POST TRAUMATIC STRESS DISORDER AND DELINQUENT BEHAVIOR AMONG JUVENILES AT KAMPIRINGISA REHABILITATION CENTRE

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I, **Nantabo Winnie Kisakye** hereby declare that this is my original work, is not plagiarised and has not been submitted to any other institution for any award.

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Approval

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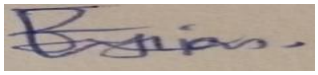
Signature: 

Dedication

This work is dedicated to my dear husband Luke Kyeyune for motivating me to study Psychology.

I also dedicate this work to my children Jeremiah, Jayla, Jenkyns as a motivation to study hard and attain greater heights than me.

Lastly, I dedicate this work to my dear mother, Betty Naigaga Wanjala. Your love and selflessness enabled me to study.

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I am forever indebted to the Almighty God for His love and faithfulness. Without His grace and guidance, I would never have come this far. Blessed be His holy name.

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Abstract

Post-traumatic stress disorder (PTSD) is associated with an increased risk of delinquent behavior in adolescents. Studies suggest that childhood trauma can lead to behavioral problems (Kilpatrick et al., 2003). With the complex relationship between PTSD and delinquent behavior, more research is needed to understand the driving forces. The study aimed to investigate the relationship between PTSD and delinquent behavior in adolescents at Kampiringisa Rehabilitation Centre. The objectives of the study were (i) to identify the nature of traumatic violence experienced by the juveniles during their childhood, (ii) to understand the perceived motivations for delinquent behavior among juveniles with PTSD, and (iii) to establish whether there was a relationship between PTSD and delinquent behavior. The research design was a mixed study using sequential explanatory design. The population was the 200 adolescents at KNRC. No validity evidence was collected for the PTSD Reaction Index for DSM-IV-Adolescent Version as the instrument was already adopted and validated. The reliability of the tool according to Cronbach's alpha for the full scale is 0.90, indicating excellent reliability meaning the items are highly consistent in measuring PTSD symptoms. Its test-retest reliability shows strong reliability with 0.84 for full scale, 0.78 for Intrusion, 0.78 for Avoidance, and 0.73 for Hyperarousal. Quantitative data were collected through questionnaires, while qualitative data were through Key Informant Interviews, and Focus Group Discussions with a response rate of 97%. A simple random sampling was done using Morgan's sample size table, followed by homogeneous sampling to collect qualitative data. Quantitative data were analyzed using SPSS and qualitative data using Hyper Research. Integration was done at the interpretation and reporting level and the fit of integration was examined. The study established that although 92.8% of adolescents were abused by their caregivers in childhood, the relationship between PTSD and delinquent behavior though present was not statistically significant. The study recommends that every child's response to trauma should be recognized, and children provided with psychological therapy to enable them process negative emotions and cope with deep psychological trauma.

Chapter One

Introduction

1.0 Introduction

This section gives an overview of the purpose and the focus of the study, including its significance and how it will contribute to professional knowledge and practice.

1.1 Study Background

This study sought to explore the relationship between post-traumatic stress disorder symptoms and delinquent behavior among juveniles. Feiring, Miller-Johnson, and Cleland, (2007) propose that when some children are exposed to traumatic events, they may participate in the juvenile justice system as adolescents. While working as a Probation Officer, I interacted with several children who had committed offences and had been committed to Kampiringisa National Rehabilitation Center (KNRC) for rehabilitation. However, even after some of them had undergone rehabilitation and were re-settled in their communities they continued with the delinquent behaviors. It is believed that children who continuously experience violence, grow to become violent adults if their social environment does not change to have loving relationships, and they do not receive psycho-socio support, (Perry, B. D. 2004). Delinquent behavior, which adolescents employ as a defense

mechanism, manifests as one of the symptoms of post-traumatic stress disorder.

The prevalence of exposure to traumatic events among American children is staggering. Estimates based on a nationally representative sample indicate that 12.5% of children are maltreated - abused, neglected, bullied. 8% are victims of sexual abuse, and more than one third of children have either directly witnessed domestic or community violence (Finkelhor, Ormrod, Turner, & Hamby, 2005)

The Diagnostic and Statistical Manual (DSM-IV) criteria for diagnosing PTSD includes exposure to trauma where the victim must have experienced a traumatic event involving actual or threatened death, threat to physical integrity or a serious injury. The exposure could be direct, witnessed, or learned about having happened to a close family member or a friend. PTSD symptoms are categorized into three clusters including intrusive recollections where one experiences recurrent, involuntary, and distressing memories of the traumatic events, distressing dreams and flashbacks. Numbing or avoidance involves efforts to avoid thoughts, feelings, or conversations associated with the traumatic event, and people, places or activities, that arouse recollections of it. There could be a numbing of general responsiveness including feeling detached from others. In the final cluster of hyperarousal, individuals have trouble sleeping, are irritable, experience anger outbursts, and difficulty concentrating. These symptoms must

persist for more than one month and cause significant impairment in important areas of functioning.

The study focused on juveniles at Kampiringisa National Rehabilitation Centre and established the traumatic events that they experienced in childhood as well as the relationship between the PTSD symptoms they exhibited and their delinquent behavior.

Various researchers have confirmed that exposure to trauma and juvenile delinquency are related. Abram et al. (2004) says that 84% of girls and 93% of boys in detention had experienced trauma at a point in time. 65% to 70% of juveniles in detention were diagnosed with psychological health conditions, with severe and complex mental health needs (Shufelt et al., 2006).

Kampiringisa National Rehabilitation Centre is located on a 327-acre block of land off Masaka Road, in Mpigi district. It was started in 1952 as the Kampiringisa Boys Approved School. It takes care of the convicted children from the Remand Homes but also acts as a transit center for the Karamojong street kids. The land is not fenced and has a busy road passing through it and a public health center. KNRC is managed by seven officers and of these, one is the Principal Probation and Social Welfare Officer (in charge), one PSWO, and five Assistant PSWOs. Four of the staff are male and three are female.

Childhood ill-treatment and exposure to violence are substantial social problems, with an estimated 25% of children being exposed to family,

school, and community violence around the world (Cohen & Mannarino, 2008). Subsequently, children become vulnerable to serious developmental disruptions and harmful long-term consequences including mental health problems, and delinquent behavior.

The Uganda Violence Against Children Survey Report (UNICEF, 2018), states that among youths aged 18 to 24 years, 75.3% females and 75.6% males experienced one or more types of violence during childhood leading to many harmful consequences, such as delinquency, substance abuse, and sexual exploitation. 90% of children have experienced physical violence, over 45% have reported emotional abuse. Up to 13% of girls and 4% of boys reported sexual abuse (UNICEF 2018). In Uganda, when children commit offences, they are committed to Kampiringisa National Rehabilitation Centre for rehabilitation. The interventions provided to the juveniles at KNRC are meant to change the behaviors of the children so that they can be re-integrated into their communities and the deviant behaviors do not surface again. However, there's no significant change in the behaviors of the juveniles even after rehabilitation. They tend to return to their former lifestyle after they are resettled in the community.

This study sought to investigate the relationship between posttraumatic stress disorder symptoms and delinquent behavior among juveniles and provide information to juvenile justice programs to address trauma-informed interventions and support to juveniles during rehabilitation.

1.2. Problem Statement

Delinquency is a defense mechanism where victim coping may result in the loss of empathy, distorted cognitions, lack of impulse control, and inability to self-regulate, among others, which can increase an adolescent's tendency towards defiance (Ford et al.,2010). Juveniles who have been exposed to violence during childhood are more likely to have arrest records during adolescence or adulthood (Cernkovich et al., 2008). Adolescents with post-traumatic stress disorder (PTSD) are vulnerable to developing delinquent behavior, which can affect their mental health, relationships, and future opportunities. Although there's a growing recognition of the link between PTSD and delinquent behavior, there is need to establish the underlying factors that contribute to this relationship. The knowledge gap prevents the development of effective interventions and treatments for juveniles with PTSD and delinquent behavior, hence the need for further research in this area.

1.3 Purpose of the study

The purpose of the study was to explore the relationship between post-traumatic stress disorder symptoms and delinquent behavior among juveniles in rehabilitation.

1.4. Study Objectives

1. To identify the nature of traumatic violence experienced by juveniles at KNRC during their childhood.

2. To establish the perceived motivations for delinquent behavior among juveniles with PTSD.

3. To explore the relationship between PSTD and delinquent behavior in adolescents.

1.5. Research Questions

1. What is the nature of traumatic violence experienced by juveniles at KNRC during their childhood?

2. What are the perceived motivations for delinquent behavior among juveniles with PTSD?

3. What is the relationship between PTSD and delinquent behavior in adolescents?

1.6. The Study Scope

This section covered the geographical scope, content scope, and time scope.

1.6.1 Content Scope

The study sought to establish the type of traumatic events experienced by the juveniles at KNRC, the presence of PTSD symptoms among adolescents, and establish whether there was a relationship between PTSD symptoms and delinquent behavior.

1.6.2 Geographical Scope

The study was conducted at Kampiringisa National Rehabilitation Centre. The center was chosen because it is the only rehabilitation centre in Uganda and adolescents who are in conflict with the law are sent here for rehabilitation after they have been convicted of an offense.

1.6.3 Time Scope

The research focused on adolescents who experienced trauma during childhood.

1.7. Justification for the Study

Exposure to traumatic events is associated with a high prevalence of PTSD among adolescents. Research shows that one in ten adolescents in countries like Uganda could have symptoms for a full PTSD diagnosis (Stupar et al., 2021). The proposed study has the potential to improve outcomes for adolescents with PTSD and delinquent behavior, by identifying effective interventions and treatments and informing policy and practice.

