhibit aggressive behaviors due to their genetic makeup. Juvenile delinquency is not only shaped by nurturance of direct adverse experiences but can also evolve from the natural occurrences the create life.

Little research has defined the relationship between childhood trauma and juvenile delinquency. Research has demonstrated that adverse childhood experiences impact many areas of an individual’s life (Baglivio et al., 2014; Burke-Harris, 2018; Bryan, 2019; Finkelhor et al., 2015, Fox et al., 2015, Hughes et al., 2017; Monnat, 2015; Sevecke et al., 2016), but literature was lacking insight from the professionals who have experience in working with at-risk youth. Prevention and interventions have been predicted to assist with the shift to socially acceptable behaviors (May et al., 2014), but there is a lack of what techniques are efficient and effective to achieving this goal. Brown (2017) suggested that there is a need for protective factors to intervene in the potential

lasting effects of trauma and childhood adversity on individuals. My study was needed to address this gap in the literature and to provide professional insight on the relationship between childhood trauma and juvenile delinquency and how professionals have experienced working with this population. Through professional insight, professionals can learn if they have the knowledge and competency to assist at-risk youth and what else is needed to address the ongoing worldwide issue of juvenile delinquency.

Problem Statement

As stated above, juvenile delinquency continues to be an ongoing issue throughout society. Previous research has shown a decline in juvenile delinquency over the years; conversely, current research shows an increase in child abuse, neglect, violence, and other trauma experiences, which increase the likelihood of juvenile delinquency, among other societal issues (Baglivio, 2014; Child Welfare Information Gateway, 2013). These increased risk factors demonstrate how juvenile delinquency will continue to be a societal issue, contributing to the relevance of this topic. Furthermore, research has argued that juvenile delinquency increases the likelihood of adult incarceration and issues with the law (Jung et al., 2017). Forensic psychology is a subspecialty of psychology that aims to understand psychology as it pertains to the legal system. Because the juvenile justice system is designed to maintain public safety by reintegrating at-risk youth back into society, the current research was significant to forensic psychology.

The current research study built upon contemporary research findings, and I aimed to bridge the connection between childhood trauma and juvenile delinquency.

Research already suggested that children are more likely to engage in problem behavior depending on the number and severity of adverse childhood experiences (Fox et al. 2015; Rhoades et al., 2016). Because ACE's increase the likelihood of problem behavior, it was necessary for further research to examine the impact of the trauma, and to develop the necessary strategies to prevent and reduce challenging behaviors exhibited by youth and adolescents. Early interventions are likely to assist children in shifting to exhibiting socially acceptable behaviors. According to Solholm et al. (2013), early systematic interventions are vital to address problem behavior and interventions should be provided by the child's target support system. Research then needed to address the other strategies needed to deter at-risk youth and adolescence from the several increased risk-factors that continue to follow them into adulthood.

It was stated that without intervention juvenile delinquents will continue exhibiting problem behavior (May et al. 2014), which will continue to be detrimental and costly to society (Lee et al., 2016). The problem may worsen when it is unknown whether professionals or other mental health providers are delivering appropriate strategies, or even if they have the necessary skills to transfer to the youth and their families. There was no clear evidence supporting the notion that behavioral health professionals have the competence to address the needs of at-risk youth and adolescents. As stated by Underwood and Washington (2016), educating professionals and providers is only one of the necessary steps in addressing the needs of at-risk youth and adolescents.

Purpose of the Study

The purpose of the study was to delve deeper into the relationship of childhood trauma and juvenile delinquency by getting perspectives of those who have direct experience with at-risk youth. The goal was to learn more from the professionals who provide or have provided services for children who have experienced childhood trauma. I sought out mental health professionals' perspectives of working with youth that have experienced early traumatic experiences as those experiences' impact juvenile delinquency. It was necessary for professionals to be knowledgeable of the children they work with, as well as, knowledgeable about their ACEs and trauma history. It is vital that mental health professionals know efficient and effective techniques because trauma alone is a huge topic today, in relation to individual mental health and behavioral health. To prevent and/or reduce future juvenile delinquency professionals need to understand how trauma impacts an individual. Finkelhor et al. (2015) discussed that exposure to trauma during childhood has lasting effects on a child well into adulthood, which is vital for professionals to be aware of. In this study, my purpose was to explore mental health professional's insights on childhood trauma and juvenile delinquency, as well as explore their perspectives on the impact of trauma on juvenile delinquency. As stated in Young et al. (2017), without appropriate techniques and practices, juvenile delinquency will continue to present a problem to society.

Research Question

The focus of this research was to gain a better understanding of the relationship between childhood trauma and juvenile delinquency. It was previously stated that

research had shown that childhood adversity, and trauma had impacted youth throughout their lives (e.g., Burke-Harris, 2018; Fox et al., 2015; Johnson et al., 2020; Underwood & Washington, 2016; Vidal at al., 2017). Research also showed that juvenile delinquents live with many, if not all, of the effects associated with childhood trauma. To draw deeper meaning to this topic it would be beneficial to understand the perspectives of those who have direct experience with this population. Therefore, the research questions were as follows:

RQ1: What are the lived experiences of administrators and mental health professionals who work with traumatized juveniles and adolescents?

RQ2: What are the common attitudes, perceptions, and opinions determined by those professionals who work with traumatized juveniles and adolescents?

Theoretical Framework

The theoretical foundation of this research was based on the biopsychosocial model. The literature used to support the research topic found that biological, psychological, and societal factors all influence childhood trauma, juvenile delinquency, and the lasting effects into adulthood. The biopsychosocial model was proposed by Engel (1977, 1992) and the assumption of this model is that biological, psychological, and social factors all work together to encompass human personality and behavior. For the argument of this study, juvenile delinquency is not only an effect of biology and the genetic predisposition inherited from parents but also nurturance of parenting styles, community involvement, and peer relationships, which is all shaped through social influences and individual perspectives. Since the model was proposed in 1977, other

researchers have aimed to explain how biological influences have an impact on the brain and individual development. The biological component consists of the research on genetics, brain functioning, and physical health (Engel 1977). By studying biological components and brain functioning, researchers can gain a deeper understanding of human health and illness. The psychological component consists of human thought, emotion regulation, and self-control (Engel 1977). This also includes the effects of childhood adversity, trauma, and the disruptions in thought and dysregulations in emotion. Lastly, the social aspects of this model consist of socioeconomic status, culture, morals, values, and other social influences (Engel, 1977). This comprises of the stressors in life and how they can also influence delinquency. This interaction between biological, psychological, and social factors is currently encapsulated in the study of epigenetics. For this study, the integrated model was used to show how each aspect influences and contributes to childhood trauma and puts individuals at risk for juvenile delinquency.

Nature of Study

Juvenile delinquency continues to be a societal issue, which is why I aimed to find a deeper understanding of the influences on juvenile delinquency. A qualitative approach was the most appropriate research strategy. According to Levitt et al. (2018), the qualitative approach allows for researchers to analyze data into words from the perspective of an individual based on his or her experience. Because I aimed to find a deeper meaning into the phenomenon of early trauma and juvenile delinquency, a phenomenological approach was the best fit. The phenomenological approach was used to delve into the concern of childhood adversity and trauma and how the effects of it

influence juvenile delinquency. This approach allowed for me to research one phenomenon through individual's perspectives (see Creswell & Poth, 2018). Furthermore, the phenomenological approach allowed the researcher to extend their knowledge based upon the experience and shared perspectives of other individuals (Moustakas, 2011). The goal of my research was to extend my knowledge and the profession on the relationship between childhood trauma and juvenile delinquency by explaining it through mental health professional's perspectives that have worked with at-risk youth. This was necessary because much research discussed the statistic of childhood trauma and juvenile delinquency, but it has not discussed what professionals are doing about their work with at-risk youth. The data gathered was from mental health professionals who provide treatment to juvenile delinquents and children who have experienced childhood adversity.

Definitions

Adverse childhood experiences: Harms that affect children directly and indirectly through their living environments (Hughes et al., 2017).

Antisocial behavior: Recurrent violations of socially prescribed patterns of behavior (Mayer, 1995).

Conduct disorder: A diagnosis typically given to children and adolescents under the age of 18, and they repeatedly violate the rights of other people, and they refuse to conform their behavior to the law (American Psychological Association [APA], 2013).

Distress: The negative stress response, often involving negative affect and physiological reactivity: A type of stress that results from being overwhelmed by

demands, losses, or perceived threats. It has a detrimental effect by generating physical and psychological maladaptation and posing serious health risks for individuals. (dictionary.apa.org)

Epigenetics: An emerging field of science that studies heritable changes caused by the activation and deactivation of genes without any change in the underlying DNA sequence of the organism. (www.genome.org)

Juvenile delinquent: Any minor under the age of 18 who has committed an illegal act.

Minor: A person who has not yet turned 18.

Problem behavior: Any defiant behavior exhibited by a child aged 10 or younger.

Toxic Stress: When individuals experience frequent and/or prolonged stressors; this can lead to a very adverse impact upon a person's emotions, thoughts, and behaviors.

Trauma: Actual or threatened death, serious injury, or sexual violence (DSM-5).

Victimization: Any act against a child or youth that increases the risk of criminal and delinquent behavior.

Assumptions

One main assumption of this study was that a relationship exists between juvenile delinquency and trauma. The literature found that childhood adversity increases the likelihood of at-risk behaviors (e.g., Dierkhising et al., 2013; Finkelhor et al., 2015; Fox et al., 2015), which are commonly exhibited by juveniles. Another assumption was that mental health professionals do not have the adequate knowledge and skills to provide effective services to at-risk youth. This assumption was made due to the lack of research

identifying what specific measures are or can be used to mitigate juvenile delinquency and assist with those who have experienced ACEs. I then presumed that there are not enough resources to provide adequate services for those at-risk youth resorting to delinquency due to trauma and/or other ACEs.

The assumptions were necessary for this study because without support juveniles will continue to resort to delinquency. According to May et al. (2018), past delinquency predicts future delinquency and without proper guidance and support, juveniles will not be able to effectively integrate back into society. This explained why professionals should be using effective techniques to intervene and mitigate juvenile delinquency in relation to childhood trauma. If professionals are not properly trained in trauma-informed practices, then it is difficult to address the major issue leading to the provisions of appropriate therapeutic techniques and practices. According to Cuevas et al. (2013), early intervention is important to prevent victimization and delinquency among minors and prevention should include methods to “minimize sexual aggression and harassment” (p. 8). Furthermore, with the support of professionals, delinquents can learn healthy behaviors to function more appropriately within society.

Scope and Delimitations

I chose to focus on childhood trauma and ACEs because current research has found that adversity predicts many of the behaviors exhibited by juvenile delinquents (see Baglivio et al., 2014; Child Welfare Information Gateway, 2013; Fox et al., 2015) and that early trauma also results in adult mental and physical health concerns (see Burke-Harris, 2018; Johnson et al., 2020). Due to the complex nature of studying how trauma

and adversity impacts individuals, the best approach for this research encompassed how biological, psychological, and societal factor's impact children throughout their lifespan. I chose to understand the perspectives of mental health professionals due to the lack of research explaining how intervention and prevention techniques would benefit the at-risk population. This can impact generalizability due to other professionals working with juveniles in a similar capacity and having experience in this field.

Limitations

One limitation of this study was the generalizability because the study was only open to mental health professionals. There are other professionals who work with juvenile delinquents, including probation officers, corrections officers, police, lawyers, and the like, but the current study focused on the mental health aspect of juvenile delinquency. Another limitation was the potential recall bias as the interview questions were based on past experiences of the participants and their work with at-risk youth. This also created a limitation because the interview questions were created specifically for this study, and participants may not have been forthcoming and honest during the interviews. I attempted to mitigate potential biases by disclosing to participants whom the data was recorded from, that the interviews and surveys were anonymous and would only be used for this research. Knowledge in this area of study presented a researcher bias and a potential limitation. Later throughout the research, it stated that I was strictly an observer in this study, and all information reported in the data section would be from the voluntary participants.

Significance

A potential contribution of this study was to provide professional insight and knowledge on the need for prevention and intervention on this topic. It allowed others to acknowledge and understand that there is a continuous need of support for social change. This research showed if professionals need more support when providing services to juveniles and at-risk youth, and possibly the type of support needed. This can then advance the practice or policy because interventions may divert at-risk youth from encounters with the law and assist them with identifying the underlying relationship between their trauma and at-risk behavior. This can create meaningful change for at-risk youth and decrease the number of criminal offenses committed by the juvenile population. Positive social change would be noticed when professionals could intervene in a way that assists at-risk youth with making healthy decisions and allowing them to be functional and normal within society.

Summary

In this chapter, I discussed the background of the study, including the research literature that supports the need for this research. The problem statement was addressed, which explained the gap in literature. Through the problem statement, I discussed the connection between the problem and the focus of the study. Next, I stated the research question, then used the theoretical framework to discuss the theory most closely associated with the topic to explain the research. Additionally, the nature of the study and definitions explained the key concepts and constructs of the study. The remainder of the chapter consisted of assumptions made by the research, the scope and delimitations of the

research, the limitations of the research, and the significance the study will have on social change.

Chapter 2: Literature Review

The problem investigated in this research project was juvenile delinquency. In the United States, arrest rates among juveniles (those under the age of 18) totaled 856,130 individuals in 2016 (Office of Juvenile Justice and Delinquency, 2017). Even though the arrest rates are high, the number was 58% less than in 2007 and was 7% less than the arrest rates in 2015 (OJJDP, 2017). Even with the decline in juvenile arrest rates, the prevalence of the issue is still substantial. One issue that research has found is that juvenile delinquents commonly meet the criteria for having mental health issues (Underwood & Washington, 2016). Often, ACEs, including trauma, are linked to challenging behaviors exhibited by minors (Baglivio et al., 2014). Due to the prevalence of juvenile delinquency, and the link to mental health concerns and trauma exposure, I aimed to find effective strategies and intervention methods to prevent traumatic events with children, thereby helping to continue to decrease juvenile delinquency. One major concern was that trauma can affect children's well-being throughout their lives (Finkelhor et al., 2015). Furthermore, even though delinquency rates are declining, more children are being diagnosed with mental health problems, as well as substance use and abuse (van Draanen, 2020), and the ACEs that put them at risk for chronic illness in adulthood (Burke-Harris, 2018).

I chose to study delinquency in Pennsylvania, where I live. In Pennsylvania, there were 24,800 delinquency-related allegations in 2017, which is a 20.6% decrease from 2013, but a 4.0% increase since 2016 (Pennsylvania Juvenile Court Judges' Commission, 2017). Further, there were 22,309 delinquency-related dispositions in Pennsylvania in

2017. This was a 22.8% decrease from 2013 and a 2.7% decrease from 2016 (Pennsylvania Juvenile Court Judges' Commission, n.d.). These figures show delinquency, while stable, is still prevalent in the state and indicate that research into the factors that contribute to juvenile delinquency would be valuable. Understanding the contributing factors to delinquency would assist professionals with appropriate prevention and intervention methods to further a consistent decline in delinquent behaviors.

The statistics above show juvenile delinquency for the Commonwealth of Pennsylvania, but I focused on juvenile delinquency in York County. According to the Pennsylvania Juvenile Court Judges' Commission (n.d.), there were 1,586 allegations and 1,323 dispositions against juveniles in York County in 2017. There were only two counties with a larger number of allegations (Philadelphia, 2,950 and Allegheny, 3,063). Because York, Pennsylvania has shown an ongoing issue with delinquency it was useful to examine any existing relationships that may contribute to issue with juvenile delinquency.

Based on a review of the statistics, across the United States and Pennsylvania, and the current research on delinquency, the purpose of this research was to determine the relationship between childhood trauma and juvenile delinquency. According to Sevecke et al. (2016), more research is necessary to determine the relationship between childhood trauma and delinquency since past experiences have been related to problematic behavior in children and adolescents. In this study, I aimed to identify whether mental health professionals can provide greater understanding regarding the link between childhood

trauma and juvenile delinquency. I wanted insight from professionals on the effects early traumatic experiences have on juvenile delinquency as well as juvenile mental health concerns.

The objective of the literature review was to provide a background to how traumatic experiences impact children and adolescents. The experiences faced during childhood and adolescence may include child abuse, neglect, dysfunctional family dynamics, brain impairment, and present effects of traumatic experiences. In the literature review, I will first explain the biopsychosocial model as the theoretical framework for this study. The model was used to examine the biological, social, and psychological aspects surrounding juvenile delinquency and the risk factors associated with juvenile delinquency. Additionally, I will discuss the emerging topic of epigenetics and how it gave further explanation of how biological, social, and psychological factors impact an individual. I will then discuss the research on the long-term effects of traumatic experiences, the relationship of those experiences to juvenile delinquency, and the effect they have on an individual during adulthood.

Literature Search Strategy

The literature review was made up of peer-reviewed journal articles, governmental reports, organizational reports, and books. I found many of the articles through Walden University using the ProQuest search engine. I also used Google Scholar. I obtained information from OJJDP, Substance Abuse and Mental Health Services Administration (SAMSHA), the United States Department of Health and Human Services, National Institute of Health (NIH), and the National Alliance on Mental Illness

(NAMI). Other organizational websites that I used were Juvenile Justice Geography, Policy, Practice & Statistics (JJGPS) for Pennsylvania, and the International Society for Traumatic Stress Studies (ISTSS). The keywords used with the search engines for the literature review were *adverse childhood experiences, antisocial behavior, conduct disorder, distress, epigenetics, juvenile delinquents, minor, problem behavior, toxic stress, trauma,* and *victimization.* All of these terms were defined in Chapter 1.

Theoretical Foundations

Juvenile delinquency is a broad topic that encompasses all aspects of an individual's life. There are several factors that increase the risk of problem behaviors among children and adolescents. According to the Child Welfare Information Gateway (2013), there are physical, psychological, societal, and behavioral influences on delinquency. Factors for increased risk of problem behavior and juvenile delinquency include parental influences, such as prenatal behaviors and parenting styles. Other risk factors include social influences, environment, and other individual experiences. Due to this complexity, the most appropriate theory to use for this framework for the research was the biopsychosocial model. This model encompasses the biological, psychological, and social aspects that delineate the risk and mitigating factors for later juvenile delinquency (Engel 1977).

The biopsychosocial model was developed by Engel in 1977. Engel (1977, 1992) argued that biological, psychological, and social factors work together to explain the wholeness of a person and their behaviors. The model states that juvenile delinquency is not only a predisposed concept based on genetics from parents, but also a concept that is

nurtured through parenting styles, community, peers, and societal experiences throughout the individual's life. Since 1977, when the theory was developed, research has been conducted to explain the biological factors of human functioning, including neuroscience and other studies on the human brain and development. The biological component of the biopsychosocial model focuses on brain functioning, genetics, and physical health. Epigenetics is another biological component and explains how changes that take place on human genes have the potential to influence human behavior (Lester et al., 2016). According to Lane (2014), understanding the brain functioning and other biological components help researchers understand human health and disease. Psychological aspects of the biopsychosocial model include thinking, emotion regulation, and self-control. Any disruption in normal patterns of thinking, emotion regulation, and self-control contributes to the internal and external behaviors of juvenile delinquency (Child Welfare Information Gateway, 2015). Social aspects of the biopsychosocial model include socioeconomic status, culture, technology, and personal beliefs. The stressors of life, real or perceived, can influence delinquent behaviors. The biopsychosocial model shows how the biological, psychological, and social factors interact and play a role in juvenile delinquency.

Conceptual Framework

The conceptual framework for this study was juvenile delinquency. A juvenile was defined as a person who has not attained his or her 18th birthday, and juvenile delinquency was defined as a violation of the United States law by a person who has not reached the age of 18, which would be considered a crime if the violation were

committed by an adult (U.S. Department of Justice, n.d.). Juvenile delinquency is an ongoing issue in the United States as well as globally (Young et al., 2017). The concepts of juvenile delinquency were best explained with the biopsychosocial model. The model related to several aspects that explain how childhood and/or adolescent trauma increases the risk for behavioral issues and potentially juvenile delinquency, as well as long-lasting effects into adulthood, including mental health and physical ailments.

The biopsychosocial model was first proposed to explain the dynamics of affecting medical patients. Engel (1977) explained that biological factors were not the only concerns when explaining the conditions of his patients. Lehman et al. (2017) agreed with Engel, noting several factors that contribute to explaining health as a dynamic system. They explored interpersonal, biological, and psychological systems and theorized how the systems interact to shape health over the lifespan. According to Lehman et al. (2017), the biological component explains the physical effects of health; the psychological component is comprised of factors such as cognitive, emotional, and motivational aspects that effect health; and the interpersonal component includes the how an individual's interactions with others other influences their health. Research has shown how biological, psychological, and social factors can lead to certain behaviors (e.g., Burke-Harris, 2018; Fox et al., 2015; Kerig, 2014; Marsligio, 2013; Raine, 2015; Sapolsky, 2017). The biological component explained that DNA is the basis of how an individual grows, develops, and functions in society, and Raine (2015) found that individuals may be hard-wired or born to engage in violent behavior. Sapolsky (2017) agreed, stating that genes are relevant to everything, including aggression, which

suggested that some people may be more inclined to engage in aggressive behaviors. The psychological component of juvenile delinquency focuses on how an individual's thoughts and feelings shape their behavior and health (Lehman et al., 2017), the interpersonal component of juvenile delinquency can be explained through the interactions with others in society including parenting, family dynamics, school, community, and peers (Lehman et al., 2017).

Literature Review

While statistics have confirmed an overall decline in delinquency, the predisposing factors and aftereffects of juvenile delinquency continue to be a societal problem. In the United States, one in eight violent crimes are committed by juveniles who are considered to be serious, chronic, violent offenders (Fox et al., 2015). Research has demonstrated that other countries have seen a decline in juvenile delinquency as well, but violent crimes are still a major concern globally. Young et al. (2017) noted that there has been a decline in juvenile delinquency in the United Kingdom, Australia, and the Nordic regions, but these areas continue to have issues with violent crimes as well as drug use and property crimes.

Based on the prevalence of child maltreatment and victimization, it was concluded that individuals will struggle as they continue throughout their lives (Fox et al., 2015). Furthermore, research has shown a connection between victimization, and delinquency, which means it was to some extent predictable that the offended is likely to become the offender. Cuevas et al. (2013) studied youth to determine how victimization relates to delinquency based on gender. Their study showed that youth who had

experienced victimization three or more times and committed violent offenses occurred 18.1% of the time in boys aged 10-17 and 13.3% in girls aged 10-17 (Cuevas et al., 2013). This supports the theory that youth who experience trauma and are victims are at a greater risk to commit delinquent acts. Cuevas et al. found that youth who had experienced fewer than three instances of victimization could become violent offenders at a similar rate, 20.8% of boys aged 10-17 and 13% of girls aged 10-17. The statistics showed the importance of further examination of the relationship between trauma, victimization, and juvenile delinquency. Furthermore, the statistics suggest the need for prevention and intervention of juvenile delinquents because of the prevalence of childhood maltreatment and victimization.

Juvenile Delinquency and Childhood

Childhood is a critical time in an individual's life because to the child must depend on caregivers and other adults to meet their physical and emotional needs (Jones & Pierce, 2020). They also stated that early childhood, from as young as infancy to 3years, is a sensitive time-period for behavioral development. This alluded to the idea that adversity can leave a significant imprint on the developing child. According to van der Kolk (2014), children need a secure base to learn how to master self-regulation and other skills that will help them learn how to take care of themselves. When children do not develop these skills, they become more susceptible to the aftereffects of adversity and trauma, which included juvenile delinquency. Lack of security begins to explain why many minors considered juvenile delinquents have been through ACEs or another type of trauma. Society is becoming more aware of child abuse, neglect, and other ACEs, and

that the effects can last into adulthood. According to Fox et al. (2015), juvenile delinquency is often a result of childhood trauma. However, juvenile delinquency rates have been on a steady decline for the past few decades. According to OJJDP (2017) arrest rates for all offenses were highest in 1996 but have shown a decline of 68% by 2015 for individuals aged 10-17. Violent crimes committed by juveniles in that age group have declined since 2006, and 2012 showed the lowest numbers to that point in the century of juvenile violent criminal arrests. The all-time low for juvenile property crime arrest rates was shown in 2015 (OJJDP, 2017).

Many children experience trauma in their daily lives by being a victim of or witnessing a traumatic event. These experiences increase a child's risk for juvenile delinquency. Researchers found that 90% of juvenile offenders in the United States had experienced trauma during childhood (Fox et al., 2015) and of that group, 30% met the criteria for PTSD (Dierkhising et al., 2013). ACEs are critical risk factors for mental, emotional, and behavioral issues in children where these factors may last a lifetime. According to Baglivio et al. (2014), there are 10 ACEs: "emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, violent treatment towards mother, household substance abuse, household mental illness, parental separation or divorce, and having an incarcerated household member" (p. 13). Each ACE could result in later problems for the child. Furthermore, the various types of childhood trauma often co-occur and increase individual stress and can cause later physical, emotional, and behavioral health issues (Nurius et al., 2015) like delinquency, substance abuse, risky sexual behavior, mental health problems, (Marsiglio et al., 2014) chronic disease, early

death, and offending (Craig et al., 2020). Another concern was that childhood adversity is more likely to result in co-occurring disorders (van Draanen, 2019) meaning the negative experiences increase an individual's likelihood of developing mental illness or substance use disorder.

Child abuse and neglect are common offenses in the United States, and the Centers for Disease Control and Prevention (CDC, 2020) reported that the estimated national victimization rate for the United States including the District of Columbia and Puerto Rico, was 676,000 out of 74,388,157 children. Of the child population, 74.8% were neglected, 18.2% were physically abused, and 8.5% were sexually abused (U.S. Department of Health & Human Services, 2016). Even though child abuse and neglect are grave offenses, children are more likely to witness domestic violence (interpersonal violence and/or family violence). Child Welfare Information Gateway (2015) explained that 30 million children in the United States were exposed to domestic violence which resulted in cognitive, behavioral, social, and emotional concerns.

National statistics showed that 9.1 per 1,000 children are likely to experience at least one traumatic event in the form of child abuse or neglect (CDC, 2020). According to Fox et al. (2015), trauma and child abuse increased the likelihood of violent juvenile behavior by 200%. Additionally, 90% of juvenile delinquents in the United States experienced childhood trauma (Dierkhising et al., 2013). Alongside juvenile behavior is the increased likelihood of at least one mental health diagnosis, but research has shown that juveniles are more likely to have comorbid diagnoses due to childhood adversity (Fox et al., 2015; van Draanen, 2019). The effects of trauma are physical, behavioral,

emotional, and societal. Child Welfare Information Gateway (2013) further explained that the outcomes of trauma were dependent upon child age and development during occurrence, the type of trauma, the frequency, duration, and intensity of the trauma. The relationship between the child and the offender also determined the outcome of the trauma. Finkelhor et al. (2015) examined the National Survey of Children's Exposure to Violence (NatSCEV II) conducted in 2011 and found that two out of five children were victims of at least one assault and 10% of those children were injured from the assault. The children were also exposed to and witnessed violence. Finkelhor et al. (2015) expressed that in the study 22.4% of minors witnessed violence and 8.2% witnessed violence in their home. Additionally, many of the children in the study were exposed to one or more types of violence; they were a victim or witnessed victimization. About 50% of the participants stated one type of exposure to violence, whereas 15% of participants stated six or more types of exposure to violence, and about 5% of participants stated 10 or more types of exposure to violence (Finkelhor et al., (2015). The study on children's exposure to violence also examined older minors and their exposure stating that children ages 14 and 17 experienced higher numbers of exposure to violence. About 70% of this group were assaulted in their lives and 71.5% witnessed violence (Finkelhor et al., 2015). Fifty-six percent were also victims of property crimes. Statistics continue to show that there is a connection between childhood victimization and delinquency and the need to explore how these events have lasting impacts on the individuals.

Along with adversity from experiencing or witnessing abuse as a child, the structure and function of a family system can be aversive to the developing child.

Divorce, separation, domestic violence (Baglivio, et al., 2014; Brown & Shillington, 2017), absent parents (e.g., incarceration or death), parental substance abuse, parental mental health issues, and other family violence (Beal et al., 2019) are other circumstances that are considered ACEs. Parental substance use and abuse impacts the child because parents are then facing their own struggles making it more challenging to be an effective parent to the child. As stated by the CDC (2019), parents who are struggling with substance use also struggle with managing personal stress, managing emotions, and being there for their children. When parents cannot be mentally and emotionally available to a child, the child may resort to their own ways of coping, which could turn into delinquency.

Regarding absent parents, children are more likely to develop risk behaviors from like smoking and alcohol consumption (Lacey, 2016), which then leads to later physical and emotional health concerns. Health concerns are likely to stem from the risky behaviors, such as juvenile delinquency, which is also a risk factor. Children may turn to risky behaviors to cope with the adversity and then develop unhealthy coping behaviors that could follow them the rest of their lives. Children and adolescents who have disruption to their family dynamics (absent parent or divorce) are more likely to commit criminal acts. Brown and Shillington (2017) found that children who did not have protective adult relationships were more likely to engage in behaviors such as substance use and delinquency. This showed that instability in childhood is adverse and can have lasting impacts on a child. According to Peguero (2020), if children experience adversity with and develop deviant behaviors, they will then continue throughout life becoming

delinquents and potentially adult offenders. To mitigate the lasting effects of adversity it is essential that professionals work toward understanding how trauma impacts the child and to develop methods to prevent later delinquency.

Juvenile Delinquency and Adolescence

Reaching adolescence is a milestone and another critical point for development in an individual's life. Younan (2018) explained that there are several changes going on at this time, behavioral, psychological, and social, and those changes make the adolescent more vulnerable to have disruptions in their development. Society places much emphasis on the role of peers and parental connection during this critical time. Huijsmans et al. (2019), explained that social influences from parents and peers have an impact on an adolescent's self-control. They also mentioned that based on the social control theory the presence of healthy supports and social relationships decreases an adolescent's likelihood of delinquent involvement. Conversely, the lack of healthy supports and social relationships increases the likelihood of adolescent delinquent involvement (Hujismans et al., 2019). Furthermore, social influences, especially peer relationships may have more of an impact on adolescent behavior. During this stage in life, adolescents are continuing to learn more about themselves and focus on self-control. In regard to juvenile delinquency, if an adolescent has low self-control, he or she is more likely to engage in delinquency (Hujismans et al., 2019). This tends to impact the individual's achievement in school, health, and it also contributes to poor achievement later in life. These factors are detrimental to delinquency even without the added struggles of childhood adversity and trauma.

Stated previously, the trauma experienced during childhood has lasting effects on minors, but trauma experienced during adolescence is also damaging and increases the risk for juvenile delinquency and future criminal behavior. Kerig (2014) stated that adolescents experienced the highest numbers of maltreatment in the United States, which could potentially result in criminal behavior. It was argued that the maltreatment and other forms of adolescent trauma affect the adolescent's adjustment, which can lead to antisocial behavior. Adolescence is a time of increased stress for the individual's development because of hormones, puberty, and their social lives (Kerig, 2014), consequently, the added chronic stress from maltreatment increases the risk of social and behavioral difficulties as well as mental health issues (Kerig, 2014; Nurius et al. 2015).

Aside from the chronic stress experienced in adolescence, peers also have an influence on juvenile delinquency. Delinquency can be a learned behavior through imitation and reinforcement (Pierce et al., 2015). During adolescence, peer relationships are vital in an individual's life and impact one's behavior. According to Haynie et al. (2014), at this stage of life adolescents spend a greater amount of time socializing with peers and are influenced by their peers' behaviors and attitudes. Researchers have found that those who have delinquent peers are likely to engage in delinquent behaviors themselves (see Mercer et al., 2016). Self-control is another factor to consider for adolescence and juvenile delinquency. Haynie et al. (2014) explained that adolescents with low self-control are more likely to have friends who are also delinquents. Adolescents use peer relationships to validate themselves and add meaning to their life. Consequently, individuals engage in delinquent behavior based on peer influence and

self-concept (Pierce et al., 2015). Another aspect to consider in regard to juvenile delinquency and adolescence is the influence trauma has on behavior.

Intimate partner violence is another form of peer relationship during adolescence and is associated with posttraumatic stress symptoms. It was noted above that witnessed domestic violence within the family during childhood has an impact on delinquent behaviors. Awareness of this also leads to the connection that many individuals who perpetuate intimate partner violence also exhibit posttraumatic stress symptoms (Mozley et al., 2019). In this circumstance, the aftermath of the trauma from childhood is either being relived or exhibited in interpersonal relationships. Additionally, exposure to violence during adolescence, and childhood, changes the perception of individuals and they may start feeling unsafe in environments that were once safe. As stated in Wagers et al. (2020), adolescents who are exposed to violence tend to have decreased expectations of the safety around them and may develop aggressive behaviors, engage in substance use, drug use, engage in violence, or even commit suicide. Adolescents involved in the juvenile justice system have higher instances of exposure to violence compared to those who are in the general population (Baglivio et al., 2014; Dierkshing et al., 2014; Wagers et al., 2020). Again, maltreatment and exposure to adverse events increases the likelihood of juvenile delinquency among adolescents.