1.8. Significance of the Study.

The findings from the research will be used by the stakeholders in the Justice, Law, and Order Sector (JLOS) including Probation Officers, the Principal of KNRC, Judges and Magistrates in the Family and Children Court (FCC), psychologists, counselors as well as police officers to respond to the trauma of individual children. Caregivers will also

understand how violent parenting can harm a child. The Ministry of Gender, Labor, and Social Development (MGLSD) will be able to use the results of the research to design interventions that address the root causes of PTSD among delinquent juveniles.

1.9 Theoretical Framework

The theoretical framework of the study was based on Sigmund Freud's (1905) Psychoanalytic theory. According to this theory, when unresolved instincts and drives within the human psyche are in conflict, delinquent behavior among youths will occur. When a child experiences traumatic violence, they may respond to it through repression where the child gets stuck at the psychological stage of the traumatic event. As a way of coping with the traumatic event, the child forgets about the experience. Later in life, the child may unconsciously engage in delinquent behavior, which behavior is one of the symptoms of post-traumatic stress disorder. The child is unaware of what is in their unconscious and the conscious which is portrayed through delinquent behavior is only the tip of the iceberg of a bigger problem.

Violent bullying, heartless blackmail of other juveniles, and lack of regret for one's actions are some of the deviant behaviors that juveniles engage in unconsciously because of the traumatic experience suffered in childhood. The study fits into this theory because as children grow into youths, they unconsciously engage in deviant behavior because they are stuck at the psychological stage of the childhood traumatic experience.

Freyd (1996) developed the Betrayal Trauma theory which provides a framework for understanding how trauma from trusted people impacts psychological outcomes. In examining the relationship between PTSD and delinquent behavior the theory proposed that childhood abuse by carers can lead to the development of PTSD. PTSD symptoms are associated with an increased risk of delinquent behavior especially in adolescents. Such trauma disrupts normal emotional and psychological development leading to emotional dysregulation, dissociation, and difficulties in forming healthy relationships, factors that contribute to behaviors that are termed as delinquent.

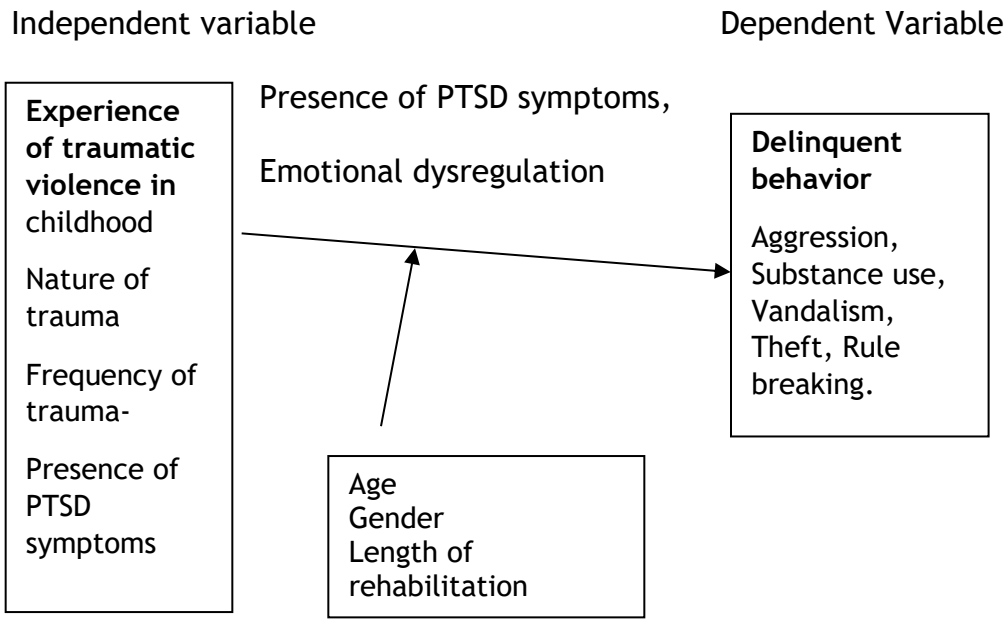
The study fits into this theory because when faced with violence in the home setting, children are helpless, and they must endure the situation because they depend on the adults for survival. Later in life, when they can express themselves, they will do so through delinquent behavior.

1.10. Conceptual Framework

When children experience traumatic violence, they manifest symptoms of post-traumatic stress disorder like delinquent behavior. To change this behavior, they are sent to a rehabilitation centre. At the rehabilitation centre, the youths may either be transformed after being rehabilitated or they may continue with offensive behavior. The outcome is dependent on the nature and the frequency of the trauma suffered, the child's age at the time of the trauma, the gender of the child, and the length of the rehabilitation. A much younger child will

overcome the traumatic experience faster than an older child, if they are removed from the traumatic event. Girls are more resilient than boys and therefore heal much faster when they undergo rehabilitation. Children who experience trauma more frequently than others need a longer period of rehabilitation.

Figure 1 – Link Between Traumatic Event, PTSD, Emotional Dysregulation, and Rehabilitation.



Chapter Two

Literature Review

2.0 Introduction

This section discusses the theoretical and empirical literature reviews as they explain the relationship between childhood traumatic violence and consequent delinquent behavior. It reviews the various psychological theories and explains the different key terms.

2.1. Theoretical Literature Review

Here focus was put on the key concepts of Sigmund Freud's (1905) Psychoanalytic theory and Jennifer J. Freyd's Betrayal Trauma theory (1996)

2.1.1. Sigmund Freud's Psychoanalytic Theory.

Sigmund Freud believed that most human behavior is influenced by unconscious thoughts, memories, desires, and feelings which are outside of conscious awareness. These include unresolved conflicts and repressed memories. Although the individual may not be aware of these unconscious thoughts and memories, they will still influence their behavior, (Feist J., Feist, G. J., & Roberts, T. 2018).

Freud proposed that the mind was made up of three parts namely, the Id, the Ego, and the Superego. The Id, which is the primitive part of personality, functions on the pleasure principle which seeks immediate

gratification. The rational part, which is the Ego, operates on the reality principle and reconciles the Id and the Superego. The Superego operates on the morality principle and integrates societal values and standards (Feist J., Feist, G. J., & Roberts, T. 2018).

He believed that during childhood, personality developed through several stages namely the oral, anal, phallic, latency and genital. Each stage is associated with specific conflicts which must be resolved for healthy development. However, when a juvenile gets stuck at the psychological stage of a traumatic event, there will be repression of memories. Despite repressing the memories, PTSD symptoms will be present. Consequently, the juvenile will develop delinquent behavior, which is a defense mechanism used by the ego to prevent unacceptable wishes from emerging into awareness (Schultz, D. P., & Schultz, S. E. 2017)

According to Freud, buried emotions could result in maladaptive responses whereby adolescents with PTSD symptoms might act out through delinquent behavior to express unresolved conflicts and emotions.

2.1.2. Jennifer J. Freyd's (1996) Betrayal Trauma Theory

Freyd (1996) developed the Betrayal Trauma theory which provides a framework for understanding how trauma from trusted people impacts psychological outcomes. In examining the relationship between PTSD and delinquent behavior the theory proposed that childhood abuse by carers

can lead to the development of PTSD. PTSD symptoms are associated with an increased risk of delinquent behavior especially in adolescents. Such trauma disrupts normal emotional and psychological development leading to emotional dysregulation, dissociation, and difficulties in forming healthy relationships, factors that contribute to behaviors that are termed as delinquent.

Examples of traumatic betrayals by caregivers include physical and sexual abuse and can lead to the development of PTSD especially if the incident caused a lot of fear, (Freyd, J. J., Klest, B., & Allard, C. B. 2005).

The theory further notes that children may block the betrayal from their mind and develop dissociative amnesia if they are dependent on the caregiver for their daily needs and survival. The brain ignores the betrayal to maintain the relationship with the caregiver and survive, leading to betrayal blindness. If the child processed the betrayal normally, they could avoid the caregiver and stop interacting with them, hence threatening their survival. This can complicate the healing process and worsen PTSD symptoms, increasing the risk of delinquent behavior (Gupta, 2023).

2.2 Empirical Literature Review

The main ideas derived for empirical study from the proceeding sections are related to the topic of PTSD symptoms and delinquent behavior. To examine the types of trauma and traumatic events experienced by the

juveniles at KNRC, to establish the relationship between PTDS symptoms and delinquent behavior, and to establish the perceived triggers and motivations for delinquent behavior among juveniles with PTSD, the literature concerning the above was reviewed.

2.2.1 Experience of Trauma

Trauma is a lasting emotional response resulting from one experiencing a distressing situation. When one experiences a traumatic event, their sense of safety, and self, and their ability to regulate emotions and relate with others is harmed (Terr, 1991).

According to the National Child Traumatic Stress Initiative (2024), more than two-thirds of children reported at least 1 traumatic event by the age of 16.

Terr (1991) submits four features common to most cases of childhood trauma. These are repeated memories of traumatic events, continuous behaviors, fears attached to trauma from violence, and altered attitudes of people, life, and the future. (Terr, 1991) proposes that childhood trauma is categorized into two types- Type I and Type II. Type I trauma comprises full, detailed memories, and misinterpretations whereas Type II trauma comprises denial, numbing, self-suggestion, detachment, and rage. These manifest as PTSD in the adolescents at KNRC. These characteristics can exist side by side and they manifest as perceptual mourning, depression, childhood disfigurement, disability, and

pain. This aligns with the Betrayal Trauma theory, which was advanced by, (Freyd 1996), and (Freyd, J. J., DePrince, A. P., & Gleaves, D. 2007). Common examples of type 2 traumatic events include childhood abuse, domestic violence, neglect, bullying, emotional, physical, verbal, or sexual abuse. Prolonged exposure to abuse leads to complex trauma and this can have a significant impact on the nervous system. The brain and body become very overwhelmed that they get stuck in "fight, flight, or freeze" mode. This impact and the distress that comes with trauma take a toll on a person's mental and physical health, (Quinn, D. 2003).
We should take into consideration that children who are in school and have high self-esteem can easily share the traumatic events that they are experiencing at home with their teachers at school and not necessarily hold the rage within themselves. This is where teachers are friendly and approachable. The teachers will play the role of the loving and caring adult which will put the emotions and behaviors of the children in check. However, for the much younger children who do not go to school and have nobody to share their experience of the traumatic events with, they could hold the rage within themselves and consequently present symptoms of PTSD.

2.2.2 Posttraumatic Stress Disorder (PTSD)

According to the DSM IV Posttraumatic Stress Disorder (PTSD) develops after exposure to extreme traumatic stressors, like direct personal experiences of actual or threatened death, serious injury, or threats to

physical integrity. It can also result from witnessing such events or learning about them happening to close associates. The response to these events naturally involves intense fear, helplessness, or horror. The key symptoms include reexperiencing the trauma – persistent reliving of the traumatic event, avoidance and numbing- avoiding stimuli associated with the trauma and experiencing a general numbness of responsiveness, and increased arousal with persistent symptoms like heightened startle response, irritability, or difficulty sleeping.

To be categorized as PTSD, symptoms must persist for more than one month, and the disturbance must cause significant distress or impairment in social, occupational, or other important areas of functioning.

The severity and duration of PTSD are greater when the trauma is caused by another human such as rape or torture. The likelihood of developing PTSD increases with the intensity and proximity to the stressor, (Mueser, K. T., & Tuab, J. 2008). This explains why adolescents who have faced traumatic events like physical and sexual abuse become violent and may as a defense mechanism end up committing crime. For instance, where a child who is tortured by the stepmother ends up assaulting her.

PTSD is categorized as acute where symptoms last less than three months, chronic where symptoms last three months or more, and with delayed onset where symptoms begin at least six months after the stressor.

However, when PTSD presents as aggressive or violent behavior and adolescents in defending themselves manifest delinquent behavior, they are brought before the courts of law. Charges are read to them and if found guilty, they are sent to KNRC for rehabilitation. At KNRC the symptoms of PTSD are addressed instead of the root causes. Consequently, there are no trauma-informed interventions or treatments offered to the juveniles.

2.2.3 Emotional Dysregulation

According to the Cleveland clinic, Emotional dysregulation is a mental health symptom where individuals struggle to control their emotions and reactions, often appearing disproportionate to the situation. Emotional dysregulation includes difficulty managing negative moods like anxiety or depression, mood swings, impulsive behavior, persistent irritability, easily frustrated by minor inconveniences, and emotions interfering with goal pursuit. The severe effects of this behavior include verbal outbursts, violent or aggressive behavior, and challenges maintaining social relationships. Emotional dysregulation can greatly disrupt life, affecting social relationships, career, and overall well-being.
When juveniles fail to have control over their emotions like anger, they will confront the cause of the stressor as a defence mechanism. Their actions will be considered as delinquent behaviour by the community and the law which will require that they undergo rehabilitation to deal with the unbecoming behaviour.

2.2.4 Delinquent Behavior.

Delinquent behavior is where a youth conducts himself in a way that is offensive to the community. The psychoanalytic theory of delinquent behavior suggests that delinquent behavior appears in the adolescence and puberty stages of human development. This behavior reflects the conflict between one's superego and childhood impulses of the oral, anal, and phallic stages that are revitalized towards adolescence. Delinquent behavior results when one's superego is very defective, weak, or incomplete and it cannot control the revived violent and primitive childhood impulses. The formation of improper superego results from experiencing violence, inconsistent discipline, and maternal deprivation among others (Schoenfeld 1971).

I do agree with Schoenfeld (1971) observes that delinquent behavior results from the conflict between the superego and one's childhood impulses. Schoenfeld argues that when an individual lacks self-control, they will follow their id and end up behaving in a way that is unacceptable to the community. Delinquent behavior results from several factors like an attempt to provide excitement and thrill, obtain social recognition, revenge against parents and others, deny dependence on others, and seek punishment to shake off the sense of conscious or unconscious guilt feeling. Delinquent behavior results from the conflict between the superego and one's childhood impulses, (Schoenfeld 1971). When an individual lacks self-control, they will follow their id and end

up behaving in a way that is unacceptable to the community. Delinquent behavior results from several factors like an attempt to provide excitement and thrill, obtain social recognition, revenge against parents and others, deny dependence of others, and seek punishment to shake off the sense of conscious or unconscious guilt feeling, (Eaton, B. 2020) Adolescents are easily influenced by peers, and they can end up acting impulsively and exhibiting behavior that is considered delinquent in the community. Once convicted by the justice system, they will end up at KNRC for rehabilitation without looking at what the causes of such behavior, (Mueser, K. T., & Tuab, J. 2008).

2.2.5 Rehabilitation

Rehabilitation focuses on addressing the underlying causes of delinquent behavior in juvenile offenders. It aims to provide them with the necessary tools for personal growth, education, and skill-building to reintegrate into society as responsible and law-abiding citizens. Research indicates that well implemented rehabilitation programs can significantly reduce recidivism rates among juvenile delinquents (Yadav and Ranaut, 2023

Rehabilitation is a process where juveniles with delinquent behavior are restored to become acceptable citizens in the community. The juveniles have committed offenses and through the court system, they are sent to rehabilitation centres for a given period such that their behavior is transformed positively. Rehabilitation is not a form of punishment but

rather a method to prevent juveniles from engaging in delinquent behavior in future and provide appropriate guidance on how to conduct oneself in the community. I believe that it is important that the root cause of the delinquent behavior is analyzed and addressed instead of addressing the symptoms of the delinquent behavior if we are to have effective interventions and reduce the rate of recidivism.

2.2.6 Relationship Between Trauma and Delinquent Behavior.

Cohen & Mannarino, (2008) state that 25% of children worldwide have been exposed to traumatic violence in various communities that they interact with. However, not all children who have witnessed traumatic violence develop behavioral challenges, yet those that do, experience consequences like delinquent behavior, poor school performance, drug and substance abuse, and mental health challenges, (Smith, Leve, & Chamberlain, 2006).

It is believed that juveniles in detention centers have most likely experienced traumatic violence as compared to those that are not in detention (Abram et al., 2004). People who have experienced traumatic violence in childhood will most likely be arrested during adolescence, (Cernkovich, Lanctot, & Giordano, 2008). Flisher et al., (1997) suggests that experiences of traumatic violence in childhood lead to mental health challenges like conduct disorder and oppositional defiant disorder. The time, the duration, and how traumatic the violence is are determinants of delinquent behavior. Children who experience violence

at a younger age will most likely suffer mental health challenges if they are not removed from the abusive situation (Maas, Herrenkohl & Sousa, 2008).

When one experiences traumatic violence, the brain is impaired in the way one thinks, behaves, and feels (Ford, Fraleigh, & Connor, 2010). Overtime, an individual is overwhelmed by the experience resulting in decreased emotional regulation and negative coping strategies. When adolescents don't receive support to cope positively, they will become defensive and will lose empathy, have distorted cognitions, lose self-control, and practice behavior offensive to the community. Damaged by childhood trauma and other societal challenges, youth within the juvenile justice system often struggle with mental health issues, like posttraumatic stress disorder, which all too often go unnoticed and untreated.

Although I have heard of instances where some of the youth at KNRC or the other remand homes in Uganda have been diagnosed with mental health issues, there are other youths in the juvenile justice system who have lost their moral sentiments and consequently infringed on social values.

Ford et al., (2010) argues that the high rates of trauma experienced among youths in the juvenile justice system have led to calls for the development of trauma- informed juvenile justice interventions to improve the treatment of this high-risk population.

While planning for the treatment of juveniles, mental assessments should be done such that individuals receive interventions for consideration should be

given to reducing the rate of recidivism. Juveniles are sent to rehabilitation to remodel their behaviors, but some come out and their behavior has not changed. Rehabilitation should not be about making the community a safe place without the presence of the juveniles involved in delinquency but rather there should be intentionality to effect behavior change.

Chapter Three

Research Methodology

3.0 Introduction

This Chapter presents the methodology used for research. It describes the study population, sampling methods, source of data, research design, sample size, techniques, and procedures used. Additionally, it explains the tools, methods, and processes that were utilized to obtain data, the anticipated results, and the ethical considerations that the researcher considered in the process of the research.

3.1. Research Design

This was a mixed methods study consisting of both quantitative and qualitative methods, and the sequential explanatory design was used. Creswell and Plano Clark (2010) state that a mixed methods design collects and analyses both quantitative and qualitative data and mixes

the analyses by merging the datasets into a cohesive whole, building the results of one on the other, or embedding one dataset in the other. It was non-experimental and depended on observations and interpretations made to make conclusions. Qualitative research was used to describe the nature of an individual's experience while quantitative research was used to examine the relationship between PTSD and delinquent behavior. Integration was done at the interpretation and reporting level where the qualitative and quantitative findings were described in a single report. This was followed by the examination of the fit of integration.

3.2. Area of study

The study was conducted at Kampiringisa National Rehabilitation Centre (KNRC). KNRC is located in Mpigi district, in central Uganda. The centre serves as a critical institution for young offenders. These juveniles, aged 12 to 18, find themselves in conflict with the law and are placed in remand homes. The centre aims to rehabilitate and reintegrate them into society, providing education, vocational training, and psychological support.

KNRC has a population that ranges from 150 to 200 children. The population always fluctuates. When new children are brought in, the number goes up. When children complete their time at the center and are taken back to their communities, the number goes down. The

catchment area of the centre has a heterogenous population with children from all over the country.

The researcher chose KNRC because it is the only rehabilitation center in Uganda where juveniles are taken for rehabilitation once the court determines that they have committed an offence.