Another factor considered for the social aspect of juvenile delinquency is bullying. Bullying is defined as a form of aggressive behavior in which someone intentionally and repeatedly causes another person injury or discomfort (American Psychological Association, 2020a). Bullying can be physical and/or verbal. Bullying can

occur across a lifespan, but since adolescents focus more on peer interactions during these years, it is important to understand the risk factors of bullying and the lasting impacts of bullying. Fujikawa et al. (2016) noted the risk factors of bullying to include: harsh parenting styles, domestic violence, child abuse, and other conflicts in the parent-child relationship. These circumstances can increase the likelihood of an adolescent choosing to use his or her experience to overpower others and become a bully or allowing the adversity to decrease self-esteem and become a victim of bullying (Fujikawa et al., 2016). Bullying, like other adversity, also has lasting impacts on the individual. Adolescents are more likely to internalize the effects of being bullied. Fujikawa et al. (2016) expressed that the internalizing symptoms as a result of bullying are depression and suicidal ideation. Sigurdson (2019) agreed and added that another internalizing symptom is anxiety. Adolescents who bully demonstrate externalizing symptoms like aggression, which is associated with juvenile delinquency and other maladaptive behaviors. Fujikawa et al. (2019) stated that bullying has several negative outcomes: mental health issues, psychosomatic and somatic problems, traumatic experiences, and increased suicidality. The outcomes of bullying have many effects on adolescents, most of which are adverse on the development of an individual.

Trauma: Development, Behaviors, and Consequences

Intergenerational Trauma

Trauma is becoming more widely accepted across disciplines as we learn how trauma effects every aspect of an individual’s being. It is now being recognized that trauma is not only characterized by experienced events but can also be characterized by

family and social history, suggesting that professionals may have to consider family history for up to three generations (Wolynn, 2016). Children and adolescents may be living with problem behaviors due to the traumatic experiences of their parents, especially their mothers. Sangalang et al. (2017) argued that trauma experienced in one generation likely effects offspring and that children experience intergenerational effects of trauma they have not been directly exposed to, which is displayed through distress, psychosocial processes, and resilience. Yehuda and Lehrner (2018), also found this correlation and noted that trauma exposure may even take place before conception.

Intergenerational trauma can be experienced through systematic oppression, which is lived through many generations if shifts are not made. It is noticed in cultures that have experienced traumatic events like genocide, war, famine, slavery, and the Holocaust and are more likely to produce offspring with intergenerational effects to trauma (Yehuda & Lehrner, 2018). Moreover, children and adolescents who do have parents and grandparents who experienced these types of trauma are also at risk for delinquent and risky behavior. Garcia (2020), researched American Indian/Alaska Native (AI/AN) youth and found that they suffer from fetal alcohol syndrome, which causes intellectual and neurodevelopmental disabilities, and the also have high rates of mental health problems including suicidality, substance use/abuse, and alcohol use/abuse. Many of the behaviors experienced by these youth are risk factors for delinquency. Surprisingly, AI/AN make up only 1% of the U.S. youth population, but they account for 40-70% of the juvenile justice population and many of the delinquent youth within the justice system have diagnosable mental health issues (Garcia, 2020). The statistics

demonstrate the need for researchers to take a closer look at intergenerational trauma and its effects on an individual. According to Garcia (2020), the coercion of assimilation towards Indigenous people has led to the disruption of their culture and contributes to historical trauma, which continues to increase mental health and delinquency on their youth. Researchers have also found that there are similar effects on Southeast Asian culture. Sangalang et al. (2017) studied Southeast Asian refugees and noted that their children were experiencing mental health issues. They also noted that the children experienced poor psychological and behavior adjustment and that lack of mental health care increased the risk for development of PTSD and depression.

Extreme poverty plays a role in multigenerational trauma as it relates to genetics. Many researchers have identified the factors that contribute to poverty and few researchers have explored what keeps people in poverty from generation to generation. Zabir (2020) explored poverty and found that it has a genetic and habitual correlation as individuals tend to fall into routine and those behaviors and genetic influences are passed down. This is under the assumption that survival and adaptation characteristics are passed down through generations. Hur and Bates (2019) also found that extreme poverty conditions were detrimental because those in countries that face such circumstances lack quality education, food, and other resources associated with successful outcomes. For example, slavery brought harsh conditions including less than adequate living conditions and educational opportunities, which has influenced many generations and has had an impact on the development of an individual. According to Mariska et al. (2019), those circumstances impact the behavior which in turn has led to increased anxiety and

depression among the population and has other lasting mental health and behavioral impacts on an individual.

Another aspect of intergenerational trauma to take into consideration was parenting styles because many of the cultural effects of trauma may have been passed onto the way caregivers choose to parent their children. Arafat et al. (2020) expressed that defining parenting is difficult because it is rooted in culture but that parenting has direct impact on the development of a child. Furthermore, the presumption was that parenting styles and parenting behaviors (positive or negative) are passed down through generations, which implies that adverse parenting styles and behaviors increase the likelihood of adverse childhood experiences and other traumatic events. Parenting styles that involve child abuse and maltreatment is prevalent around the world and researchers are attempting to determine the link between it and parenting. Capaldi et al. (2019) studied intergenerational family violence and noted that there is a connection between maltreatment from parent to child and that it could increase the likelihood of the child resorting to maltreatment as a parent, but they also noted that parents may not be choosing maltreatment, but rather that is what they resort to due to lack of self-control. Nonetheless, the parent could be reliving their own trauma and the unhealthy coping results in trauma to child. Whether it is intentional or not, the expression of nonverbal post-traumatic stress symptoms by a parent to a child increases the adversity a child may experience (Yehuda & Lehrner, 2018). Adversity during childhood and adolescence dramatically increases the risk of juvenile delinquency.

The Relationship Between Juvenile Delinquency and Trauma

Trauma affects almost every person who has experienced it, and each traumatic event had the potential to impact an individual for a lifetime. According to van der Kolk (2014), trauma has lasting impacts not only on the individual but also on the families and others close to the individual. Additionally, the impact of trauma leaves lasting impressions on emotions, biology, and immune system; mind, body, and brain (van der Kolk, 2014). He went on to explain that trauma is not only a lived experience but also the aftermath of the trauma leaves the individual living in fear, pain, and horror. Individuals suffering from trauma are not safe in their own bodies (van der Kolk, 2014). A psychiatric definition describes a trauma as an experience that produces psychological injury or pain. According to the DSM-5, trauma is defined as actual or threatened death, serious injury, or sexual violence (American Psychiatric Association, 2013). Yet, another definition of trauma is any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have long-lasting negative effects on a person's attitudes, behavior, and other aspects of functioning (Trauma, n.d.). Reviewing different definitions of trauma shows that trauma can be based on individual experience, and may affect individuals differently, but national statistics show that trauma is common among children (Child Welfare Information Gateway, 2013; Fox et al., 2015; Finkelhor et al., 2015). Children are exposed to trauma and become victims of trauma every day. Trauma does not only include child abuse and neglect (Child Welfare Information Gateway, 2013), but includes

witnessing domestic violence (Baglivio et al., 2014), death of a loved one, and other tragedies (Bielas et al., 2016).

Whether research calls the victimization trauma or an adverse experience, the experience influences individual behavior, physical health, and mental health well into adolescence and adulthood. Marsiglio et al. (2014) explained that not all children who experience trauma have lasting negative impacts, but the experience of trauma does place a child at risk for developmental problems, mental health problems, poor academic achievement, and/or juvenile delinquency. Additionally, researchers have found that trauma may play a role in later substance abuse (Brown & Shillington, 2017; Marsiglio et al., 2014) including the potential abuse of prescription medication. These findings from research show that various aspects of human development should be examined to identify the relationship between trauma, delinquency, and the effects.

One explanation of the relationship between trauma and juvenile delinquency was the family environment. Children who came from dysfunctional families and lived in poverty, were at an increased risk for juvenile delinquent behavior. Black (2016), found that 22% of children in the United States live in poverty and the increased stress has an impact on mental and physical health. Along with living in poverty, the dynamics of the family increases the risk of aggression and delinquency in children. The amount and severity of violence in the home increases the risk, as well as, corporal punishment, which is another form of violence/abuse (Mueller-Bamouh et al., 2016). The increased violence from dysfunctional families plays a role in the cycle continuing among minors.

Vidal et al. (2017) discussed the cycle of violence theory stating that repeated maltreatment increases the risk for delinquent and/or violent behavior. Based on their study, about one in three children who have experienced chronic and repeated maltreatment were at a greater risk for entrance into the juvenile justice system. This implies that maltreatment towards children increases the likelihood of them engaging in delinquency as a result of learned aggressive behavior. Other factors that played a role in juvenile transition from the child welfare system to the juvenile justice system included age, gender, ethnicity, and family environment (Vidal et al., 2017). Social aspects of trauma increase the risk for chronic stress in adolescents. Trauma experienced during adolescence increases the risk for anxiety (Chaby et al. 2014; Lukianoff & Haidt, 2018) because adolescents are vulnerable to many changes throughout this stage of life. This also increased other mental health concerns including, but not limited to, depression, substance use/abuse, drug use/abuse, and PTSD (Bielas et al., 2016; Brown & Shillington, 2017; Burke-Harris, 2018; Carliner et al., 2017; Chaby et al., 2015; Hinnat et al., 2015; Lukianoff & Haidt, 2018; Mercer, et al., 2016; Merrick et al., 2017).

Consequences of Trauma

Physical health consequences of trauma on a minor include visible marks, such as scrapes, burns, and broken bones, as well as physical health concerns (Children Information Gateway, 2013). According to the Centers for Disease Control (2020), about 1,670 children died from abuse and neglect in the US, and 1,580 children died in 2014. Based on the statistics the number of deaths from child abuse and neglect are rising. Another physical health consequence is traumatic brain injury, which can result from

abusive head trauma or impaired brain development. Children can become visually impaired or suffer from motor and cognitive impairments (Center for Disease Control, 2020) depending on the severity of the brain trauma. Additionally, chronic health concerns may result as a physical consequence of childhood trauma. Adult survivors of childhood trauma are prone to heart disease, hypertension, liver disease, diabetes, and obesity (Center for Disease Control, 2020; Child Welfare Information Gateway 2013).

Childhood and adolescent trauma have emotional affects and/or can impair the individual's ability to build lasting relationships with others, show emotion, and use coping skills. Children who have suffered trauma showed difficulty with expressing their emotions, recognizing their emotions, and understanding their emotions (Fox et al., 2015). Abused and neglected individuals lose trust in others, isolate themselves, and can be fearful (Child Welfare Information Gateway, 2013); psychiatrically, they can suffer from depression, anxiety, chronic stress, and eating disorders (Center for Disease Control, 2020; Fox et al., 2015). In children, the psychological effects of trauma include learning difficulties, attention deficits, and conduct disorder. The severity of the traumatic event increases the likelihood of psychopathy (Sevecke et al., 2016). Individuals are likely to have social difficulties, attachment issues, and exhibit antisocial traits, including borderline personality disorder (Child Welfare Information Gateway, 2013). Previously stated, childhood trauma is a risk factor for juvenile delinquency and stated in Underwood and Washington (2016), 50-75% of juveniles meet the criteria for mental illness, and incarcerated juveniles are diagnosed with at least one diagnosable mental health disorder.

The behavioral consequences of child abuse and neglect are common among adolescents. Behavioral concerns stemming from childhood trauma may affect adolescence are substance abuse, teen pregnancy/risky sexual behavior, and juvenile delinquency (Child Welfare Information Gateway, 2013). Consequently, other behavioral consequences include becoming an abusive youth (Brown & Shillington, 2017; Cuevas et al., 2013; Fox e al., 2015; Garofalo et al., 2015; Marsligio et al., 2014), increased juvenile arrest rates, increased school dropout rates, as well as later adult violent and criminal behavior (Center for Disease Control, 2020; Child Welfare Information Gateway 2013). Behavioral concerns are prevalent in juveniles who experienced childhood trauma because the common mental disorders increase the likelihood of aggressive behaviors (Underwood & Washington, 2016). For example, mood disorders like depression, increase an individual's likelihood to exhibit aggressive behaviors towards others and self-injurious behaviors (Underwood & Washington, 2016). The consequences of trauma on minors are detrimental and demonstrate the need for research to understand the full effects of all the factors that contribute to delinquency.

Long-Term Consequences of ACEs and Trauma

Mitigating childhood adversity is not only important to prevent juvenile delinquency but also to prevent long-term health concerns later in adulthood. Social, emotional, and physical health consequences are likely to be a result of trauma and adverse childhood experiences on minors and juveniles, which last well into adulthood. Children who grow up with a low socioeconomic status are more likely to suffer from higher chronic disease and mortality rates (Monnat & Chandler, 2015). Adults who have

had adversity during childhood are also more likely to smoke, drink, and engage substance use. According to Merrick et al. (2017), individuals who experienced six or more ACEs were at higher risk for depression (2.73 times), attempting suicide (24.36 times), drug use (3.73 times), and drinking (2.84 times). Childhood adversity increases stress levels and also leads to emotional dysregulation in individuals, which makes it difficult for the individual to handle situations. Bryan (2019) stated that exposure to ACEs predicts adulthood obesity and eating disorders. The toxic stress that stems from adverse childhood experiences has a lasting impact on the physical health of adults. Childhood adversity contributes to the onset of metabolic syndrome, atherosclerosis, chronic obstructive pulmonary condition, diabetes, and cancer (Sonu et al., 2019). These lasting effects show the need to research the link between traumatic experiences and juvenile delinquency to minimize future health concerns.

Su and Stone (2020) found that many adult survivors of childhood trauma suffer from somatic symptoms, emotion dysregulation, interpersonal stability, memory disorders, re-experiencing and dissociation, avoidance, and shame. Under somatic symptoms, anxiety and chronic pain have also been correlated with the effects of childhood adversity on adult survivors. Professionals have found that patients with chronic pain have some form of psychological deprivation and traumatization (Kascakova et al., 2020). Moreover, they noted that childhood adversity increases anxiety and depression in adults, which may be the reason that adults with chronic pain also live with anxiety or vice versa. Other symptoms experienced by adults include irritable bowel

syndrome, chronic fatigue, fibromyalgia and adults may resort to unhealthy coping, such as, substance abuse and eating disorders (Su & Stone, 2020).

Aside from the somatic symptoms, adults also experience emotion dysregulation. As stated by Su and Stone (2020), this comes from a trauma survivor reliving the traumatic experience and not being able to control their intense emotions. Trauma survivors are disorganized from within (van der Kolk, 2014), so when reliving these experiences individuals feel a sense of powerlessness and need to learn healthy coping skills to manage the intensity of their emotions (Su & Stone, 2020). The dysregulation of emotions is correlated with many of the other emotion-related experiences of adults with childhood. The instability in adult relationships, like marriage is due to the inability to distinguish between safe and unsafe behaviors because of the lack of trust stemming from their trauma history (Su & Stone, 2020). Adults also have a difficult time remembering all the details of their trauma, which is the reason for distorted memories. The distorted memories are often what the trauma survivor is reliving and increases the development of PTSD (Su & Stone, 2020). A combination of all these symptoms and remembrance of the childhood trauma correlates with the adult experiencing dissociation, wanting to avoid events that trigger the past trauma, and leaving the adult feeling a sense of shame (Su & Stone, 2020). Much of the aftermath math of childhood trauma carries over into adulthood, which suggest that intervention to increase healthy coping during childhood and adolescence could minimize or mitigate the experiences during adulthood.

Neurological Concerns and Issues

Biology and Behavior

In order to understand the background of juvenile delinquency and criminal behavior it is important to understand the biology of human behavior. Raine (2015) suggested that criminal behavior was thoroughly explained through evolution and researching the human brain. Historically, human behavior was explained by survival of the fittest, suggesting the traits that helped individuals survive were carried on from generation to generation (Palumbo et al., 2018). For example, males are known for being dominant and hunter/gatherers, whereas females are known for being motherly and nurturing. We can then predict that in juveniles, males are likely to be more violent than females.

The biological perspective of crime, violence, and deviant behavior examines prenatal care, family history of violence, DNA, neurotransmitters, and brain functioning. According to Raine (2015), brain scans have shown that deviant individuals have different brain patterns compared to nondeviant individuals. The prefrontal cortex, which is responsible for brain processes such as impulsivity, aggression, and emotion regulation, has helped researchers gain a better understanding of criminal behavior. Many juvenile delinquents and at-risk youth struggle with attention, impulsivity, hyperactivity, emotion regulation, and antisocial behavior (Burke-Harris, 2018; Child Welfare Information Gateway, 2015; Child Welfare Information Gateway, 2013), which are all regulated by the prefrontal cortex. Studying brain structure and function has given

researchers the ability to study the process of predicting antisocial and criminal behavior among at-risk youth and juveniles.