3.3. Sources of Information

3.3.1. Primary Data

The juveniles living at Kampiringisa National Rehabilitation Centre who had experienced traumatic events were considered. Given that all the children at the center had passed through the courts of law before they were registered at KNRC, they all had committed delinquent behavior. This allowed the researcher (through questionnaires, and in-depth interviews), to identify the traumatic events that they had experienced, and how PTSD contributed to delinquent behavior. Information was also gathered using a Key Informant Interview with the Principal of KNRC.

3.3.2. Secondary Data

Secondary data was obtained using a desk review from previous research and publications done by other authors related to posttraumatic stress disorder, and delinquent behavior as well as journals, books, articles, policies, and regulations.

3.4. Population and sampling techniques

3.4.1 Population

The study population is an entire group of subjects or people that the researcher is interested in. At the time of the study, there were 200 adolescents at Kampiringisa National Rehabilitation Centre, and this was the population that was considered.

3.4.2 Sample Size and Sampling Techniques

Convenience sampling was done, and this was followed by purposive sampling. To determine the sample size, (table 1), Krejcie and Morgan (1970)'s table for sample size was used. The table provides pre-calculated sample sizes for various population sizes. The corresponding sample to the population of 200 was 132 adolescents. The marginal error was ±7% and the confidence level was 95%. These were assigned codes.

Table 1: Krejcie and Morgan Table for Determining Sample Size

Table for Determining Sample Size of a Known Population

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	346
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	354
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	191	1200	291	6000	361
45	40	170	118	400	196	1300	297	7000	364
50	44	180	123	420	201	1400	302	8000	367
55	48	190	127	440	205	1500	306	9000	368
60	52	200	132	460	210	1600	310	10000	370
65	56	210	136	480	214	1700	313	15000	375
70	59	220	140	500	217	1800	317	20000	377
75	63	230	144	550	226	1900	320	30000	379
80	66	240	148	600	234	2000	322	40000	380
85	70	250	152	650	242	2200	327	50000	381
90	73	260	155	700	248	2400	331	75000	382
95	76	270	159	750	254	2600	335	1000000	384

Note: N is population size. S is sample size

Source: Krejcie & Morgan, 1970.

3.5. Variable Definitions and Measurements

3.5.1 Experience of Trauma

Trauma is a lasting emotional response resulting from one experiencing a distressing situation. When one experiences a traumatic event, their sense of safety, and self, and their ability to regulate emotions and relate with others is harmed, (Terr, 1991).

The measurement used was a nominal scale where respondents chose one option that best described their experience of trauma to the following statements: (0) not applicable, (1) emotional violence, (2) neglect or negligent treatment, and (3) physical violence, and (4) sexual violence.

3.5.2 Delinquent Behavior

According to the Oxford Advanced Learner's Dictionary, delinquent behavior refers to actions, especially by young people, that show a tendency to commit crimes or engage in antisocial activities.

The Penal Code Act, CAP 120 (1950) of Uganda categorizes offenses into minor and major offenses, often referred to as misdemeanors and felonies, respectively. Minor offenses or misdemeanours are less severe offenses and result in lighter penalties. They include petty theft - theft of items of low value, public nuisance- acts that disturb public peace or safety, and minor assault- physical attacks that do not result in serious

injury. Major offenses or felonies are more severe offenses and carry heavier penalties, including long-term imprisonment or even death. These include murder- the unlawful killing of another person with intent, rape- non-consensual sexual intercourse, robbery- theft involving the use of force or threat of force, and treason- acts against the state such as attempting to overthrow the government.

The measurement used was a nominal scale where the severity of the delinquent acts was categorized as a misdemeanor (1) or felony (2) in line with the Penal Code Act, Chapter 120 (1950).

3.6. Procedure for Data Collection

The researcher received an introduction letter from the university which was presented to the Permanent Secretary at the Ministry of Gender together with an application letter requesting to conduct a study at Kampiringisa National Rehabilitation Centre. After receiving the response from the Permanent Secretary, the researcher shared the application and response with the principal of KNRC together with the copy of informed consent.

Data collection was conducted by a team of 8 people with 7 well-trained research assistants and the principal investigator who were knowledgeable of the English and Luganda languages. The research assistants underwent 1 physical training.

Voluntary participation was emphasized, and all participants received detailed information about the study and their willingness was sought

using a consent form. To enhance confidentiality, participants used coded numbers instead of their names.

4 (3%) participants chose not to participate in the study due to the language barrier. They spoke Karamojong and there was no translator, hence questionnaires were administered to 128 adolescents.

Simple random sampling was done to ensure that every individual had an equal chance of being selected. This was followed by purposive sampling that allowed for the selection of participants with specific experiences related to childhood trauma to allow for an in-depth understanding.

The participants were divided into 8 groups each comprising 16 respondents. The questionnaires were administered, and questions were read and translated in the local language (Luganda), as the participants responded to one question at a time. These were then collected and reviewed.

To collect the qualitative data, the completed questionnaires were reviewed, and purposive sampling was conducted where 12 boys and 10 girls that had posttraumatic disorder symptoms and had experienced traumatic events in childhood were selected. These were further interviewed in four Focus Group Discussions, two for boys and two for girls. One FGD was conducted with the 6 staff members present, and one Key Informant Interview was conducted with the principal. All the questions asked here were open-ended to enable respondents to freely express themselves. We could not conduct one-on-one interviews with

the respondents because this was not in line with the rules and regulations of the rehabilitation center.

Notes of the discussions held during the 5 FGDs and KII were documented during the interviews. There were no audio recordings because it is against the regulations of the institution.

3. 7 Data Collection Instruments

The study collected quantitative data using the UCLA Posttraumatic Stress Disorder Reaction Index for DSM-IV-Adolescent Version to measure exposure to traumatic events (Appendix A). The tool was advanced by the National Child Traumatic Stress Network (NCTSN). The self-administered questionnaire screened the juveniles to establish if they had been exposed to traumatic situations. The tool assessed PTSD symptoms among the juveniles. The scale evaluated how regularly the symptoms of PTSD occurred among the juveniles during the month of January (rated at 0 = never to 4 = most times). The items were related to the avoidance, intrusion, and arousal criteria in the DSM IV. Trauma-related guilt and fear of recurrence were assessed as associated features. Tabulation of UCLA PTSD-RI score total, and B, C, and D score subscales, were permitted by scoring algorithms. An in-depth assessment was conducted by administering a questionnaire with 27 items to the juveniles that were randomly sampled. On average it required 30 minutes, 20 to complete the questionnaire and 10 to score it. It was administered once. The format for the response was both Yes or No and

a Likert Scale ranging from 0 which was None to 4 which was most. The questionnaires were in hard copy where each of the 128 participants accessed a copy that they completed.

This was followed by Focus Group Discussions which were used to collect qualitative data from the adolescents using purposive sampling. These adolescents had PTSD and had suffered childhood trauma. The adolescents were divided into four groups, two for boys and two for girls, who met the criteria of severe symptoms of PTSD.

Open-ended structured interview questions were administered to the four groups to address research questions on causality, generalizability, and the effects of traumatic violence and delinquent behavior. This was done using semi-structured questionnaires.

A Focus Group Discussion was also used to collect data from the 6 social workers who worked with the adolescents. This information was collected using semi-structured interviews.

A Key Informant Interview with semi-structured questions was used to collect behavioral information about the adolescents from the principal of KNRC. This was to gain an insight into the situation of PTSD and delinquent behavior.

3.8 Quality/Error Control

3.8.1. Validity

Tools for collecting data that directly connected to the objectives of the study were examined to confirm the quality of the findings. Amin (2005) defines validity as the degree to which the tools accurately measure the variables that they are intended to assess. However, since the instrument that was used was already adopted and validated, no validity evidence was collected for the Posttraumatic Stress Disorder Reaction Index for DSM-IV-Adolescent Version.

Considering Amin's (2005) assertion that expert opinion determines content validity, the principal researcher double-checked the questionnaire to ensure its thoroughness before it was administered. The UCLA Posttraumatic Stress Disorder Reaction Index for DSM-IV-Adolescent Version has been validated through various studies. Here is a summary of its validity.

Table 2: Validity of the *UCLA PTSD Reaction Index for DSM-IV-Adolescent Version*

Table

Aspect	Details
Internal Consistency	High internal consistency, indicating reliable measurement across different items [1].
Criterion-Referenced Validity	Demonstrated criterion-referenced validity, correlating positively with depressive symptoms [1].
Diagnostic Accuracy	High diagnostic accuracy, effectively distinguishing between youth with and without PTSD [1].
Test-Retest Reliability	High test-retest reliability, ensuring consistent results over time [2].
Cross-Cultural Validity	No significant differences in scores between racial/ethnic groups [2].

3.8.2 Reliability

Amin (2005) defined reliability as the degree to which a research tool yields consistent results after several trials. Thus, dependability and consistency in the results of the research process are connected.

The UCLA PTSD Reaction Index for DSM-IV is a widely used tool for assessing PTSD symptoms in adolescents. Its reliability is as follows;

Internal Consistency measures how well the items on a test measure the same construct. Cronbach's alpha for the full scale is 0.90, indicating excellent reliability. Subscale alphas

are 0.82 (Intrusion), 0.79 (Avoidance), and 0.67 (Hyperarousal). Cronbach's alpha of 0.90 indicates excellent reliability, meaning the items are highly consistent in measuring PTSD symptoms. Subscale alphas show good reliability for Intrusion and Avoidance, and acceptable reliability for Hyperarousal.

Its test-retest reliability: Pearson coefficients show strong reliability with 0.84 for full scale, 0.78 for Intrusion, 0.78 for Avoidance, and 0.73 for Hyperarousal. The test-retest reliability assesses the stability of the test over time. Pearson coefficients close to 1 indicate strong reliability, meaning the test produces consistent results when administered at different times.

For qualitative data, the field notes would be typed using systematic coding procedures to ensure accuracy and consistency. Data would be reviewed and explored looking for patterns and repeated themes that

emerged. A coding system would be developed to represent the various themes in the data, after which Hyper Research would be used to manage and analyze the data making connections between the themes and the research questions.

3.9 Data Processing and Analysis

For quantitative data, the Statistical Package for Social Scientists (SPSS) computer program was used. Data was entered into Excel and then imported to SPSS. The variables were defined, and the data was cleaned to handle missing values. Descriptive statistics were used to provide simple summaries about the sample characteristics while inferential statistics (t-test) were used to explain the relationship between the two variables.

For qualitative data, the field notes were typed using systematic coding procedures to ensure accuracy and consistency. Data was reviewed and explored looking for patterns and repeated themes that emerged. All the researchers coded the data to ensure inter-rater reliability. A coding system was developed to represent the various themes in the data. Codes were assigned to the data after which recurring themes were identified. Hyper Research was used to manage and analyze the data making connections between the themes and the research questions.

3.10 Ethical considerations

Ethical clearance to conduct the study was sought from the UCU Research Ethics Committee and from the Permanent Secretary of the Ministry of Gender, Labor, and Social Development.

Respondents were assured of their safety, privacy, and confidentiality. They were informed of their right to decline or to withdraw from the research whenever they wished. All participants were allowed to understand the implications of their participation and requested to provide written consent as proof of their willingness to participate in the study.

3.11 Methodological constraints

Given that Kampiringisa National Rehabilitation Centre is an institution where juveniles who have come in conflict with the law are committed, there were many restrictions around the interactions with the adolescents. One-on-one interviews with the adolescents were discouraged and the researcher had to engage the adolescents in FGDs under the supervision of the staff members. This discouraged the adolescents from freely expressing themselves. The researcher addressed this by providing the adolescents with sheets of paper where they wrote the responses to the questions that were asked.

Some of the adolescents from the Karamoja region understood neither English, Luganda nor Kiswahili. The researcher allowed them to withdraw from the study since there was no translator.

The voices of the respondents could not be recorded using any device because this was contrary to the regulations of KNRC. The researcher asked for permission to document the notes during the interview.

Chapter Four

Data Analysis, Presentation, and Interpretation of Findings

4.0 Introduction

In this chapter, the data that was collected from the field was analyzed, interpreted, and presented concerning the research questions. The significance of the results was explained within the research context.

4.1 Data Cleaning and Verification

During the data collection process, the researcher reviewed the submitted questionnaires for completeness and consistency, and feedback was provided to the research assistants in a timely manner. The researcher validated all submitted data and 3% of the respondents (4) who withdrew were not considered.

After the validation process, 128 responses were used during the study, yielding a response rate of 96.9% (with a non-response bias of 3.07%). This response rate (96.9%) was higher than the minimum acceptable rate of 68% for quantitative research studies according to Human Relations 2022. The high response rate was attributed to the study area, in an institution where the respondents were mobilized by the staff to

participate in the study. Each validated respondent was assigned a unique code for purposes of confidentiality. Data was captured in Excel and imported into a data statistical package (SPSS) version 20.0 for analysis into frequencies and percentages.

4.2 Data Analysis, Presentation and Interpretation

This chapter presents the analysis and interpretation of results based on the data collected from participants. The data collection was premised on the study objectives shown in chapter one section 1.4, namely

1. To identify the nature of traumatic violence experienced by juveniles at KNRC during their childhood.
2. To establish the perceived triggers and motivations for delinquent behavior among juveniles with PTSD.
3. To explore the relationship between PTSD and delinquent behavior in adolescents.

In the presentation of the findings, the demographic characteristics of the respondents were presented first. Demographic characteristics were relevant in understanding variations that existed amongst the study population (Hammer, 2011). This covered gender, age group, and education status.

Table 3: Socio-Demographic Characteristics

Variable	Category	Frequency n=128	Percentage

Gender	Male	118	92.8
	Female	10	7.2
	Total	**128**	**100.0**
Age	12- 13	14	10.94
Group	14- 15	73	57.03
	16- 17	41	32.03
	Total	**128**	**100**
Education	No Formal	08	6.25
Status	Education		
	Pre-primary Sch	12	9.38
	Primary Sch	74	57.81
	Lower Sec Sch	34	26.56
	Upper Sec Sch	00	00.00
	Total	**100**	**100.00**
Female	Primary Sch	4	40
Education	Lower Sec Sch	6	60
Status	**Total**	**10**	**100.00**

Source: Primary data, 2024

4.2.1 Gender

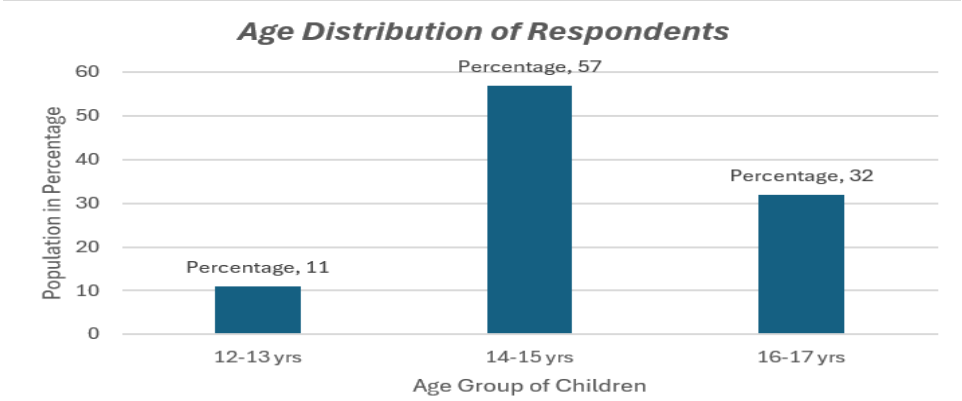
Of the 128 respondents that were interviewed, 118 (92.2%) were male while 10 (7.8%) were female. From these results, male adolescents are more involved in delinquent behavior compared to female adolescents. For every 1 girl that engages in acts of delinquent behavior, there are approximately 11.8 boys.

4.2.2 Age Group

14 (10.94%) of the respondents were aged between 12 to 13 years. This is the smallest group, indicating fewer participants in the early adolescent stage.

73 (57.03%) were aged 14 to 15 years. This group has the highest number of respondents implying that majority of respondents are in the middle adolescent stage. 41 (32.03%) of the respondents were aged 16 to 17 years, a significant representation of late adolescents. These trends suggest that the population is predominantly composed of early to mid-teens, with a peak in representation around the 14-15 age range.

Figure 2: Age Distribution of Respondents



Source: Primary Data, 2024

4.2.3 Education Status

08 (6.25%) of the respondents had no formal education, while 12 (9.38%) of the respondents had enrolled in pre-primary school. 74 (57.81) participants had completed primary school and 34 (26.56%) had enrolled in lower secondary school. None of the respondents had reached upper secondary school.

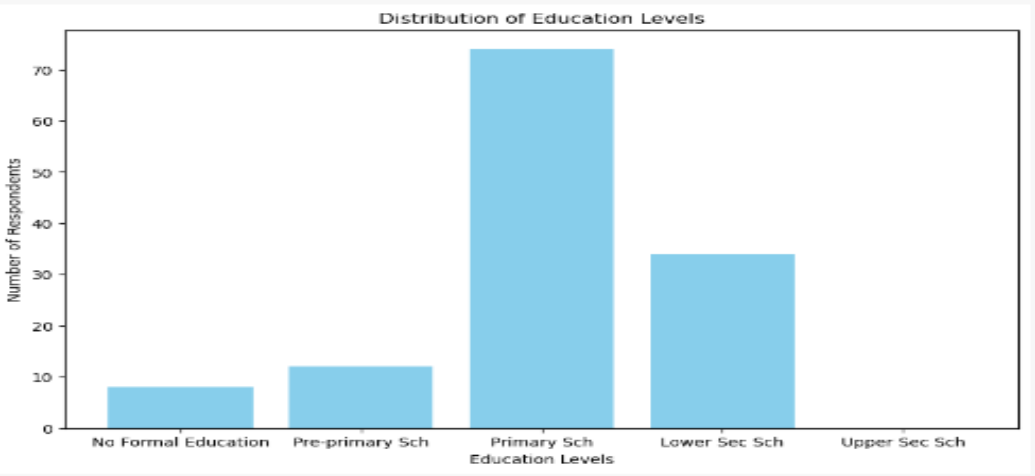
A small minority, 6.25% or 8 respondents, had no formal education, indicating that there could be significant barriers to accessing educational resources.

A slightly larger group, 9.38% or 12 respondents, were enrolled in pre-primary school, suggesting early childhood education was within reach for some but not all. The majority, 57.81% or 74 participants, completed primary school, which is typically the most accessible level of education and often compulsory. Over a quarter, 26.56% or 34 respondents, progressed to lower secondary school, showing a substantial drop-off

from primary education, which could be due to various factors such as socioeconomic barriers, academic challenges, or personal circumstances like PTSD which could lead to indulging in delinquent behaviour. Notably, none of the respondents had reached upper secondary school, highlighting a critical gap in the continuation of formal education beyond the lower secondary level.

This distribution suggests that while primary education is relatively well-attended, there are significant challenges in transitioning to higher levels of education. The absence of respondents at the upper secondary level is particularly concerning and warrants further investigation into the causes, which could include involvement in delinquent behaviour because of PTSD hence ending up at KNRC for rehabilitation.

Figure 3: Distribution of Education Levels



Source: Primary data, 2024

4.2.4 Female Education Status

04 (40%) of the 10 respondents had enrolled in primary school while 06 (60%) had enrolled in lower secondary school. The older respondents who had attended secondary school committed more delinquent acts compared to their counterparts in primary school.