Two areas that have received more attention in regard to antisocial and criminal behavior were traumatic brain injury (TBI) and the advancement of technology for brain imaging. As described by Williams et al. (2018), traumatic brain injury results when an external force causes injury to the brain and these injuries have the potential to cause death and disability to an individual. TBI does not have to result in major injuries or deficits to an individual, but many researchers are finding the detriment behind it. Such detriment includes poor memory, poor attention, poor concentration, poor planning, and poor emotion regulation including impulsivity and poor social judgment (Williams et al., 2018). When children and adolescents experience TBI it can impact their brain structure and function, which can have lasting impacts on their behaviors. It was noted that damage to the frontal lobe from TBI puts an individual at risk for aggression, lack of control, and poor decision making (Williams et al., 2018). At this critical stage in life children and adolescents are at risk for behavior problems that could affect them in school and has the potential to increase delinquency through adolescence and criminal behavior through adulthood.

Brain imaging has also played a role in professionals learning more about the relationship between brain structure and delinquency and other criminal activity. Researchers have focused on low self-control as a means to predict criminal activity and now they are starting to use imaging as another way to understand causes of low self-control. According to Meldrum et al. (2018), brain imaging has shown direct areas of the

brain that are associated with low self-control, which increases the risk for delinquency and criminality. They found that low self-control was the mediation between anterior cingulate cortex activity and juvenile delinquency. Researchers and professionals may benefit from learning more about brain imaging and activity to continue to study the process of criminal activity and delinquency among children and adolescents.

Brain Development and Functioning

Focusing more on childhood adversity and the brain, it was noted that the toxic stress associated with these experiences affects all the areas of the brain that are responsible for aggression, judgment, fear, memory, social control, and hormones. As stated by Burke-Harris (2018), repeated toxic stress during childhood dysregulates normal brain functions by overacting the amygdale (fear response) and releasing too much hormone; therefore, inhibiting an individual's ability to control their impulses. Many delinquents are frequently diagnosed with attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorder (CD; Carliner et al., 2017), which are all diagnoses associated with poor impulse control, noncompliance, poor academic achievement, and lack of social functioning. This was an implication that juvenile delinquency can be a result of improper brain functioning since the same brain functions that assist individuals in thinking and controlling their behavior is impaired due to repeated childhood adversity, which then results in toxic stress. Childhood adversity and trauma are the main reasons that individuals are not able to develop a healthy brain. Researchers have linked unhealthy brain development (Burke-Harris, 2018) to internalizing and externalizing behaviors in adolescence (Carliner et al., 2017), as well as

adulthood illness including: cardiovascular disease metabolic syndrome, obesity, diabetes, and inflammatory disease (Johnson et al., 2020).

Any experience has an influence on the developing brain. Positive experiences contribute to healthy brain functioning, and negative experiences contribute to dysfunctional brain development. The Child Welfare Information Gateway (2015) stated that toxic stress could cause reduced volume in several areas of the brain. These areas include: the hippocampus, which is responsible for learning; the corpus callosum which is responsible for interhemispheric communication, emotion, arousal and cognitive abilities; the cerebellum, which is responsible for motor behavior and executive functioning; a smaller prefrontal cortex, which plays a role in behavior, cognition, and emotion regulation; overactivity in the amygdala, which is responsible for emotional triggers (the fight of flight response); and abnormal cortisol levels, which can effect learning, socialization, and cognitive processes (Child Welfare Information Gateway, 2015). If brain development and functioning are altered by traumatic experiences, we can expect children and adolescents to struggle in school, struggle with building relationships with others, and resorting to problematic behavior and delinquency. In these instances, the traumatized brain has not developed appropriately; and therefore, has not learned how to handle difficult situations appropriately. The disruption in the brain and improper hormone release, stemming from childhood adversity, is the reason individuals' resort to impulsive behaviors. As stated by Burke-Harris (2018), repeated and prolonged adversity stresses normal brain functioning, which hormone receptors to become repeatedly

overloaded. In turn, the brain is telling the body to “find” things that will help the brain reach the same stimulation as the adverse experience or trauma used to bring.

Further, maltreatment effects social, behavioral, and emotional functioning. These effects are persistent fear response, hyperarousal, increased internalizing symptoms, diminished executive functioning, delayed developmental milestones, weakened response to positive feedback, and complicated social interactions (Child Welfare Information Gateway, 2015). A persistent fear response is detrimental to any minor because he or she would view many situations as dangerous and unsafe making an individual to constantly be in a state of survival mode. A dysregulated stress response does not allow an individual to determine the difference between positive and tolerable stress (Burke-Harris, 2018), which puts the body in fight or flight response at times it does not have to be. Due to this dysregulated stress, children may react to situations in aggressive or maladaptive ways, which may in turn be labeled as delinquent behavior. According to Child Welfare Information Gateway (2015), these behaviors can contribute to the future development of PTSD or other anxiety disorders.

These behaviors and behavioral health diagnoses demonstrate the hyperarousal experienced by traumatized youth. Hyperarousal is defined as an individual being sensitized to trauma based on exposure to chronic, traumatic stress. When minors experience hyperarousal, they are unable to effectively interpret situations and are unable to be calm because they are always on alert (Child Welfare Information Gateway, 2015). For example, harsh parenting styles result in stress sensitivity, which increases the likelihood of externalizing behavior from the minor. Such harsh parenting styles include

child abuse and maltreatment, and Afifi et al. (2017) found that spanking, which can be considered harsh parenting is potentially harmful to minors. Hinnant et al., (2015), concluded that harsh parenting and low resting respiratory arrythmia contributed to delinquency in middle childhood and adolescence because the individuals are not able to regulate their emotions resulting in delinquency, including substance use and potential addiction.

Another effect of maltreatment on brain functioning was increased internalizing symptoms, which can lead to the later development of anxiety and depressive diagnoses. Nurius et al. (2015) also added that childhood adversity increases the likelihood of suicide risk and personality disorders. Traumatized youth may also struggle with personal well-being and emotional stability (Child Welfare Information Gateway, 2015). Another problem with increased internalizing symptoms is that youth, and adolescents are prone to self-medicating and turn to substance use and abuse (Parrish et al., 2016). Conversely, research has shown that internalizing symptoms contribute to substance use, and that substance use contributes to internalizing symptoms. When children and adolescents exhibit these behaviors, it shows the results of disrupted brain development from childhood maltreatment (Child Welfare Information Gateway, 2015). Maltreatment also causes structural and neurochemical damage. The damage effects working memory, impulse control as well as cognitive and mental flexibility (Child Welfare Information Gateway, 2015). Diminished executive functioning affects a minor’s success in school, including academic achievement, intellectual impairment, attentiveness, and IQ level. It can be concluded that delinquent behaviors stem from the individual’s inability to focus

in school and control behaviors. If the child is struggling to focus it could lead to externalizing and problematic behavior. According to Savage et al., (2017), inability to control emotions is in relation to physical aggression and violent behaviors, which also gives way to the reciprocal relationship between academics and delinquency. Understanding the impact of childhood adversity and trauma on brain development is only one aspect of the long-term consequences of traumatic experiences on an individual.

Genetics and Epigenetics

So far, there was evidence in this chapter that growth and development is a strong predictor of risky behaviors and the onset of juvenile delinquency. Looking beyond growth and development, genetics has an influence on individual behavior, including personality and risky behaviors (Sapolsky, 2017). The study of genetics gives researchers the ability to learn more on individual behavior, individual disorder/illness, and individual personality. According to Sapolsky (2017), more specifically, genetics plays a role in intelligence quotient, schizophrenia, depression, bipolar disorder, autism, attention deficit disorder, compulsive gambling, and alcoholism. Many of these behaviors and mental health concerns are also present in individuals who have lived through trauma and present in delinquents. Raine (2013) studied aggression and violence and found that genetics accounts for 40% - 50% of antisocial behavior among children. This showed that genetics make up for much of the aggressive behaviors that we notice in children and adolescence. Conduct disorder is another mental health diagnosis characterized by aggression that is influenced by genes and is specifically noticed in children and adolescents. Based on research by Salvatore and Dick (2019), there is chromosomal

evidence that genetically links children diagnosed with conduct disorders to families with alcohol dependence and suicidality and delinquent siblings. Furthermore, Raine (2013) used twin studies for research on genetics and found that aggression and violence are heritable, and environment has minimal influence on aggression and violent behaviors.

The specific gene that has been linked to antisocial behavior in individuals is the MAOA gene, which produces the monoamine oxidase A enzyme. Stated by Raine (2013), this gene guides the metabolism dopamine, norepinephrine, and serotonin and that mutations to this gene have significant impacts. A mutation in this gene results in no function of MAOA, which is involved in impulse control, attention, and other cognitive functions (Raine, 2013). A disruption to normal functioning by neurotransmitters increases chances of mental health disorders that are often found in juvenile delinquents. These disorders are ADHD, alcoholism, drug abuse, impulsivity, and/or other risky behaviors (Raine, 2013). Genetics has a significant impact on child, adolescent, and delinquent behavior, and while studying genetics researchers get the opportunity to understand the impacts. Conversely, while genes do play a role in behavior, Sapolsky (2017) also argued that genetics is not the only factor to consider because environmental effects on an individual can be lifelong and even multigenerational, which can be described through the study of epigenetics.

Epigenetics was another area that researchers examine when they focus on the biological aspect of human behavior. Epigenetics is a field of research that focuses on brain development since it explains that genes can be altered but not change the structural component of DNA (Child Welfare Information Gateway, 2015). This was pertinent to

the current topic because it suggested that environment plays a role in human behavior. It was mentioned earlier that adverse experiences increase the likelihood of delinquency (Finkelhor et al., 2015; Fox et al., 2015), and it was noted that not every minor who experiences trauma resorts to delinquency or other maladaptive behaviors (Marsligio et al., 2014). Appling the information to epigenetics, some children and adolescence may have the genes that increase their likelihood of violence, but depending on their environment, including family, peers, and community, they could or could not show signs of maladaptive behaviors, delinquency, or violence.

Epigenetics also explained how gene alterations take place during gestation and can increase the likelihood of aggression and problem behaviors during childhood and adolescence. Stated in Palumbo et al. (2018), the stress experienced during pregnancy, especially during the first trimester is detrimental because the stress or other prolonged adverse experiences increase the tendency for children and adolescents to have the externalizing behaviors of delinquency and conduct disorder. The critical windows on epigenetic modifications due to stress and trauma are during the prenatal period, childhood, and adolescence. Other research had similar findings and stated that stress during prenatal periods can be linked to later mental health issues and that other long-term effects during the prenatal period include difficulties with learning, anxious behavior, struggles in attention, and interruptions in cardiovascular responses (Kiyimba, 2016).

Since epigenetics discusses that gene alterations do not change the structure of DNA, it was also pertinent to understand that these alterations can also be reversed.

According to Nugent et al. (2016), an individual's environment and how he or she responds to the environment can change the effects on the genes. This implies that support from others including parents, peers, and community can have positive effects on human behavior. Sapolsky (2017), suggested this is what is meant by rewiring the brain and noted that adversity does not have to dictate long-term physical and mental health consequences. The biopsychosocial model explained that there are various aspects that encapsulates human behavior and that each factor has negative or positive influences on what behaviors people exhibit. Kiyimba (2016) explained that these reversible influences can take place during the prenatal stage (by modification through medication) or during childhood, adolescence, and adulthood through psychotherapy or other intervention techniques.

Summary and Conclusions

Childhood trauma and other forms of childhood adversity are detrimental for any youth. The literature used in this chapter defined several themes that acknowledge the need for the current research study. Previous research concluded that adverse childhood experiences may lead to delinquency (Brown & Shillington, 2017; Fox et al., 2015; Marsiligio et al., 2017; Vidal et al., 2017;), other areas of struggle during adolescence, mental health struggles (Monnat & Chandler, 2015), and chronic illness in adulthood (Burke-Harris, 2018; Johnson et al., 2020). Negative outcomes do not always result from childhood traumatization, but negative consequences are more likely depending on the number of adverse experiences, the severity of those experiences, and the amount of exposure to those experiences. These experiences put children at risk to for serious

mental, physical, and behavioral outcomes. The experiences may also have an impact on an individual in adulthood; ultimately leading to premature death (Johnson et al., 2020). The research has started to define a common link between childhood trauma and delinquency but there is still much research needed to gain a better perspective on this issue.

Research has found that without proper prevention and intervention strategies, the lasting effects are more likely to occur and are more difficult to mitigate. What research has not determined is what providers can do to mitigate the lasting effects on traumatized individuals. Henceforth, the purpose of the current study was to gain a deeper understanding of the link between trauma and juvenile delinquency through the attitudes and experiences of mental health professionals who have worked with traumatized juveniles and adolescents. The research can then further hypothesize the appropriate measures needed to provide adequate care to minimize juvenile delinquency and the lasting effects of childhood trauma.

In chapter two, I used the introduction to restate the problem and purpose statement of the current research study. Next, the literature strategy review listed the types of resources used to support the problem and purpose of the research. The literature strategy review also listed the keywords used throughout the literature. Then, I explained the theoretical foundation by discussing the most appropriate theory to bring a better understanding to the research phenomenon. The conceptual framework built upon the theoretical foundation as I identified the concept of this phenomenon and expounded the importance and significance of this topic. Last I used the literature review to synthesize

previous research and explain how it relates to the current research. Next, chapter three will discuss the specifics of the research and the methodology behind it.

Chapter 3: Research Method

Purpose

The purpose of the current study was to understand the relationship between trauma and juvenile delinquency. Past research has confirmed that many juvenile delinquents have experienced trauma and live with mental health issues (Finkelhor et al., 2015; Fox et al., 2015). For this study, trauma was defined as any event that can cause significant distress for an individual, for example, child abuse, neglect, death of a loved one, abandonment, family violence, or witness of a tragedy. After discussing the relationship between trauma and delinquency, I examined trauma-informed care and how this technique assisted with the prevention and intervention of future juvenile delinquency. A qualitative design was used to explore this phenomenon and gather information from participants to discover common themes related to this dilemma. After gathering the information, I drew conclusions to gain a deeper understanding of the relationship between trauma and juvenile delinquency.

Major Sections

In this chapter the research design and rationale will be explained. After presenting the research question and defining the central phenomenon, I will explain the importance and appropriateness of the selected research design. This chapter also includes discussion of my role as a researcher, including an explanation of my relationship with participants and how I mitigated potential biases as well as potential ethical issues and how to address these concerns. In the next section, methodology, the following areas will be addressed: identify the population, identify and justify the

sampling strategy, state how the population is selected, and describe how the population meets the criteria for participation. This section will address the number of participants and the procedures used to identify, recruit, and contact the participants. The relationship between saturation and sample size will also be described. Next, I will identify the data collection instrument and discuss published data, collection instruments, and any original data collection methods created. Further procedures for pilot studies, recruitment, participation and data collection, and the data plan will then be discussed. Last, I will discuss of the issues of trustworthiness before summarizing and concluding the chapter.

Research Design and Rationale

Research Questions

The focus of this study was to examine the relationship between trauma and juvenile delinquency. Much research has found that trauma during early childhood has significant impacts on an individual as they continue to grow and develop (Finkelhor et al., 2015; Fox et al., 2015; Johnson et al., 2020). According to Burke-Harris (2018), childhood trauma was also a link to adult mental health issues and chronic illness in adulthood. Due to the immense amount of research linking trauma to delinquency and mental health concerns the research questions are as follows:

–RQ1: What are the lived experiences of administrators and mental health professionals who work with traumatized juveniles and adolescents?

RQ2: What are the common attitudes, perceptions, and opinions determined by those professionals who work with traumatized juveniles and adolescents?

Central Concept and Phenomenon

A qualitative approach was used to find common themes and opinions about trauma, juvenile delinquency, and trauma-informed care for juveniles and at-risk youth. The qualitative approach was the most appropriate method since my objective was to find a deeper meaning and understanding about the social dilemma of childhood/adolescent trauma and juvenile delinquency. The qualitative approach was suitable for the current study because qualitative research analyzes data into words based upon participant's experiences (see Levitt et al., 2018). Qualitative research also serves a purpose because the research aims to describe a phenomenon. According to Creswell and Poth (2018), researchers use the qualitative method to explore social issues in detail to learn about the problem or social phenomena.

Research Tradition

The focus of the current study was to examine the relationship between trauma and juvenile delinquency as well as define trauma-informed practices that have the potential to prevent or intervene with current juvenile delinquency. My goal was to explain in greater detail the phenomenon through the eyes of mental health professionals and those alike who work with traumatized and at-risk youth. A phenomenological approach was used to explore this topic. The phenomenological approach was the best method because the research was focused on one topic and attempted to learn more about the topic from a group of individuals. The information and data were provided by professionals who have experience with traumatized/at-risk youth, the juvenile population, and provide treatment for the individuals.

Rationale

The qualitative approach was the best method because the information being sought was not able to be quantified. According to Quieros et al. (2017), a qualitative approach would be beneficial because the research allows for an exploratory and flexible analysis and there is a bigger proximity between the researcher to the indemnified problem of the study. The purpose of the current study was to explain the phenomenon and provide insight on how to address the issue of juvenile delinquency and trauma. With the phenomenological approach I aimed to provide a more accurate picture of the effect trauma has on juvenile delinquents and at-risk youth.