4.2.5 Relationship between Juveniles and Perpetrators of Violence

Thematic analysis was used to analyze the qualitative data. From the information shared, the perpetrators of abuse were as follows;

Guardians were 40 (31.3%) which was the highest figure implying that abuse was perpetrated most by the people who are responsible for the children's wellbeing. Community Members were 36 (28.1%) suggesting that juveniles were vulnerable to abuse within their broader community hence a need for community-wide awareness and prevention programs.

Fathers were responsible for 24 (18.8%) of the abuse. The high incidence of abuse by fathers suggests a need for targeted interventions that address family dynamics and provide support for fathers to prevent abusive behaviors.

Mothers 5 (3.9%), Siblings 5 (3.9%), and Neighbors 5 (3.9%) were responsible for perpetrating abuse as shown above. These numbers, while lower, still indicate that abuse can occur within the immediate social circle of a juvenile, where they should feel safest.

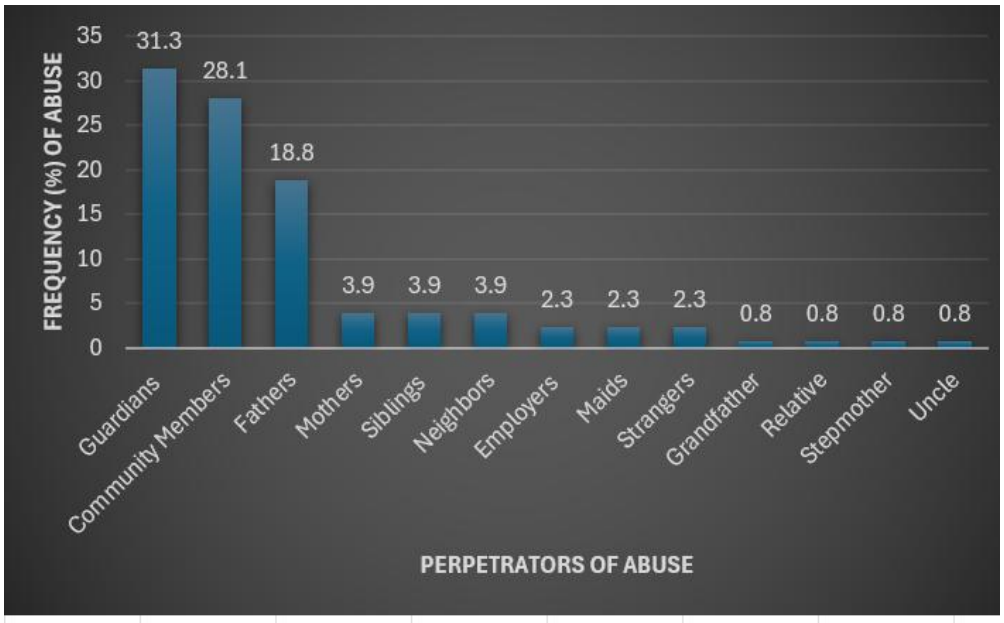
Employers 3(2.34%), Maids 3 (2.34%) and Strangers 3 (2.34%) perpetrated abuse as indicated. Abuse by employers and strangers, though less

frequent, points to risks juveniles face in work environments and public spaces. The abuse was also perpetrated by grandfather 1(0.8%), relative 1 (0.8%), stepmother 1 (0.8%) and Uncle 1 (0.8%). While these figures were relatively low, even a single instance of abuse is significant and warrants attention.

This analysis suggests that juveniles face abuse from a variety of sources, both within the family and the community at large. It underscores the importance of comprehensive strategies that include education, support systems, and legal frameworks to protect juveniles from abuse. Additionally, it's crucial to foster a safe environment where juveniles can report abuse without fear of retribution or disbelief.

Figure 4:

Relationship Between Juveniles and the Perpetrators of Violence



Source: Primary Data, 2024.

4.2.6 Delinquent Acts Committed by Juveniles at KNRC

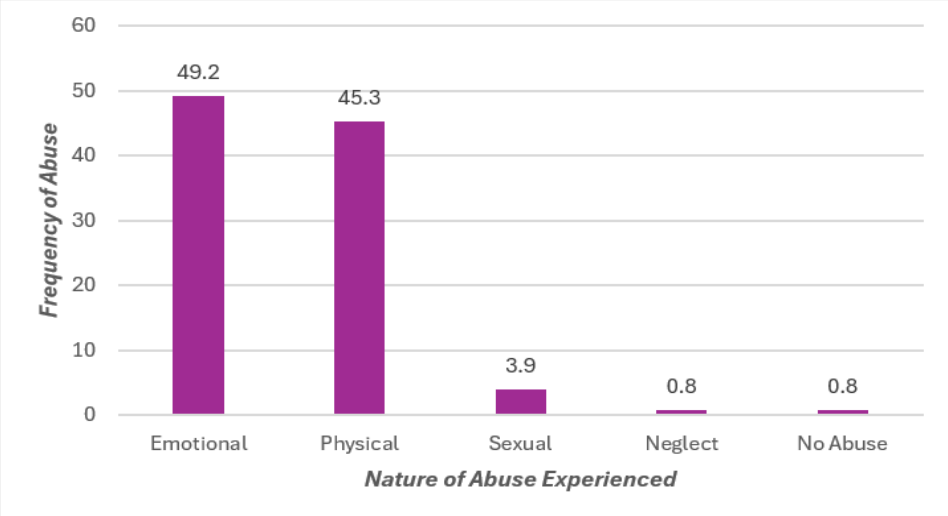
From the FGDs held with the adolescents, the staff members, and the KII with the Principal of KNRC, the most rampant offense for which the adolescents were committed to the center was aggravated defilement. The adolescents were committed to KNRC for the following offenses, aggravated defilement, murder (5), arson, theft, housebreaking and theft, malicious damage to property, aggravated robbery (4), robbery (1), defilement, and rape (7). However, the aggregated data was not shared fully even when the researcher requested it.

4.3 Nature of Traumatic Events Experienced by Juveniles

63 (49.2%) of the respondents shared that they had experienced emotional abuse, 58 (45.3%) reported physical abuse, 5 (3.9%) reported sexual abuse, and 1 (0.8%) reported negligent treatment. 1 (0.8%) reported not having experienced any abuse during childhood. The types of abuse reported can all be traumatic and consequently lead to PTSD. Emotional abuse at 49.2% leads to complex PTSD involving chronic trauma and causing several extensive issues with negative self-thoughts, emotional regulation, and interpersonal relationships.

Figure 5:

Nature of Traumatic Violence Experienced by Juveniles in Childhood



Source: Primary Data; 2024.

4.4 Relationship Between PTSD and Delinquent Behavior in Adolescents.

To establish the relationship between PTSD and delinquent behavior, the UCLA PTSD DSM-IV Adolescent version was administered to the adolescents. A score of 38 signifies the presence of PTSD. (DSM-IV). The respondents who scored 38 and above were put in one group and those who scored less than 38 were grouped in another group.

46 members who scored 38 and above were placed in Group One while 82 members with a total score of less than 38 were placed in Group Two. Using SPSS, a t-test was conducted to determine the differences between the means of the two groups. The mean for group one was 2.33, Standard Deviation 0.990, and Standard Error Mean 0.146. For group two, the mean was 1.87, Standard Deviation 1.097, and Standard Error Mean 0.121. This means that there was no statistically significant

difference between the means of the two groups at the 5% significance level.

Figure 6: T-Test for the Two Groups

Group Statistics

	Score	N	Mean	Std. Deviation	Std. Error Mean
PTSD	>= 38	46	2.33	.990	.146
	< 38	82	1.87	1.097	.121

4.5 Presentation of Qualitative Data

The following section presents the information that was gathered through qualitative research. Qualitative Data analysis was collected concurrently with quantitative data using focus group discussions and key informant interviews. A total of 5 FGDs and 1 KII were conducted. 2 FGDs were conducted with the male adolescents, 2 FGDs with the female adolescents, 1 FGD with the staff members, and 1 KII with the Principal. These collected data on the traumatic events experienced in childhood, the relationship between the juveniles and the perpetrators of the violence, and the causes of the violence and how they affected the juveniles. Data was also collected on the behavior for which they were committed to KNRC, and the relationship between experience of traumatic events and delinquent behavior.

In interacting with the respondents to ascertain the traumatic events experienced by the adolescents in childhood, their relationship with the perpetrators, the causes of the violence and their effects on the adolescents, and the behavior for which the adolescents were committed to KNRC, the following information was shared.

4.5.1 Perceived Motivations for Delinquent Behavior among Juveniles with PTSD.

46 (36%) of the adolescents had a score of at least 38 and above in the UCLA PTSD Index for DSM IV, implying that they had symptoms of PTSD. All the 10 girls were within this category. 4 FGDs were formed of five girls each and six boys each, a total of 22 respondents, as that was the number that the staff approved of.

In the FGDs, the adolescents shared what had triggered or motivated delinquent behavior as follows:

Some adolescents developed negative emotions towards their abusers and when they became strong enough to fight back, they fought back as a defence mechanism because they were overwhelmed by the situation. For instance, the adolescent who beat up his stepmother when he could no longer endure her mistreatment.

All the adolescents who were charged with sexual abuse had deep psychological trauma from witnessing their caregivers having sex. This happened because of poverty where the children and caregivers shared a single room and the caregivers indulged in sex thinking that the children

were asleep. Most of the adolescents developed feelings towards the opposite sex and ended up having sex with younger girls, behavior that is considered delinquent. Consequently, they ended up at KNRC.

Poor self-regulation and difficulties adhering to social norms was also a trigger for delinquent behavior. For instance, an adolescent shared that he was always mocked and ridiculed by his caregivers and stepsiblings. Consequently, his self esteem was destroyed, and he had to act contrary to the social norms to get attention that he would never get when he did the right thing. He beat up a child in the neighborhood who mocked him resulting in grievous assault. This act led him to KNRC.

Some of the adolescents shared that they had indulged in delinquent behavior because of drugs and substance abuse. One of the boys shared that when he was under the influence of drugs, he was very confident and could do anything. He had raped a woman under the influence of drugs and was arrested, tried, and committed to KNRC.