Role of the Researcher

For this research study, my role was solely to observe and gather information from participants. I interviewed mental health professionals who work or have worked with minors and traumatized youth. A demographic questionnaire (see Appendix A) defined the age range of the youth the participants work with, where the subjects worked, and how long they have worked with minors and traumatized youth. I developed interview questions for the participants to delve deeper into their area of expertise and the population they work with. The rationale for this was to gather as much information from the participants to find common themes that were necessary to draw conclusions about the phenomenon.

The demographic questionnaire and interview questions were used to collect subject data. I had access to the participants through previous employment with behavioral health services. No research for this study was conducted at my place of

employment; rather, I reached out to agencies in the community for research participants to avoid bias within the study. Doing so, also demonstrated that participation in the study was strictly voluntary. Since the participation was voluntary, one concern was not obtaining an adequate number of participants for the study. To mitigate this problem, I reached out to other agencies when more participation was needed. Reaching out to several agencies in the community demonstrated that I did not have control over the participants and that I was gathering information for the sole purpose of becoming an expert in the relationship between trauma and juvenile delinquency.

One potential researcher bias is that I was familiar with behavioral health rehabilitative services in my community. I knew some individuals who worked in the community programs. Participation in this research study was completely voluntary and participants were informed of the process. One way to manage the potential bias was to use all the information that was gathered within the research. Additionally, I mitigated conflicts as researcher by clarifying my role as the observer to each participant. I gave them full details about the research before individuals committed to their role as a participant. One final way I managed researcher bias was to search for agencies and participants outside of York County, where the study was conducted.

Methodology

Participant Selection Logic

For the purpose of this study, the population included mental health professionals who were master's level, or above. The participants could be licensed or nonlicensed but were required to have experience working with juvenile delinquents or at-risk youth. The

population in this study was chosen based on meeting the above-mentioned criteria. Purposive sampling was best fit because I was using a specific population to learn more about one topic. Researchers use purposive samples when a specific sampling unit appears to represent the population (Frankfort-Nachmias et al., 2015). My research required a certain group of individuals to learn more about the current research topic. By using purposive sampling, the focus was on individuals who represent professionals who know and understand the current dilemma of juvenile delinquency and trauma.

In this research, I reached out to different agencies and organizations via email who hire master's level and above professionals who are licensed and nonlicensed. This was the most convenient and appropriate method to ensure that participants met the criteria for this study. This also warranted the voluntary nature of the study. After identifying participating agencies, the next step was to learn about the agency through the strategies mentioned earlier. As a researcher, I verified their credentials through the agency supervisor. After the information was verified and validated, participants were given the questionnaires before recording the interviews.

Creswell and Poth (2018) stated that a participant sample size of five is sufficient, but I used 20 participants. This research required a minimum of 15 participants and maximum of 25 participants to ensure that there was an accurate representation of the population, and that enough information was gathered to define common themes of professionals working within the field. The goal was to gather quality data, that was not specifically focused on the number of participants (see Hennick et al., 2017). It was not guaranteed saturation would occur within this study; however, saturation was important

because it shows that the study can be replicated and that accurate information has been gathered (see O'Reilly & Parker, 2012). Saturation also shows that no new information has been found within the research. The purpose of reaching saturation is for a researcher to find repeating patterns until no new information is found and the research can be discussed in generalized terms (Hennick et al., 2017; Saunders et al., 2018). This implied that the more participants within the study, the more the research data can aid in finding the common themes and understanding the data (see Creswell & Poth, 2018).

As stated above, I reached out to agencies to recruit participants. For them to contact me if interested in the research, the participants responded via email. When reaching out to the agencies, they were given the specific criteria for the participants, and their emailed responses included their qualifications to participate within the research. This assisted me with screening potential participants to ensure they met the participant criteria. The purpose of this step was to save time. It was more efficient to screen participants before beginning the interview process, to mitigate gathering data from unqualified participants. The goal was to obtain qualified participants for the study that can provide the best results as possible.

Instrumentation

I provided demographic questionnaires and interview questions to the professionals for the purpose of data collection. Because this was a qualitative study, open-ended questions were required in gathering the information to allow for narrative and thorough responses. All the answers provided were used to answer the research question to assist with further understanding of trauma and its link to juvenile

delinquency. The development of the questionnaires came from the need to obtain background information from the subjects. Even though the participants may be similar in nature, the differences were noted and used to define themes within the research. This allowed the subjects to offer answers leisurely and describe their experiences based on the research topic. The demographic questionnaire and interview questions were developed by me, which ensured that the questions were aligned with the research question. Furthermore, a recording device was appropriate to determine that I was asking participants the same question the same way to reduce researcher bias and error. Since all instruments used in this were developed by me, it was important to take measures to maintain sufficiency. The recording device was also used to ensure the data collection process aims to reach saturation and research validity.

Procedures for Recruitment, Participation, and Data Collection

In planning, the research data was only going to be collected from mental health professionals who work within the field of behavioral health rehabilitative services (BHRS). However, upon recruitment it was difficult to get willing participants and I expanded my data collection to those professionals who had current experience working with the target population. I collected the data in the form of a demographic questionnaire and recorded interviews by reaching out to local agencies who potentially had candidates that would qualify to participate in the study. The eligible research participants were given a demographic questionnaire and they were interviewed individually from a list of pre-typed questions. Interviewees were asked the same questions but depending on responses; I asked follow-up questions as a means to collect significant data. The

interviews included audio recording, which aided in the data interpretation process. This aided in gaining a full understanding of participant's perspectives. According to Saunders et al. (2018), it is essential to collect data until no new codes or emergent themes are found. At this point is when the researcher can state that saturation was obtained.

All participants were debriefed before any data collection. The debriefing information was provided in letter form. When necessary, I discussed the debriefing letter after the participant had read it for further clarification. The purpose of the debriefing letter was to explain to the participants the purpose of the study, the concern for the research, contact information for any further questions, comments, or concerns, and to withdraw from the study before, during, or after the interview process. At the conclusion of the data collection process, I debriefed participants on how the information was used and how it impacted the research. No follow-up interviews were needed for this study.

Data Analysis Plan

The data analysis plan for this study connected the data collected to the research question to bridge the gap between trauma and juvenile delinquency. The questionnaire explored mental health professionals' experiences that work with juveniles and at-risk youth who have experienced trauma. I used NVivo software to assist with decoding the information obtained during the research. I chose to use NVivo software because decoding qualitative research can be time consuming, and this systematic approach assisted with data management (Zamawe, 2015). Hand-coding was also a decoding process used to find repetitious words and phrases, as well as common themes to understand more about the relationship between trauma and juvenile delinquency. I

included all the data from the questionnaires and interviews. I separated the information into themes and categories based on participant responses. The data was also entered in NVivo and analyzed for themes and patterns. All gathered information was used for data analysis as a precautionary method to avoid researcher bias and to ensure all participant responses were used to support the deeper understanding of the research phenomenon.

Issues of Trustworthiness

Credibility

Participants provided their credentials and status as a mental health professional to show credibility. This provided their background and their experience within the mental health field. Furthermore, participants volunteered their time to provide open and honest information from the questionnaires and during the interviews. Prolonged engagement ensured credibility as my purpose was to build trust with participants and gather rich data (see Korstjens & Moser, 2018). To demonstrate this approach, the interviews consisted of open-ended questions, and follow-up questions were asked for clarification and to encourage in-depth responses. My goal for this research was to demonstrate credibility by building positive rapport with participants. I gave the participants the nature of my role as a researcher and informed them of their rights as participants.

Transferability

Thick description was the most appropriate strategy to use for this study because it assists with learning more about trauma and juvenile delinquency through the eyes of the participants since they have experience working with juveniles and/or at-risk youth.

The purpose of thick description is to give depth to context by providing feelings, actions, and meanings (Korstjens & Moser, 2018). Participants provided perceptions and assumptions about childhood trauma as it related to juvenile delinquency. Through the details and thorough explanations from the participants, I was able to gain a deeper meaning and better understanding of this phenomenon. Even though there was research on juvenile delinquency and trauma, my research aimed to shed light on the connection, which demonstrated the need for profound description from those individuals who have experience in the field.

Dependability

Triangulation was one method used to reach the quality of the data. According to Creswell and Poth (2018), triangulation is used to bring a better understanding to the research by using multiple sources of data. I used questionnaires, interviews, and secondary resources to validate the information used in this study. To avoid misrepresentation, I used all the data gathered to ensure dependability. All gathered information from this research was documented to allow any outside researcher to critique the material (Moon et al., 2016). The purpose was to establish consistency throughout this research study. I used all collected data to maintain consistency in the outcomes and to show if there were any inconsistencies within the research.

Confirmability

I kept a journal documenting the steps taken during the research, as well as my personal opinions to avoid researcher bias and any other ethical concerns. The main objective in keeping a journal was for me to be cognizant of personal opinions and

feelings in the various aspects of the research, including data collection and data analysis. The journal also assisted with research dependability because it mitigated my potential biases and left room for an audit trail. Keeping notes assisted with verifying participant findings versus my findings. The purpose of confirmability was to confirm that the conclusions have been shaped through the analysis of data retrieved from the participants (Korstjens & Moser, 2018). This research study relied on the information from the participants to provide the understanding to the research phenomenon.

Intra- and Intercoder

Since this was a small research study, I was the only one collecting data and using software to interpret the data. It was not necessary to add another data collector or interpreter due to the nature of the study. One drawback to this was the potential personal bias due to providing the interpretation of the data, which could have possibly led to me overlooking data and/or themes. To avoid this error, I coded and recoded the data to review any missed data and consulted with a mentor to mitigate researcher bias.

Ethical Procedures

I reached out to agencies in the area to determine their interest and willingness to have their employees participate to gain the access of potential participants. The agency's administrator was debriefed on the study, and I asked for eligible participants for the study. The participants were given informed consent before participating in the research study. Since I work within a professional realm related to the purpose of the research, participants were made aware that they may have prior knowledge of the researcher.

Participants were made aware that the research was conducted separate from the researchers' current work-related role.

Furthermore, the research participants comprised of individuals over the age of 18. The consent form for this population explained how the researcher learned about prospective participants. The consent form also discussed possible risk, if necessary, and provided a resource list if the risks have the potential to trigger distress for the participants. No other special considerations were needed because a vulnerable population was not studied, and the research was not conducted in an educational setting, or the researchers place of employment. I did not offer gifts for participation and ensured participants were aware that the study was voluntary and explained their rights as a research participant.

If participants withdrew or had to unexpectedly leave the research study, I explained that all collected data was confidential and was used for the data interpretation process. Because the research was based on participant opinion, it was necessary for me to use all data to increase the validity of the study. If a participant refused to have their data included in the research, I made a note that all information was not able to be used for data interpretation. Participants also had the option to obtain copies of the information they provided. The data was treated confidentially. No names or personal identifiers were used when interpreting the data. It was not difficult to maintain confidentiality since the purpose of the research was to identify patterns and themes within the research. I was the only person to have direct access to the participant information and did not share the data with anyone. All paper data, and recorded information was concealed in a lock box for

safety. Any data stored on the computer was coded with the NVivo software, and the computer was password protected. Data will be stored for five years after the completion of the research study.

Summary

Chapter 3 discussed the research criteria for the current study. The focus of this qualitative study was the phenomenological approach to discuss and gain a better understanding of the relationship between trauma and juvenile delinquency. Throughout this chapter, I explained my role as the researcher and how my role had an impact on the study, including my relationship with participants and possible research bias and other related ethical concerns. The method's section of this chapter identified the study subjects, sampling strategies, and data collection. Further, ethical concerns were addressed as well as the strategies to mitigate the concerns. I provided the methodology for the current research, which discussed participant selection, the most appropriate method for participant selection, and how to ensure the voluntary participation for individuals who participate in the study. Last, I discussed the issues of trustworthiness and the methods that were appropriate to mitigate ethical dilemmas. Next, Chapter 4 will explain the actual research conducted.

Chapter 4: Results

The purpose of this qualitative study was to gain a better understanding of the relationship between juvenile delinquency and childhood trauma. The phenomenon was explored through conversations with professionals who work with this population. Through the interview process, I was given a new perspective on the professionals' experience and how they view their work with traumatized youth and/or juvenile delinquents. The research questions for my research were

–RQ1: What are the lived experiences of administrators and mental health professionals who work with traumatized juveniles and adolescents?

RQ2: What are the common attitudes, perceptions, and opinions determined by those professionals who work with traumatized juveniles and adolescents?

I relied on the use of a demographic questionnaire to ensure that participants met the criteria to participate in the study and gathered specific background information about them in relation to their professional work. The demographic questionnaire was competed by participants when they were given the letter of consent. I also relied on a one-on-one interview to gather data for the research study to reflect upon the two research questions. The interview questions are in Appendix B.

The purpose of this chapter is to explain the entirety of the research study. First the setting will be explained, followed by the demographics of the research and participants. The next sections will explain the data collection process and the data analysis. Next, evidence of trustworthiness will be discussed, which includes credibility,

transferability, dependability, and confirmability. This leads into the results section before providing the summary of the chapter.

Setting

Several factors played a role in the setting of this research. I originally planned to interview participants in-person, but due to COVID-19, I relied on voice-recorded phone interviews. COVID-19 may have also impacted participant recruitment because some of the agencies that participated had limited personnel or those eligible participants were too busy with work. This contributed to the difficulty of obtaining agency approval and recruiting participants after an agency gave formal approval. This resorted to a change in participant recruitment. I added a recruitment flyer, which allowed easier access to eligible participants, and in turn, increased the number of participants used in the data collection process.

The subjects who participated in the study all have experience working with at-risk youth, including traumatized youth, adjudicated youth, and juvenile delinquents; however, the target population of BHRS (now known as Intensive Behavioral Health Services) employees as described in Chapter 3 was not attainable because the agencies declined to participate, or once approval was attained eligible candidates declined to participate. Regarding recruitment, I also had to search outside of York County due to local agencies not being willing to participate. On the other hand, all the individuals who participated in the study were in Pennsylvania, and all participants had experience with traumatized youth and/or juvenile delinquents. The participants also worked within a capacity that directly involves the professional working with the population. The study

itself discussed the trauma of the clients they have or had, which could have led to vicarious trauma due to the participants being asked to recall traumatic experiences that their clients have been through.

Demographics

All the participants in this study were at least 18 years of age or older, had at least a master's degree, and had experience with traumatized youth and/or juvenile delinquents. The study consisted of 20 participants. Three participants were male and 17 were female. Of the participants, five had 1-5 years' experience; three had 5-10 years' experience, and 12 had over 10 years' experience. One participant noted that he had been in the field since 1976, and another participant shared that she had been in the field for 35 years. One participant discussed that she was getting ready to retire. In reference to degrees the subjects earned, 17 participants held a master's degree and of those participants, 10 were licensed and seven were nonlicensed. The remaining three participants were postmaster's: one held a PhD, one was in the dissertation phase of her Ph D, and one had a certificate in a specialty area. Three of the participants disclosed that they had minimal experience with juvenile delinquents due to the area they worked in and had more experience with traumatized youth. The participants ranged in their different roles with the children but worked with the children in efforts to assist them with healthy functioning in society. The different roles identified on the demographic questionnaire or expressed during the interview were educators in a therapeutic setting, therapists, an adoption worker, and an evaluator. The types of degrees also varied among participants and included art therapy, psychology, criminology, counseling, social work, history,

curriculum and instruction, school counseling, education, administration of criminal justice, mental health counseling, and special education. Please see the table below for more demographic information about the participants.

Table 1

Participant Demographics

Gender	3 male	17 female		
Degree Type	5 psych	10 psych-related	5 non-psych related	
Highest Degree	10 masters - licensed	7 masters non-licensed	3 post-masters	
Organization Experience	5 (1-5 years)	3 (5-10 years)	12 (10+years)	
Specialty Training Frequency*	7 yearly	5 quarterly	4 monthly	2 weekly
Supervision**	13 yes	7 no		

*- one participant did not specify how often specialty training was given

**- supervision was dependent upon various factors including degree type, job title, and licensure status

Data Collection

The recruitment process for this research study was to send out agency approval letters. Once an agency approved to participate, they would send email addresses for eligible participants. After that, step was completed, I sent the eligible participant the letter of consent and demographic questionnaire. Once consent was obtained the interview was scheduled. Few participants were obtained using this method, which led to the creation and approval of a recruitment flyer. This process was similar, as the recruitment flyer was sent to an agency, and the appointed person sent the flyer out to

potential eligible participants. Eligible participants then reached out to me via email (email included on the recruitment flyer) and then I responded by sending the letter of consent and demographic questionnaire. Each demographic questionnaire was saved in a folder. Interviews were scheduled with each participant.

At the beginning of each interview, I introduced myself, explained that the interview was 18 questions, asked each participant if they had any questions, and then let them know when I started recording. Each interview was conducted over the phone and was recorded with a digital voice recorder. Each participant only completed one interview with no follow-up questions after the interview. The interview had 18 questions and I allotted time for participants to share anything extra after the completion of the questions. The length of the interviews varied with each participant. The shortest interview lasted 7 minutes, and the longest interview lasted 48 minutes.

After the interviews were completed, I transcribed them with Free Transcriptions. The interviews were uploaded and transcribed through the website, then the original transcriptions were saved as a Microsoft Word document. I edited the transcriptions in a separate Word document. I listened to the recordings' several times to increase accuracy and match the transcript to the original audio. After all the interviews were transcribed, I moved onto coding the data.

Data Analysis

After the transcriptions were completed, they were hand-coded in Word and I used different colors to distinguish the codes that I found. I based the codes on the interview questions. I highlighted passages that fit the general codes and then created a

separate document and narrowed those codes down into words or phrases. The information yielded over 100 words or phrases associated with the information gathered during the interviews. I used the hand-coding method to become more familiar with the data presented in the interviews before using the NVivo software.

After taking a break from the data, I uploaded the transcriptions into NVivo and used the software to create new codes from the data. First, I created one code and reviewed each of the 20 interviews for references to that specific code. After I did it that way, I changed my method and went through one interview at a time, line-by-line, and created themes based on the information presented. When I went through all 20 interviews, I went through each code (28) and either added new codes or created new codes under an already existing code (e.g., barriers to treatment: client barriers to treatment, COVID barriers to treatment, lack of resources, parental barriers to treatment, and professional barriers to treatment). I ended up with a total of 52 codes.

Some of the codes that appeared in the data included professional competence, field experience, trauma-informed care (TIC), barriers to treatment, negative behaviors, client success, positive coping, self-awareness, parental involvement, caregiver struggles, trauma, vicarious trauma, and therapeutic approach. The codes that appeared served to capture as many characteristics associated with working with at-risk youth as possible. Examining the data from that angle, I could gain a better understanding of how professionals experience working with this population. The biggest theme regarding professionals working with traumatized youth and delinquents are that they want to support the population they serve regardless of the barriers they face. For example, when

discussing COVID-19, many participants shared there was an increase in no-shows and canceled sessions, some clients were reluctant to open up, and telehealth, in general, was not as effective as in-person sessions. Even though professionals are faced with many barriers to treatment, they have learned to find their own support to be effective with the clients they serve. Their experiences are that they need to be self-aware and understand that working with traumatized youth and delinquents will come with reluctance from clients, and they will experience vicarious trauma or negative feelings from hearing client stories, but they still persevere because the children need safety, stability, and support in their lives to carry out normal daily functions. Conversely, the professionals do recognize they have limits because they are human and there are things out of their control. All things considered, they still do the best they can to cause a change in the lives of traumatized youth and juvenile delinquents.

After reviewing the codes, six main themes emerged. The themes are discussed in the results' section but are listed in the table below.

Table 2

Emerging Themes

Research Question 1 - Qualitative: What are the lived experiences of administrators and mental health professionals who work with traumatized juveniles and adolescents?
Theme 1: Some professional caseloads consist of clients who have all lived through a traumatic experience.
Theme 2: Vicarious trauma and/or negative thoughts/feelings are common among individuals who work with at-risk youth.
Theme 3: Professionals must adapt to potential barriers that stem from working with at-risk youth.
Research Question 2 – Qualitative: What are the common attitudes, perceptions, and opinions determined by those professionals who work with traumatized juveniles and adolescents?
Theme 4: Professionals are focused on how they can be an effective support for the clients they serve. Subtheme 4a: Building rapport with the client is important to professionals. Subtheme 4b: Professionals are interested in any training that will help them be more effective with the clients. Subtheme 4c: Professionals must be self-aware and practice self-care to be an effective support for the children they serve.
Theme 5: Professionals find it necessary for parents/caregivers and other supports to be involved to create success for the child.
Theme 6: COVID-19 has impacted treatment for traumatized youth and juvenile delinquents, and it may have been a traumatic experience for this population.

Evidence of Trustworthiness

Credibility

In reference to credibility, participants completed a demographic questionnaire describing the population they worked with (ages, location, types of services provided, etc.), and they also confirmed their eligibility to participate in the study. The demographic questionnaire also addressed the geographic location (urban, suburban, or rural) of the population served. The first few questions of the phone interview also verified participant eligibility and professional experience by participants sharing if they work with traumatized youth and/or juvenile delinquents. Each participant shared they had experience with traumatized youth and/or juvenile delinquents. Many of the participants stated their experience with the population they served and their specific titles/roles in the organization they worked for. Another measure of credibility was that agencies only provided information for candidates who met the inclusion criteria to participate in the study.

Transferability

Transferability was demonstrated while conducting the interviews as participants shared stories about their experiences with the population and discussed how they interact with this population. Through the interview, participants connected how the trauma impacted various aspects of the child's life, including their behaviors and/or involvement within the juvenile justice system. Participants recalled different aspects of their job with this population and how the experience on the job demonstrates the link between childhood trauma and juvenile delinquency. Participants explained how traumatic events

this population went through are reflected through their behaviors and by their mental health diagnoses.

Dependability

The method used to ensure dependability was triangulation because I used multiple sources to reach quality data. The demographic questionnaire disclosed background information of the participants and the population they serve. The interviews could serve as another source for participants to discuss their experiences, thoughts, and perceptions about working with traumatized youth and/or delinquents. The interviews brought out many of the topics discussed in the literature review section. The first major topic was childhood trauma, which was one of the main criteria for professionals to be eligible to participate in the study. This demonstrated that trauma is still prevalent in society, and many of the adverse childhood experiences are what participants notice in the population they serve. COVID-19 was not mentioned as traumatic experience for at-risk youth in the literature review, but a few participants mentioned that they foresee it having a lasting impact on children due to the loss and isolation some of the children have experienced during this time.

Confirmability

I used a journal during my data collection process, but not as often as I expected. I used the journal to document my thoughts and feelings before, during or after the interview. I used the journal more during the data analysis to ensure that my personal thoughts did not influence the way I interpreted the data. For example, I recognized when I thought I was very familiar with the interviews, so I changed the way I looked for the

codes, and I also took time away from the data to reduce misinterpreting it. I also consulted with my committee chair before making final decisions about the conclusion of my research.

Results

The results of the data analysis included the six themes that were outlined in the table above. This section expounded on the professionals' perspectives regarding the themes that emerged.

Theme 1

The purpose of the research was to get a better understanding of professionals who have experience working with at-risk youth. Some of the professionals disclosed that most of their caseloads consisted of children who had direct and indirect experience with traumatization. Fifteen participants mentioned that the "majority" or "all" of their clients have been traumatized.

> I would say that the majority of them have been through more than one trauma. Uh, physical abuse, sexual abuse, neglect, um domestic violence, and community violence. Um, including gun violence, gang violence, um, and their primary trauma would have been from the, from experiencing the events directly and then also from things like being removed from their family, put in foster care, put in group homes. (P#10)

Professionals that reported percentages stated that "10%," "20%," "at least 50-75%," "95%," or "100%" of their clients have experienced trauma. One participant shared,

> I work with over 100 kids. So, um, I would say the majority of them have been through trauma. They've either been through some sort of abuse, . . . parent dying, . . . parents being in jail, domestic abuse. Um, to be honest if you said the trauma I would, I have probably dealt with it as far as kids and older kids, high school kid's traumas. People that have seen their friends killed. People that have killed. Um, people that have seen their parents killed. People that have seen their siblings killed. (P#14)

Overall, the participants in this study currently work with children or adolescents who have been traumatized. Furthermore, the majority of the participants shared they the majority of their clients have been through at least one type of trauma.

Other traumas that professionals said their clients experienced included parental substance abuse, loss (including death or out-of- home-placement), lack of appropriate parenting, divorce or parent separation, abandonment, and different forms of abuse. One of the participants has noticed that "a lot of the traumas came from that like generational trauma by like racism, and then I guess just a lot of like family trauma, inner family trauma." Other participants have noticed an increase in children that have been sexually abused. "Recently, we've been seeing a lot more cases with um, the child presenting with a history of sexual, like being the recipient of sexual abuse or being sexually hurt in some way." Another participant said, "I've observed somewhat of a trend that many of my clients, especially my female clients, seem to get the brunt of the sexual abuse, when there's a parent that suffers from addiction." Professionals have noticed different types of

trauma from the population they serve and that the trauma did not start with the youth they are currently serving.

When it comes to trauma, a participant expressed,

> I think. . . so many things that could fall under a trauma. So, something, traumatic to me might not be traumatic to someone else. So, I think it's really about how the person, you know, deals with it and processes it." This assists professionals in how they approach trauma with this population. A professional mentioned that she treated the "individuals as individuals" and "not putting their diagnoses, you know, before the person and um, acknowledging that, you know, obviously first, they're a person. Trauma is not who they are. It's something, you know, that has happened to them. It's not who they are or what they're about. (P#7)

Participants deal with so much trauma in the population they serve and have experienced many of the common traumas, but in different capacities. However, working with traumatized youth in this capacity could have a lasting impression on professionals, and some of them were open to sharing their lived experiences.

Theme 2

The second theme was that vicarious trauma and/or negative thoughts are common amongst those who work with at-risk youth. Some professionals believed that vicarious trauma is expected in this field by stating things like, "I think that you can't do this kind of work and not experience vicarious trauma," "I think you know; vicarious trauma is something that kind of comes along with the job," "You can't help but not be touched by a lot of what these; the population has been through when you're dealing with

PTSD," and "I guess it's kind of inevitable with our field." Which led to professionals sharing their experiences of being triggered or experiences of vicarious trauma while working with this population. One person said,

> Oh, I've definitely received vicarious traumatization's. When you have kids telling you horrible, horrible, horrible things every day, multiple times a day, it's hard not to be vicariously traumatized. I know I try my hardest not to visualize things and try to block things. . . But sometimes they slip through the fences and yes; I've had nightmares. And I will tell you now, to this day that when I hear kids shouting, I get triggered and that sense of uh-oh crisis situation. You know, I; I sort of get a heightened sense of um anxiety. (P#16)

Another participant explained vicarious trauma this way:

> I like to think of it like, my gas, my emotional gas tank because I think that obviously when I hear things that are traumatic, I'm kind of expecting that. But also, I'm not necessarily experiencing them first-hand. . .. But I think that I really notice at the end of the day, the week, the month is that my emotional gas tank just keeps kinda like trickling down. (P#15)

Professionals seemed to experience vicarious trauma in different ways and for different reasons, but they all seemed to share how vicarious trauma was unique to the profession.

Sometimes the vicarious trauma or heightened emotions stemmed from "similarities in our backgrounds," and recognizing that "some cases are tougher than others. And, you know, sometimes it may be hard to take that home with you." One participant shared that she had similar experiences to the clients disclosing that

> I would say yes. I've had trauma. Um, you know, parents separating at a young age. Um, different types of abuse through relationships. Um, I made some poor choices when I was a teenager as far as, um, substance use and the peer group that I hung out with. (P#20).

Professionals who share similar backgrounds with their clients seemed to be more at-risk to experience vicarious trauma because maybe some of the stories were triggers or negative reminders for them.

Years of experience was also mentioned as a reason some of the participants experienced vicarious trauma. “Yes, I think as a new clinician, it’s definitely, um, hard to hear these stories,” and “I’ll get used to hearing it, you know, further in my career. I think if it was 10 years down the line it wouldn’t be as traumatic, but I think starting out, yeah; it's definitely taking a toll.” Another participant described,

> In terms of working with this population over time, sometimes when I like first kind of started out in the job years ago, um, it was; I was a little bit more sensitive to the issues. Nowadays, it doesn't affect me as much, but I would say that, um, sometimes there’s still stories that I hear that it, it’s hard to stop thinking about them… it can kind of cast a little bit of like a black shadow. Like uh, this is so sad, you know, seeing all these horrible stories. (P#10)

Another person shared, “I would say yes, um how it’s affected me, I would say, um, it’s made me a little bit more jaded to everybody's, uh, situation.” The consensus seemed to be that working with traumatized youth and/or juvenile delinquents can have an impact on professionals mentally, physically, and emotionally, but the professionals recognized

that it comes with the nature of the work. Vicarious trauma and personal triggers are not the only barriers that professionals face, but they still choose to work with and support their clients.

Theme 3

There are many barriers that professionals face when dealing with at-risk youth. Theme 3 reflected the need for professionals to adapt to potential barriers. One barrier is push back from the individuals themselves. “There’s so much resistance especially from people with trauma and trusting.” Other resistance is from “personality disorders . . . some students that I’ve seen that don’t want help or are in complete denial that they need any help.” Another way to view it is “sometimes they can run away . . . if they’re really, really traumatized. . . They don't want to get in touch with the feelings. They just . . . avoid it at all costs. Uh, and so, they’ll just go.” The way the client views his or her trauma adds to the barriers to treatment because participants noted that the children just want to “feel normal” so, “it's really common for people to play off the trauma as somebody else probably have it worse” or “they think that it doesn't impact them as much as they think it does.” The child’s perception of his or her trauma is important to understand because it can be one extreme or the other. “I think it has to go back to that whole idea of this worldview, this creation worldview in which they have no control. They are the victim. They can do nothing to to improve their situation.” “Then you have the clients that, you know, exaggerate. And sometimes, um, make situations that actually didn't occur and lie about it.” Another participant noted that traumatized youth struggle with accepting treatment

> because when we're children, we are taught that the world is a safe place. And when a trauma hits us over the head we learn at a very young age that the world is not a safe place. And what we thought was safe is dangerous. The world we thought was safe is dangerous. And so, we’re very confused. And when you're confused about people and such and what has happened to you, you tend to isolate and tend to believe that you're either damaged or not normal. I get that a lot, I’m not normal. (P#17)

Overall, client perceptions of their trauma have to be taken into account because “I really think everybody’s experience is subjective,” so client barriers will be presented differently, and professionals have to adapt.

Another common barrier to treatment is lack of parental involvement in the client’s treatment. One of the biggest barriers with parents and/or caregivers has been mentioned already, but it’s that they are a contributing factor to the child’s trauma. But for those who are physically present in the lives of the traumatized youth, one participant said, “I believe that their parents or caregivers often get frustrated, and they have a tendency to path pathologize the child like, oh my God, you're um, very abnormal. This anxiety or depression or trauma you’ve experienced is just weird.” A professional noted that

> A lot of their families make sure to keep everything, you know, in house, and not put their business out there. So, they have a lot of fear of being rejected or shunned from their family. Um, even if that family isn’t healthy environment. (P#20)

Furthermore, “sometimes there’s like a lot of resistance to providers coming into the home. Sometimes the clients have been coached to by family members or other people to not talk about certain situations and sometimes that’s a barrier.” Parents have internal struggles that create a barrier to treatment because “sometimes they kind of get in their own way and the way of the kids healing because of their own, um like, generational trauma that they’ve experienced themselves too.” Other perspectives included, “the lack of skills that some parents have. Or even just ways that they've been taught to parent that are just not ok,” and

> parents can be a huge barrier because they lack understanding. . . or they may have some trauma themselves that they’re dealing with or have not dealt with. They don’t really know how to help their child or they themselves are in denial. (P#7)

Even though this study focused on traumatized youth, the literature review included research about the long-term effects of childhood trauma. Based on the interviews, it appeared that some of the parents and caregivers experienced trauma themselves. One participant did share her experience with traumatized adults who experienced childhood trauma. She shared that she was facilitating a group on self-care with adults,

> and we had putty, like you know silly putty that you play with when you’re little. And, she had a trigger. She had a flashback because her childhood made her remember that she was molested when there was silly putty and she was playing with it as a child. (P#17)

Other details she shared that demonstrated adulthood struggle with childhood trauma was,

> You have people that move job by job by job, and they can't handle a job because of their trauma, they've not learned to get through. Um, you have people who go through divorces. They're marriage after marriage after marriage, they have had a trauma, or traumas they haven't wanted or bothered to or are too embarrassed to get help. (P#17)

This reveals a possibility of why caregiver's struggle with supporting their child who has experienced trauma.

Other barriers that were discussed during interviews were the lack of resources that families had. One was lack of transportation because "you have to rely on the parents to bring the children to therapy and they aren't always the most reliable." Participants brought up attendance regarding cancellations and no shows. One participant shared that insurance also presented a barrier at times for clients. The lack of resources was also noticed during the peak of COVID-19. When everything was shut down, professionals had to rely on telehealth which was not always conducive to treatment. "It's been harder to maintain, um, a full case load size, uh, just because of the higher rate of no-shows and cancellations." Telehealth made it harder to engage clients in treatment. A few participants explained, regarding COVID-19, that telehealth created "challenges of engaging kids online and coming up with creative ways to do that" as well as, "not being able to reach as many students because of the virtual stuff" and not "having that private space where they can actively and openly talk to me. And so, privacy was really hard."