PTSD can cause negative thoughts about an individual or their surroundings, distorted feelings like blame or guilt, and loss of interest in activities that were previously enjoyable which could cause one to venture into something more enjoyable. An adolescent shared that he felt unwanted at home and blamed himself for his mother leaving his father. He lost interest in family life, and he joined a street gang to explore new things like pickpocketing and house breaking. One day, they

broke into a house, and they were arrested and committed to KNRC after trial.

These triggers of delinquent behavior highlight the importance of addressing the underlying trauma and providing appropriate treatment and interventions to juveniles with PTSD to prevent delinquent behavior. The Counselling psychologist should foster an environment that builds strengths, constructive goals and prosocial values. The goal of rehabilitation should be support rather than punishment. It is important to focus on treating the root causes of the trauma rather than the delinquent behavior itself.

4.5.2 Experiences of the Adolescents

81 (63.3%) of the adolescents had been traumatized by the abuse from the people they lived with at home. These included guardians, fathers, mothers, stepparents, grandparents, siblings, maids and other relatives. Since the abuse was happening in the homes, the adolescents had to live with it and pretend like it was nonexistent because their survival and wellbeing was attached to the perpetrators. This aligns with Freyd's (1996) Betrayal Trauma theory. One of the adolescents said that ***"After my mother left, my father married another woman and that was the beginning of my suffering. My stepmother hated me so much. Although she had children who were older than me, she made me stay at home to do all the housework while her children went to school. I would cook food and she would give me very little and give***

most of it to her children, and this would make me very angry. My father worked away from home and would return over the weekend. My stepmother would tell him how I had refused to go to school and had disrespected her. My father would get his leather belt and beat me relentlessly without even giving me an opportunity to defend myself. I put up with the mistreatment because I had nowhere to go since I did not know where my mother was. Eventually, I went to live on the streets."

A female adolescent shared that "***My mother could not meet our needs as a single mother. She had six children, and she earned a living through casual labor. She used to quarrel with us and beat us whenever she did not have money. She would even beat me for no reason. One day I burnt the food because I was playing, and she beat me very badly. I dropped out of school in primary six because we had no school fees, and as the eldest child I had to work to support my mother take care of my siblings. Someone got for me a job as a house girl. When I reached there, the work was too much, and my boss used to shout at me and beat me whenever I did something wrong. After six months, I wanted to leave but she refused to give me my money. I became very angry and decided to revenge on her baby. When I knew that she had gone to work, I tried to strangle the baby, but she found me. She beat me and took me to the police. The judge sent me here in the children's prison."***

The statement about strangling the baby was corroborated by a staff member who shared that most of the girls had been convicted of attempted murder. They were working as maids who tried to kill the babies of their bosses.

Asked why a male adolescent was at KNRC, he said that "***I got tired of the mistreatment by my stepmother in the absence of my father. One day when she accused me falsely for stealing money, I became very angry and beat her in the presence of my father. I was brought here, and I would rather remain here than return to that home.***"

A female adolescent shared that, "***My father used to beat my mother whenever he returned home. One day, he fought with her in the middle of the compound. He was seated on her and hitting her while my mother screamed for help. I ran out from the house, picked a piece of firewood which was in the compound and hit him on the head so that he would let go of my mother. He fell off and died and then I was arrested and brought here.***"

"***I grew up in a very poor family and my stepmother used to mistreat me. I was not able to attend school and so my father got for me a job as a house maid. I used to beat the baby for disturbing me when I was doing my housework, and when my boss found out, she chased me away. I left but later broke into the house to steal clothes. She caught me and took me to the police after telling my father. They brought me to Kampiringisa but what worries me most is that I***

cannot go back to the village because they all know that I am in prison. The people will laugh at me when they see me," an adolescent girl shared during the FGD.

4.5.3 Perspectives of KNRC Staff

The FGD with the staff members also revealed that most of the adolescents lived in broken families. Some stayed with guardians, others with single mothers, and some with their fathers and stepmothers. At the time of the study, none of the adolescents at KNRC came from a home with both biological parents. They shared that most of these adolescents had faced traumatic experiences in the form of neglect, gross mistreatment, denial of education, food, and mistreatment by stepparents. They were forced to go on the streets because of the hard life at home, and because they did not experience love. One staff member said that "***The way the adolescents relate with one another shows that they never experienced love but rather violence in their family settings. They are very rough with one another.***"

In a KII with the Principal, she shared that "***The juveniles who come to this place commit both misdemeanors and felonies. However, the most predominant offense is aggravated defilement.***" Aggravated defilement, according to the Penal Code Act (PCA) Chapter 120 of Uganda, refers to more severe circumstances of defilement, which is a term used to describe the act of having sexual intercourse with minors under the age of 12 years. "***Many of these children come from broken***

families, and they have experienced abuse ranging from emotional abuse, physical abuse, sexual abuse, negligent treatment, and exploitation. This abuse is experienced in the family setting, and the children grow up while resenting their caregivers and become very bitter towards them. Some end up running away from home and living on the streets and they end up indulging in crime with influence from their peers."

From this comment, we see the relationship between traumatic violence that happens in the home setting, and delinquent behavior when adolescents move to live on the street.

A staff member shared that "***The children have gone through violence before joining peer groups that influence them in committing offences. Some of them have been raised by elderly grandparents who have no influence over these children as they grow older. Adolescents who have committed sexual offenses live in a single room with their caregivers and they see them having sex. As their bodies mature, they develop feelings and end up sexually abusing younger girls as they are afraid of approaching girls who are their agemates. This is because their agemates will ask for money, yet they do not have it.***"

The Principal and staff members shared that adolescents were admitted to the institution when they were scared, shy, withdrawn and hopeless.

“They have heard that they are going to a children’s prison, and they are scared after passing through the courts of law,” the principal shared. Adolescents on arrival are placed in isolation and provided with counselling and guidance for at least one month especially for those that have committed violent offenses like aggravated robbery, aggravated defilement, and murder. After that they are joined with the other children where group counseling is done. The adolescents are provided psychosocial support, sessions on mindset change, vocational skills, co-curricular activities, and formal education for some.

The period spent under rehabilitation ranges from six months for the misdemeanors to three years for the felonies. The adolescents are then resettled in their communities.

In response to how many adolescents had returned to the centre after rehabilitation, the principal said that “***There are only two boys, one is a refugee and the other a street child.”***

In response to the relationship between experience to traumatic events and delinquent behavior, the staff mentioned that although most of the adolescents who committed crime had experienced violence in the family setting, there were some that had not experienced violence but committed crimes due to peer influence.

Chapter Five

Discussion of Results

5.0 Introduction

The study examined the nature of traumatic violence experienced by juveniles at KNRC during their childhood, explored whether there was a significant correlation between PTSD and delinquent behavior in adolescents, and established the perceived motivations for delinquent behavior among juveniles with PTSD at KNRC.

5.1 The Nature of Traumatic Violence Experienced by Juveniles at KNRC During their Childhood.

The results of the study revealed that 63 (49.2%) of the respondents had experienced emotional abuse, followed by 58 (45.3%) who had experienced physical abuse during childhood. Only 1 (0.8%) respondent reported not having experienced any abuse during childhood. 127 (99.2%) of the respondents had experienced some form of abuse during childhood. The types of abuse reported can all be traumatic and consequently lead to PTSD.

Emotional abuse, which was the highest traumatic violence reported, leads to complex PTSD involving chronic trauma and causing several extensive issues with negative self-thoughts, emotional regulation, and interpersonal relationships.

The study also revealed that most of the violence towards children was perpetrated within the family setting. It accounted for 60.24%, with guardians at 31.3% and fathers at 18.8%. The other perpetrators in the family setting were mothers, elder siblings, and maids. Members from the extended family like uncles, and grandfathers also perpetrated violence in the family setting. Since most of the abuse takes place in the family setting, this implies that abuse occurs within the immediate social circle of children, where they should feel safest. Given that the children depend on the adults for survival, they bear with the abuse in return for provision of basic needs like food.

These results align with the Betrayal Trauma Theory advanced by Freyd (1996). The theory notes that children who are abused by their caregivers may block betrayal from their mind and develop dissociative amnesia. This is because they are dependent on the caregiver for their daily needs and survival. The brain ignores betrayal to maintain the relationship with the caregiver and survive, leading to betrayal blindness. If the child processed the betrayal normally, they could avoid the caregiver and stop interacting with them, hence threatening their survival.

According to Freud's Psychoanalytic theory, when unresolved instincts and drives within the human psyche are in conflict, delinquent behavior among youths will occur. When a child experiences traumatic violence, they may respond to it through repression where the child gets stuck at

the psychological stage of the traumatic event. As a way of coping with the traumatic event, the child forgets about the experience. Later in life, the child may unconsciously engage in delinquent behavior, which behavior is one of the symptoms of post-traumatic stress disorder. The child is unaware of what is in their unconscious and the conscious which is portrayed through delinquent behavior is only the tip of the iceberg of a bigger problem.

According to Freud, buried emotions could result in maladaptive responses whereby adolescents with PTSD symptoms might act out through delinquent behavior to express unresolved conflicts and emotions.

This behavior reflects the conflict between one's superego and their childhood impulses that are revitalized towards adolescence. Delinquent behavior results when one's superego is very defective, weak, or incomplete and it cannot control the revived violent and primitive childhood impulses, (Schoenfeld 1971).

The results from the study fit in with my proposition that children face violence in the family setting by the people who are responsible for their survival. However, they cannot voice it out at that time and this later manifests as PTSD.

5.2 Perceived Motivations for Delinquent Behavior among Juveniles with PTSD at KNRC.

From the study findings, the following were the perceived motivations for delinquent behavior among the juveniles with PTSD; negative emotions towards their abusers, deep psychological trauma, poor self-regulation and difficulties adhering to social norms, drug and substance abuse.