COVID-19 contributed to increased caseloads, and one participant said, “last year, my workload quadrupled. This year my workload is triple. . . We are short-staffed” and “it affects what we can do with the kids because there's so much paperwork that has to be done.” One other barrier created due to COVID-19 was

> I think with some of my clients during covid, you know; they were working on their traumas or their mental health, and then there was this big shift to dealing now with this situation. So, we had to focus on, you know, how they were getting through dealing with covid and putting other things on the back burner because we had to deal with the present situation. (P#18)

COVID-19 seemed to take a toll on the mental health profession, but professionals had to adjust and provide the necessary support their clients needed in the moment.

Theme 4

The fourth theme I found was that professionals are focused on how they can be an effective support for the clients they serve. Working with traumatized youth and/or juvenile delinquents can be a “daunting task” and requires special attention from the professionals in this field.

> I feel like being in the field, for as long as I have, it’s more so for me it’s just more, um, direct now where I just feel like I'm better at helping them now where if you're not as experienced, you might feel like helpless in terms of being able to help people. (P#10)

In this field, professionals have recognized that it takes a certain skill to be a healthy support for the population they serve. The professionals who work with traumatized

youth, and juvenile delinquents have come to understand that this population requires more than training, “So, I don’t think that trainings can actually make somebody be like that, you know what I mean? Sometimes I think it’s more of just are you naturally the type of person that can help somebody improve themselves.” Even with the training they receive when they come into this field, they still feel they need continuing education and professional experience in different areas to be an effective support for the children. “Um, it’s just; it's a growth; it's a growth pattern or it’s development. Growth and development in your own job and personally too.” The participants in this study recognized that professionals in this field need a healthy balance of training, experience, and passion to be effective at what they do.

Subtheme 4a: Building rapport with the client is important to professionals.

This emerged as the professionals shared how they focused on how they can be an effective support for the clients they serve. The evidence emerged as many of the participants discussed how they work toward gaining client trust, building rapport, and building relationship with the client regardless of their position or the clients placement type. One participant explained it this way,

> I have a great deal of sensitivity and compassion for what they've been through and what their history might be like. So, I never assume anything and always very sensitive to their situation. . . I just kind of try to build rapport and connections, and relationships with them, so that they feel comfortable and trust me in order to um, feel like I’m somebody that they can talk to or open up to. I guess when I'm working with them I just try to get to know them as much as I can so that I can

> figure out what the best, um, source of support and treatment would be for them. (P#10)

The literature mentioned that having support is positive for at-risk youth because it promotes healthy development. Participants noted that the children have had some “horrible” experiences and since they don’t have healthy supports

> a lot of them don’t even realize or believe that what they went through is trauma. That’s just how they were raised and that’s how they’re used to doing things. A lot of them will, you know, say that it's not a big deal or say that doesn't bother them. (P#20)

The professionals know it is trauma and that they have to approach it in a healthy manner. A participant shared,

> I like to give the kids power over, who hears about their narrative, and I like to bring humor at appropriate times as a comforting agent. But also, I sense that I’m an adult who’s on their side, and at the same time want them to know that their words are safe with me. (P#16)

The participants in this study recognize the need to build rapport and a healthy connection with their clients to be an effective support in their lives.

Subtheme 4b: Professionals are interested in any training that will help them be more effective with the clients.

Alongside building rapport and connection with the clients they serve; professionals expressed the need for continuing education and trainings that enable healthy functioning for this population. When asked what trainings would be most

beneficial when working with traumatized youth and juvenile delinquents, one participant said, “Anything that deals with kids. Anything that deals with understanding their behaviors. Anything that deals with mental health issues. Um, anything that deals with trauma.” This demonstrates the importance of needing to understand more about the population of at-risk youth because before they become at-risk they are kids and then they are kids with specific needs. This also reveals that

> there’s so many trainings that we can do for trauma, but just being a general level therapist, it’s really hard to get a lot of trainings you need for so many different things that could happen or occur to someone. (P#1)

The participants shared that so many trainings can be beneficial in the work that they do because the youth they work with have individual and diverse needs regarding trauma.

The literature review discussed how trauma has a significant impact on the lives of juvenile delinquents. It appeared that professionals have found that trauma trainings or anything trauma-related would be beneficial when providing services to this population. Many participants were interested in more trauma trainings since many children across all settings experience trauma, “I think that trauma-focused cognitive behavioral therapy should be a requirement for all people.” Many of the participants mentioned specific trainings or techniques that included, “more training on EMDR,” “professional development for trauma-informed care and trauma-based therapy,” “specific trauma healing techniques,” and “PTSD training about the neurobiology of trauma.” One participant said, “I'd like to have opportunities to remain aware of new research about trauma and new ways to intervene.” The caveat professionals mentioned when dealing

with trauma in this specific population is that it can be a trigger for the children and cause more trauma, so a participant responded that he would like to know how "to better educate the kid without creating additional trauma." There are so many things that professionals want to learn when serving this population because they want to be as effective and efficient as possible.

Even though childhood trauma was a primary focus of this study, participants felt that any training that would benefit this population is necessary. Other trainings involved, "training on the LGBTQIA community," "court training," "a case management course," "grief and loss," "relaxation techniques for anxiety," "more training in the areas of play therapy, art therapy, and sand-tray therapy," "suicide prevention, identity crisis," and "motivational interviewing." It appeared that professionals are dealing with more than just trauma with the population they serve. Some professionals recognized the need to be competent in this field and be cognizant of their own limitations and how they can be better equipped to work with their clients.

Subtheme 4c: Professionals must be self-aware and practice self-care to be an effective support for the children they serve.

Professionals working in this field acknowledged the need for increased self-care while working with at-risk youth. Professionals mentioned taking time off work, exercise, having personal and professional supports, increasing self-awareness, and religion as means of taking care of their own needs to be available to work with the target population. One professional said,

> If you're feeling stressed out or, um, burned out, then it's important to take time to recenter. So, if it means taking a mental health day off work and um, you know, getting yourself feeling better then that's one thing you could do. (P#10)

A few recognized that pets are helpful, "I spend time with my dogs because they provide me a lot of comfort," and "hugging my pets. Um, I'm a big animal lover, so I think they radiate anti-anxiety." Along with support from pets, participants identified the need for support from family, friends, and/or coworkers. They spoke of "supervisions, and just being able to reach out and talk to other therapists." One participant emphasized "I am a huge, huge advocate for therapists engaging in their own therapy." While another highlighted that "I spend a lot of time, energy, and money on self-care: acupuncture, massages, Reiki, which is a form of Japanese energy healing." A different form of self-care for a participant was "just turn the television on when I can and not talk. Relax and daydream and go somewhere else in a mindless show." It appeared that it did not matter the type of self-care that participants engaged in, they all recognized the necessity of taking "care of yourself before you can be effective at your own job." Another participant shared, "you don't want to end up a wounded healer," which shows the importance of a professional being healthy in their role to accommodate the needs of the youth.

If professionals are not self-aware and do not create boundaries around the work they do, it can be a struggle for them and their client. One participant said that he has "to be careful of where my daily energy is, where my level of emotional vibration is" because

> if you go in and you're compromised; you're ill. . . any kind of thing that's going to drop your vibration. . .because you're just very open to it and you absorb all that negative energy. So, you have to be careful, maintaining yourself. Uh, so that you have that protection over you. (P#6)

Another participant knows, “when I have down time, there's plenty of time to think and that's not always good.” So, understanding and knowing personal limitations and creating boundaries is something appropriate for professionals to do. A participant shared that she has learned self-awareness and can manage herself but has witnessed coworker's struggle with self-preservation. She shared that some of the juveniles have “nothing better to do than to try to harass the staff and get a reaction out of them. And I've definitely seen, um; horrible situations come of staff not being able to control their own responses.” It is necessary for professionals to maintain themselves to be an effective support for the at-risk youth they serve. If professionals continue to practice professional competence to be an effective support for at-risk youth, they will keep in mind, “not to take home, you know, some of the pain um, can’t fix, can’t solve every problem out there. Can’t save everybody.” This profession is geared toward assisting youth with improving their quality of life, but it vital that professionals understand their limits because not all of their clients are ready for improvement and for some the intervention may come a little bit too late.

Theme 5

It was mentioned above that lack of parental/caregiver involvement is a barrier to treatment. Professionals have noticed that the support of the family is conducive to treatment for traumatized youth and juvenile delinquents, generating the fifth theme of

my study. A way to encourage parental involvement is “making sure that the family sees themselves in that way of supporting in the appropriate way” because “it really involves the whole family.” One professional does “multi-systemic therapy, which is a family family-oriented therapy.” A few participants shared that the mindset of the family influenced the child’s engagement in treatment.

> I did a lot of conversations and relationship-building with the family aside from when the child was there. Um, so I would have conversations with the family and then, you know, conversations with the child and then do family therapy. And I've definitely found it’s a lot easier to get the parent's buy-in because then, you know, it’s a united front for that kid. (P#20)

The support from parents, caregivers, and other natural supports is needed to increase the likelihood of success for the at-risk youth. The professionals are not able to do it all. The youth need the support from all who are willing.

Parental involvement was also noted as a needed support for the traumatized youth during and after the completion of a program. “My organization offers family advocacy, you know, the crisis nursery; Parents support group, parenting classes.” Another participant said, “We also make referrals. . . since we don't offer any parenting, um, therapy, but we still understand that it's important for the parent to also go through therapy if their child has been traumatized.” One program provides training to foster parents to help “them understand the behaviors there that are trauma-related and helping them, give them tools to work through the emotions and helping them de-escalate the kids and understanding what stages they’re in, so that they can work best with them.”

One agency has an "incredible years program, um, which is preventive" and it "teaches parents on appropriate parenting to kind of reduce, um, you know, traumatic behaviors." The goal for professionals regarding the family system is "being able to help the families be able to break those cycles" and to get "them to buy-in and to see the true intentions and that the program can actually support them and help them." Not only do professionals see the benefits their work can do for the child, but they also notice the benefit of the entire family to live and maintain the healthy family system.

Theme 6

It was mentioned above that COVID-19 was a barrier to treatment for at risk youth. Theme 6 was that COVID-19 impacted treatment for traumatized youth and juvenile delinquents and, for some, it may have been a traumatic experience. It has impacted this population in different ways regarding treatment. Some professionals saw some benefits of COVID-19 because when transportation was a barrier, it created a convenience and provided flexibility for some of the clients. COVID-19 increased relationship between professionals and their clients because "I see how they're living, and I've met their pets. And I see; I get a glimpse of their personal life and they see mine. And it helps in the um, therapy session to add that piece of personalization in your session." She also disclosed "with covid, a lot of work has been coming out of my home, and I have not been affected by it. So, I've been very very fortunate." Even though COVID-19 had some detrimental impacts on society, some professionals did have a few positive results from COVID-19.

Conversely, not all participants have had a positive outcome due to COVID-19. Some have found it to be a problem for the work they do. A few participants described their experience and feel that COVID-19 has made it difficult to be effective while providing treatment. Telehealth “is very impersonal and depending on the individual I’m working with, some of them just do not respond well to virtual. Some of ‘em, you know are much more engaged if it's in-person” Another participant shared,

> we’re back in-person, um, however, . . . I don’t think that wearing masks during therapy are real useful . . . you know, I think it’s real important to be able to read, like, you know, visual cues, social cues as you're working with somebody. It's nice for me to see like what is their like, uh, affect. It’s a lot harder to tell whenever they are, you know, have a mask on and I have a mask on. So, it’s also harder for them to see that I, that I’m conveying empathy. (P#7)

Participants noted that COVID-19 took away the therapeutic component of therapy and shared that it has been harder for them to be effective in the roles that they play in the lives of the youth they serve.

Participants also discussed the toll that COVID-19 appears to be taking on mental health. The most common discussion was that professionals are noticing longer waiting lists for clients since COVID-19 started. “Our waitlist has gotten really long regarding um, I think a lot more people are seeking therapy because um, there's a lot more emotional issues and abuse that has occurred during the pandemic.” According to participants, mental health needs are increasing.

> There's a lot of initial evaluations being referred to me for kids in middle school and high school for anxiety and depression. So, it's not even kids that are struggling with learning, it's just they don't even wanna come to school because they have so much anxiety that it's overwhelming to them. (P#

Another concern is that "I think that everyone was dealing with a lot of stressors because of the uncertainty of the situation." Additionally,

> I think that it has been very traumatic and very stressful for the entire world, for everyone to have been locked up for about two years and to have dealt with all of this disease and sadness and loss. So, that's one of the things I'm concerned about is what is the long-lasting impact, especially on children from this particular pandemic and event. (P#15)

Another participant agreed and advised that

> there's a lot that's going on now that I think society has to pay attention to because. . . ten years from now the mental health of these young people might really be hard to, uh, understand because of covid has shifted mental health in the past two years. I don't think we understand how much it's really traumatizing them. (P#17)

Experiences that were shared about the clients included clients experiencing loss while in placement and not being able to have physical contact with their families.

> I saw kids lose their parents while in placement. I had a female who lost her mom. I had a male who lost his mom, and, due to covid, were not able to leave, and they

> were not able to, you know, go to these ceremonies or be with the family during their losses. (P#20)

It also impacted academics and the social aspect of school for youth. For example, “You know that social aspect and caused a lot of a lot of kids to, you know be more introverted and not want to be around people.” The same participant shared, “I have a youth right now that he was an athlete. He played three sports. He got all A's. And now he’s failing all of his classes. He stopped playing any sports, and he is anti-social.” COVID-19 seemed to have a significant impact on professionals and their clients.

Summary

The themes that emerged from the research focused solely on the lived experiences and common attitudes of professionals. The personal interviews consisted of eighteen questions, which encapsulated much more from the professionals, and how they experience working with traumatized youth and juvenile delinquents. Each question focused on a specific aspect of the professional’s experience. Below is a summary of each of the eighteen questions.

1. Do you or have you worked with traumatized youth and juvenile delinquents? (Yes or no). Please describe the population you work with.

   All of the participants have experience with the population. Three participants shared that their experience with the juvenile delinquent population is minimal due to them serving the suburban and rural areas.

2. How many of your clients have been through at least one type of trauma (i.e. domestic violence, child abuse, incarcerated parent, gun violence, etc.)? Please explain their primary and secondary traumatic experiences.

   In the responses the participants argued that all of their clients have been though trauma. The participants with minimal contact with the delinquent population mentioned lower percentages, such as 10% and 20%. Another participant shared that 50-75% of her caseload had at least one traumatic experience. For the other participants, they mentioned that their clients had experienced at least one type of trauma, but as the discussions unraveled it appeared that many of the clients have experienced more than one type of trauma with the primary trauma being a form of child abuse from a caregiver and the secondary trauma being removed from the home. They also talked about the different traumatic experiences that youth face while in out-of-home placement. Other traumas that were discussed included loss due to sudden death, parent overdose, violence, and trauma associated with COVID-19, such as loss, increased mental health concerns, and lack of security/stability.

3. Describe/explain the types of trauma you have noticed in the population you work with?

   Participants shared that their clients have been through an array of traumatic experiences. The list includes domestic violence, divorce/parent separation, parental substance abuse, witnessing violence (community violence, gang violence, domestic violence, witnessing child abuse), child abuse, gang

involvement, sudden loss/death, COVID-19, abandonment, being in placement, sex trafficking, lack of parenting, medical trauma, generational trauma, and neglect.

4. What is your approach strategy in your initial session with a trauma victim (ex. Why are you here? Benefits of counseling experience? Explain your trauma.)?

   The initial sessions with clients were focused on assessment gathering, understanding the family dynamic, and building rapport or therapeutic alliance with the clients. Participants shared that many of the children have been through several types of treatment, so it was important that they took the time to get to know the child and tailor their therapeutic approach to the needs of the child.

5. Of those who have experienced trauma, in the population you serve; what are some of the trauma-related behaviors you have noticed? What are the common trauma-related behaviors?

   The trauma-related behaviors that were commonly noticed were related to PTSD symptoms and ADHD symptoms. The list of trauma-related behaviors included isolation/avoidance, lack of focus/impulsivity, self-harm, aggressive behaviors, emotion dysregulation, minimizing trauma/not acknowledging trauma/normalizing, substance abuse, negative worldview, the children tend to be people pleasers, difficulties in school, hypervigilance and hyperarousal, and the cycle of recidivism.

6. How does the population you work with minimize or enhance their traumatic experiences?

Regarding minimization, many of the professionals talked about children denying and refusing to acknowledge their traumatic experiences and saying that the way they lived is normal. Some participants shared that this made it harder for the youth to open up and work through their traumatic experiences. Those professionals who saw enhancement of traumatic experiences shared that the youth would overreact, exaggerate experiences, and/or blame others and have a negative worldview. It was also noted that sometimes the children would be struggling with acknowledging and understanding that their parents and/or caregivers' actions were not right or healthy.

7. What treatment techniques do you use when working with this population?

   This is another area where participants differed because they had different therapeutic approaches. Some professionals named specific techniques they used, such as CBT, DBT, TIC, art therapy, play therapy, Rogerian Therapy, and anger management techniques. Some professionals mentioned that they used whatever was most beneficial to the child, which meant combining different approaches to adapt to the child's individual need.

8. Have you heard of trauma-informed care (yes or no)? Do you currently practice using trauma-informed care/techniques (yes or no)? Please explain.

   All of the participants had heard of trauma-informed care. There was one participant who said he does not practice using trauma-informed care, and one participant said she was not sure if she uses trauma-informed care. There were also participants who were unaware of the specifics of TIC. Overall, the

participants were cognizant of the idea that they approach their clients if they have been through some type of traumatic experience.

9. What are the common barriers to treatment you face when providing these services to the clients you work with?

   The common barriers to treatment for professionals were lack of resources (transportation, and technology), parent/family/generational trauma, attendance, COVID-19, resistance to therapy, retraumatization/negative cycles, no supports, substance abuse, mental health, privacy, trust, the system, and concerns about professionals

10. Does your company/organization provide training on trauma-informed techniques?

    Many of the participants said that their organizations do provide the training or that they had access to that specific training.

11. Is there a specific technique that you would like more training on? (yes or no and please explain your response).

    The participants expressed their want for additional training. The common areas were anything that pertained to trauma, child development, grief and loss, and how to build connection with the clients. Other areas of continuing education included trainings on the LGBTQIA+ population, suicide prevention, crisis intervention, identity crisis, art therapy, and motivational interviewing. Those who did not mention specific trainings indicated that they would take any training offered because they enjoyed continuing their education.

12. On average, how long do your organization's treatment services last?

    There was a wide range of length of stay in treatment and they all depended on the type of program the child was in. Some services lasted for a few months all the way up to two years. Professionals who worked in a traditional outpatient therapy setting stated that services lasted indefinitely.

13. Explain what the success of an individual looks like to you.

    Professionals agreed that success was related to any forward progression of the client. This looked different for each professional, but they mentioned things like ability to be in class without crying, making positive choices, using coping skills, getting adopted, reintegrating with their families, finishing school, not entering into the juvenile justice system, and lower recidivism rates.

14. What training(s) do you think would be beneficial while providing treatment services to at-risk youth?

    Participants differed in their responses to this question, but many of the responses resorted back to trauma-informed approaches, how to be a better support for the clients, encouraging and assisting parents to be a support for the children, and how to deal with mental health.

15. Do you feel that your organization provides the appropriate services to make a change in the lives of traumatized youth and delinquents? (yes or no. Please explain either response.)

    Many of the participants felt that their agencies did have appropriate services and that their agencies were doing the best they could. A few mentioned that some of

the services needed to be improved, but thought that overall, their agencies were making a difference.

16. Do you feel that you have experienced vicarious trauma (yes or no. Please explain.) Have you been personally triggered by the population you have worked with (yes or no. Please explain.)?

    A common response to this question was that vicarious trauma is to be expected in this field. Each participant experienced vicarious trauma in a different way but noted that they come across different struggles at times. Common topics of struggle included instances that involved sudden death, trauma to very young children, or topics that the professional could personally relate to. Very few participants discussed that they were triggered by the population. One participant shared that he gets triggered by yelling or certain smells, another participant noted that she has witnessed co-workers being triggered by the population, and another participant mentioned that she get triggered when some of the kids she works with shows a sense of entitlement.

17. How do you manage and/or work through the vicarious trauma and/or personal triggers?

    Supervision was the most common way that the participants manage the stressors associated with working with this population. Self-care was also common among participants. This included different hobbies, exercise, religion, therapy, being with family/friends/pets, or learning self-awareness in order to create the necessary boundaries to continue working with the population.

18. How has your current work been affected due to COVID-19 (increased caseload, virtual sessions, limited training, etc.)?

    COVID-19 has had a significant impact on treatment. Many professionals had an appreciation for telehealth because it allowed services to continue and minimized some of the barriers; conversely, telehealth did create other barriers, such as people not logging on or, more importantly, telehealth limited confidentiality, privacy, and safety for some clients. Some professionals noticed an increase in sexual abuse during COVID-19 and an increase in mental health struggles, which made waitlists for treatment services longer. Other concerns that arose from COVID-19 for professionals included quarantines, decrease in staff support, increase in caseload, and increase in paperwork. Even though there were drawbacks to COVID, some participants shared they have not been personally or professionally affected due to COVID because they maintained their health and were able to continue to provide treatment for their clients, even if it was through Zoom or over the phone.

Chapter 4 discussed the process of data collection and how the data was then analyzed. Codes were identified, and then themes emerged to give explanation to the two research questions created to make meaning of professionals working with traumatized youth and juvenile delinquents. After providing the results of the research study, I summarized each interview question. In Chapter 5, I will provide the interpretation of my findings and provide insight on what other researchers should explore based on the findings of this study.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to gain a better understanding of the professionals' experience of working with traumatized youth and/or juvenile delinquents. This was the focus because juvenile delinquency is prevalent in society, and the goal was to learn how professionals in the field experience their work with this population. The research questions were geared toward understanding professionals' lived experiences as well as their personal opinions and attitudes towards working with this specific population. Using a demographic questionnaire and personal interview, I was able to learn their perspective and work toward understanding their perspective from the emergent themes found while analyzing the data.

After analyzing the data, it appears professionals are doing their best to be an effective support for the clients they serve. Professionals explained the need for more training, especially on the topic of trauma. Increasing the amount of training could promote more effectiveness and efficiency from professionals to assist traumatized youth and juvenile delinquents. Professionals also shared the need for children to have healthy supports, which includes parents and caregivers, as well as healthy professional supports. Six key themes were discovered while analyzing the data. These themes were (a) some professionals have caseloads which consist of youth who have all experienced some type of childhood trauma, (b) vicarious trauma and/or negative thoughts are common amongst those who work with at-risk youth, (c) professionals must adapt to the barriers that come from providing services to at-risk youth, (d) professionals are focused on how they can be an effective support for the clients they serve, (e) professionals believe it is necessary

for parents and caregivers to be healthy supports for the population, and (f) COVID-19 has impacted their work with this population.

Interpretation of the Findings

Many of the findings were consistent with the literature review from Chapter 2. During the interviews, professionals noted childhood trauma played a role in the juvenile delinquency, which stemmed from many of the ACEs described in Chapter 2. They shared parental divorce/separation, domestic violence, child abuse, abandonment, neglect, community violence, generational trauma, and sudden losses were some of the common traumas their clients have experienced. Another traumatic experience that professionals mentioned that was not stated in Chapter 2 was COVID-19. This study was conducted during the pandemic and there was not much research on the topic; however, professionals noted that the pandemic could be of concern while working with their current clients and clients to come. During the interviews, some professionals thought that it had been traumatic for the children and there could be lasting impacts. Specific impacts of COVID-19 that were discussed were death and loss, isolation, and mental health concerns, including depression and anxiety.

Another topic that was briefly discussed by participants was that some of the children have parents who suffer from trauma, which they noticed to be a barrier to treatment for their target population. In Chapter 2, I discussed generational trauma and how the cycle of trauma repeats itself in various forms. During the interviews, participants discussed the amount of child abuse, neglect, and abandonment that their clients have experienced from a parent or caregiver, including foster caregivers.

Participants shared those parents/caregivers may have trauma they have not dealt with or lack of parenting skills. One participant mentioned a few trauma-related behaviors in adulthood, including not being able to keep a job and struggling in adult relationships. Overall, the professionals knew what their role was while working with at-risk youth and worked toward being a positive support for their clients because their ultimate goal was to see their clients live a normal functioning life.

Concerning professionals' common attitudes, perceptions, and opinions, the professionals agreed trauma-informed care is necessary when providing support to traumatized youth and juvenile delinquents. Some of the professionals acknowledged that the trauma-informed approach encouraged them to build a positive rapport with the clients. The trauma-informed approach also allowed them to tailor professional skills and techniques to the child's individual needs. They also acknowledged they needed to be emotionally present for the clients they work with. The professionals relied on their own supports and self-care to provide the most efficient and effective treatment to their clients.

Limitations of the Study

One limitation of the study was that I was not able to get professionals who worked in behavioral health services, (now intensive behavioral health services). When I reached out to agencies that provided these services, I was not able to obtain agency consent or there were no staff willing to participate after agency approval was obtained. This led me to reach out to other agencies that provided other services, but the agencies did have employees who met the inclusion criteria to participate in the study. Conversely,

this approach allowed for me to conduct more interviews than originally planned, and I could interview professionals who had experience in different fields with the target population. The participant population included therapists, an evaluator, an adoption agency worker, staff that worked in a therapeutic school setting, and professionals who worked in group homes or secured facilities. Since this was a qualitative study, the data did not need to be quantified, but the participant population consisted of mainly women; only three men participated in the study.

Recall bias is also another limitation of this study because the professionals were asked to recall their experiences with the target population. Since the interview questions were tailored to this study, this could have created another limitation as many of the professionals did not deviate from their responses and answered the questions that they were asked. This could have limited the information that professionals provided. Participants were given the opportunity to share final comments after the last question was answered, but few professionals disclosed information at the conclusion of the interview. This also presented the limitation of researcher bias because of previous knowledge about this population and having similar experiences with the target population. To mitigate researcher bias, I kept a journal to record thoughts and ideas that were present during data collection and during data analysis.

Recommendations

The limitations of this study showed that it may be beneficial if future research continued to explore other professionals who have experience with traumatized youth and juvenile delinquents. It may also be beneficial for the study to be expanded to other areas

in the state of Pennsylvania to determine if other professionals have similar experiences and/or opinions. Another recommendation would be to explore this topic from a quantitative or mixed methods approach. A quantitative approach would allow for a much larger participant size and could make it easier to reach out to eligible participants within the state. This could also increase generalizability of the research.

Regarding the data and analyzation, it is recommended that further research expound on the emergent themes from this study. Professionals appeared to have much to say about their experiences with this population, and it is recommended that this topic continue to be explored. COVID-19 as trauma for youth should be explored regarding how it has impacted their mental health and behavior. Professionals also discussed the importance of support for traumatized youth and juvenile delinquents, and this can be a separate topic focused on with professionals. Another topic could include support from the professionals themselves due to the participants discussing how vicarious trauma plays a role in the field they work in.

Implications

A possible implication of this study would be on an organizational level and possibly a policy/societal level. Professionals expressed the need for more trainings, especially any training pertaining to trauma. It appears that professionals want more support to be supportive of the clients they serve. Many of the professionals shared that they feel they do have support from their employers, but they see the need for improvements in some areas. This could also lead to policy changes as the need for trauma-informed care is necessary when working with this population. If the county or

state recognizes this need, it can turn into a requirement for professionals who work with traumatized youth and increase their professional competence and performance. The need for social change is evident in this area because if there is no change then juvenile delinquency rates will not continue to decline. Professionals see the need for more professionals in the field to assist with increasing the healthy functioning of traumatized youth and juvenile delinquents. The results revealed that there could possibly be other trauma concerns for youth stemming from COVID-19. As the literature stated, early intervention with this population is necessary, population and healthy supports are necessary to increase normal functioning for the youth.

Conclusion

In summary, there is a lot that goes into understanding childhood trauma and juvenile delinquency. Mental health professionals are learning more about how the short, medium, and long-term effects play a role in the lives of traumatized youth and delinquents all the way up into adulthood. Those who provide support to this population are doing what they can to be a positive support for the youth because they know that the trauma can be detrimental for them. Research over the past 15 years has focused on prevention and intervention for traumatized individuals and new research is needed to continue exploring this topic and identifying what could be most beneficial to promote healthy functioning for traumatized youth and delinquents. It takes more than one person to assist traumatized youth with being successful because the trauma impacts every aspect of the child's life. Family support and community support, including school and professional, is needed to make these changes a reality. Based on the interpretation of the

interviews, it seems that often the intensity, frequency, and duration of trauma is so detrimental for a person that long-term success may not be achieved. However, with the right healthy supports, professionals may be able to create a long-term healthy impact of the lives of traumatized youth and juvenile delinquents so that they can live a relatively normal life within society.

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Appendix A: Demographic Questionnaire- Agency Personnel

1. What is the specific age group that your company/organization provide services for?

   ____

2. Which area(s) do your company/organization service? (circle all that apply)

   A. Urban B. Suburban C. Rural

3. What races and ethnicities are serviced by your company/organization?

   ____

4. What is the length of time that your company/organization provides services?

   A. 0-12 months B. 1 – 2 years C. More than 2 years (please specify length of time)

5. Who is involved in the services that your company/organization provides?

   A. Child only B. Child and Caregiver (s) C. Entire Family

6. What are the criteria that individuals need to meet to be eligible for the services provided by your company/organization?

   ____

7. What locations does your company/organization use to service the population you work with? (circle all that apply)

   A. Home B. School C. Community (specify)

8. What is your gender?

   A. Male B. Female C. Non-Binary D. Transgender MtF E. Transgender FtM

F. Choose not to disclose G. Other

9. What is your highest degree of education? (please circle one)

   A. Master's Degree (licensed) B. Master's Degree (non-licensed) C. Ph.-D D. Graduate Post-Master's

10. If you are licensed, what type of clinical license do you have?

    ____

11. What is your degree in? And specify major and/or minor.

    ____

12. What is your current job title and your specific role and function?

    ____

    ____

    ____

13. How long have you worked in that field? (please circle one)

    A. Less than a year B. 1 – 5 years C. 5 – 10 years D. Over 10 years

14. If you have worked in this field for less than a year, has your role or function changed over the years? Please provide brief explanation.

    ____

    ____

15. How long have you been with the current company/organization? (please circle one)

    A. Less than a year B. 1 – 5 years C. 5 – 10 years D. Over 10 years

16. Do you feel that the training you had for this role prepared you for your current position? Yes or no and please explain.

    ____

    ____

    ____

17. How often do you receive specialty training for this field of work? (please circle one)

    A. Never B. Yearly C. Quarterly D. Monthly E. Weekly

18. Do you have supervision within your current role? How often?

    ____

19. Is there a published job description from your agency?

Appendix B: Interview Questions

1. Do you or have you worked with traumatized youth and juvenile delinquents? (Yes or no). Please describe the population you work with.
2. How many of your clients have been through at least one type of trauma (i.e., domestic violence, child abuse, incarcerated parent, gun violence, etc.)? Please explain their primary and secondary traumatic experiences.
3. Describe/explain the types of trauma you have noticed in the population you work with.
4. What is your approach strategy in your initial session with a trauma victim (ex. Why are you here? Benefits of counseling experience? Explain your trauma.)?
5. Of those who have experienced trauma, in the population you serve, what are some of the trauma-related behaviors you have noticed? What are the common trauma-related behaviors?
6. How does the population you work with minimize or enhance their traumatic experiences?
7. What treatment techniques do you use when working with this population?
8. Have you heard of trauma-informed care (yes or no)? Do you currently practice using trauma-informed care/techniques (yes or no)? Please explain.
9. What are the common barriers to treatment you face when providing these services to the clients you work with?
10. Does your company/organization provide training on trauma-informed techniques?

11. Is there a specific technique that you would like more training on? (yes or no and please explain your response).
12. On average, how long do your organization's treatment services last?
13. Explain what the success of an individual looks like to you.
14. What training(s) do you think would be beneficial while providing treatment services to at-risk youth?
15. Do you feel that your organization provides the appropriate services to make a change in the lives of traumatized youth and delinquents? (yes or no. Please explain either response.)
16. Do you feel that you have experienced vicarious trauma (yes or no. Please explain.) Have you been personally triggered by the population you have worked with (yes or no. Please explain)?
17. How do you manage and/or work through the vicarious trauma and/or personal triggers?
18. How has your current work been affected due to COVID-19 (increased caseload, virtual sessions, limited training, etc.)?

Appendix C: Recruitment Flyer

Researcher is seeking participants with experience working with traumatized youth or juvenile delinquents

There is a new study called *"Mental Health Provider's Perspectives: The Link Between Childhood Trauma, Juvenile Delinquency and Long-Term Effects within the Youth Development Center"* that could help mental health providers and agencies with insight on how to better support traumatized youth and delinquents. For this study you are invited to participate in an interview to describe your experience working with traumatized youth and/or juvenile delinquents.

This survey is part of the doctoral study for Vanay L. Frederick-Ellis, a Ph.D. student at Walden University.

About the study:

- One 10–15-minute demographic questionnaire.
- One 30–45-minute phone interview.
- To protect your privacy, no names will be collected

Volunteers must meet these requirements:

- 18 years old or older
- Be master's level or above (licensed or unlicensed)
- Have current or past experience with traumatized youth or juvenile delinquents.