The study findings agree with Freud's psychoanalytic perspective on the fight-or-flight response. The fight-or-flight response, or the acute stress response, is a physiological reaction to perceived threats or stress which prepares the body to either confront or flee from the threat. It is a manifestation of the ego's defence mechanisms. When faced with a stressful situation, the ego decides whether to confront the issue head-on (fight) or avoid it (flight). This decision-making process is influenced by the individual's past experiences, unconscious fears, and desires.

The fight-or-flight response can be linked to the concept of anxiety, which Freud described as a signal to the ego that something dangerous is about to happen. The ego then must manage this anxiety and decide on a course of action which is the delinquent behavior among the adolescents.

5.3 Relationship between PTSD and Delinquent Behavior in Adolescents

The study revealed that 46 (36%) of the respondents had symptoms of PTSD. These scored 38 and above on the UCLA PTSD Index DSM-IV Adolescent version. These respondents were placed in one group and those who scored less than 38 were placed in another group.

All the adolescents at KNRC had engaged in delinquent behavior and they were consequently committed to the centre for rehabilitation. From the study, the staff shared that the most rampant offence for which the adolescents were committed to the centre was aggravated defilement. The other offenses included murder, arson, theft, housebreaking and theft, malicious damage to property, aggravated robbery, robbery, defilement, and rape. All these adolescents were tried in courts of law before being committed to KNRC. This was indicative of the delinquent behavior among adolescents.

The results from the t-test (Pearson correlation) which was conducted to determine if there were differences between the means of the two groups showed that there was no statistically significant difference between the means of the two groups at the 5% significance level. This means that the relationship between PTSD and delinquent behavior though present, was not significant.

These findings are in line with Vaughn et al. (2014)'s study where the relationship between PTSD and delinquency was examined in a sample of over 500 adolescents. The study established that while PTSD was

associated with increased symptoms of depression and anxiety, it was not significantly related to delinquent behavior.

In the examination of the relationship between PTSD and delinquency in a sample of over 100 juvenile offenders, Kerig et al. (2012) found that while PTSD was associated with increased symptoms of anxiety and depression, it was not significantly related to delinquent behavior. These findings are similar with my findings.

DeLisi et al. (2021) state that trauma reactions have no direct significant effect on psychopathy, and psychopathy does not mediate the relation between trauma reactions and the examined outcomes. This is in line with the research findings.

The findings of the study relate to Wilson et al., (2009) who observed that statistically, there's no direct link from early violence exposure to antisocial behavior but suggest that many factors influence this relationship.

Freyd (1996) advanced that PTSD symptoms are associated with an increased risk of delinquent behavior especially in adolescents. Such trauma disrupts normal emotional and psychological development leading to emotional dysregulation, dissociation, and difficulties in forming healthy relationships, factors that contribute to behaviors that are termed as delinquent.

The study set out to establish if the relationship between PTSD and delinquent behavior was significant in line with Freyd's (1996) Betrayal

Trauma Theory. The results of the study revealed that this relationship though present. was not statistically significant, implying that not every child who is victimized or exposed to traumatic events develops PTSD and commits delinquent behavior.

While the study did not find a significant relationship between PTSD and delinquent behavior, it did not necessarily find no relationship at all. It was found that the relationship between PTSD and delinquent behavior was not statistically significant.

Chapter Six

Conclusion and Recommendations

6.0 Introduction

This section highlights the conclusions and recommendations of the study in line with the objectives.

6.1. Conclusion

Much as children develop PTSD because of childhood trauma, and later engage in delinquent acts as teenagers, the relationship between PTSD and delinquent behavior, though present, is not statistically significant.

6.1.1 The Nature of Traumatic Violence Experienced by Juveniles at KNRC During their Childhood.

1. The high incidence of emotional (49.2%) and physical (45.3%) abuse experienced by juveniles within the family setting is alarming. Furthermore, this abuse is perpetrated by the immediate family members (60.24%). Although the family setting is the inner circle where a child should feel the most secure, children experience lots of abuse. Most of the children (99.2%) who experience abuse live in broken families. Most of them live with guardians, others with biological fathers and stepmothers, and others with single mothers. These perpetrate violence against children due to frustration, lack of love for children who are not biological, and poverty.

6.1.2 Perceived Motivations for Delinquent Behavior among Juveniles with PTSD.

1. The study findings indicate that the delinquent behavior among juveniles with PTSD at KNRC is motivated by several factors:
2. Negative emotions towards their abusers, which may include feelings of anger, resentment, or a desire for revenge.
3. Deep psychological trauma resulting from their abusive experiences, which can have a profound impact on their mental health and behavior.
4. Poor self-regulation, which refers to difficulties in managing emotions and behaviors in a socially acceptable way.

5. Difficulties adhering to social norms, which can lead to behavior that is seen as deviant or delinquent.
6. Drug and substance abuse, which can exacerbate existing issues and lead to further delinquent acts.

6.1.3 The Relationship between PTSD and Delinquent Behavior in Adolescents.

1. The study conducted at KNRC found that all the adolescents had engaged in various forms of delinquent behavior, with aggravated defilement being the most common offense. Despite the high rates of emotional and physical abuse (94.5%) experienced during childhood, the statistical analysis using a t-test (Pearson correlation) revealed no significant relationship between PTSD and delinquent behavior at the 5% significance level. This suggests that while many adolescents who experience abuse exhibit delinquent behavior, not all develop PTSD.
2. While the study did not find a significant relationship between PTSD and delinquent behavior, it did not necessarily find no relationship at all. It was found that the relationship between PTSD and delinquent behavior was not statistically significant. The findings are in line with Vaughn et al. (2014) and Kerig et al. (2012)'s studies in examining the relationship between PTSD and delinquent behavior.
3. The findings highlight the resilience of some individuals, indicating that trauma does not inevitably lead to PTSD or delinquency in every case.

4. These motivations are complex and interrelated, often stemming from the juveniles' traumatic experiences and the subsequent challenges they face in coping with their past.

6.2 Recommendations

6.2.1 The Nature of Traumatic Violence Experienced by Juveniles at KNRC During their Childhood.

1. Community education programs should be implemented to raise awareness about the signs of abuse and its long-term effects. Positive parenting techniques should be encouraged, and support provided for at-risk families.
2. Robust support systems should be established for children who have experienced abuse, including counseling services, and legal advocacy. Adolescents should be offered therapeutic programs that address complex PTSD and help children develop healthy coping mechanisms and interpersonal skills. This will ensure healing and rehabilitation.
3. By addressing the root causes of abuse and providing comprehensive support for victims, we can mitigate the long-term effects of childhood trauma and help prevent the cycle of violence from continuing. It's crucial to create a safe environment for children, both within the family and in the wider community.

4. Creation of confidential and accessible reporting systems for children to report abuse without fear of retribution is essential.
5. Provision of accessible mental health services for children and families affected by abuse, including therapy that addresses trauma and promotes emotional regulation should be put into consideration.
6. By implementing these recommendations, we can work towards creating a safer and more supportive environment for children, reducing the incidence of abuse, and helping those affected by it to heal and thrive.

6.2.2 Perceived Motivations for Delinquent Behavior among Juveniles with PTSD.

From the study, these are the recommendations.

1. Provision of access to psychological counseling and therapy to help juveniles process negative emotions towards their abusers and cope with deep psychological trauma will ensure emotional support and therapy.
2. Implementation of behavioral intervention programs that focus on improving self-regulation skills and adherence to social norms.
3. Offering specialized substance abuse treatment programs that address the specific needs of juveniles with PTSD.
4. Education of juveniles on social norms and the consequences of deviant behavior, along with teaching conflict resolution and positive social interaction skills.

5. Establishment of mentorship programs that connect juveniles with positive role models who can provide guidance and support.
6. Regularly monitor the progress of these interventions and evaluate their effectiveness in reducing delinquent behavior and supporting juveniles' recovery from trauma.
7. These triggers of delinquent behavior highlight the importance of addressing the underlying trauma and providing appropriate treatment and interventions to juveniles with PTSD to prevent delinquent behaviour. The counselling psychologist should foster an environment that builds strengths, constructive goals, and prosocial values. The goal of rehabilitation should be support rather than punishment. It is important to focus on treating the root causes of the trauma rather than the delinquent behavior itself.

6.2.3 Relationship between PTSD and Delinquent Behavior in Adolescents.

Here are some recommendations to address the issue of delinquent behavior among adolescents.

1. Programs with a focus on building resilience in children and adolescents should be developed. These programs can teach coping strategies, problem-solving skills, and ways to foster positive relationships.

2. Individualized support should be provided with the recognition that each child's response to trauma is unique. Provision of personalized support considers the individual's experiences, strengths, and needs.
3. Staff at KNRC should be trained in trauma-informed care to ensure they understand the impact of trauma and how to support those who have experienced it. More still, a counseling psychologist can be recruited to support with this.
4. While the UCLA PTSD Reaction Index provides a structured approach to assessing PTSD symptoms, clinical judgment is essential in interpreting the results. Clinicians consider the context of the symptoms, the adolescent's overall mental health, and other factors that might influence the assessment. If the assessment indicates the presence of PTSD symptoms, it may be followed by a more detailed evaluation and the development of a treatment plan.
5. By implementing these recommendations, we can better support adolescents who have experienced trauma and help prevent the development of delinquent behavior.

6.3 Areas for Further Research

Research in Uganda should focus on PTSD as an independent factor instead of focusing on trauma in general to increase the interventions for adolescents with PTSD.

To evaluate the efficiency and effectiveness of various therapeutic approaches in the context of Uganda, there's need for more research on

effective and efficient interventions and therapies for PTSD among adolescents and juvenile delinquents in Uganda.

There’s need for longitudinal studies to track the impact of PTSD on delinquent behavior to understand how PTSD influences delinquent behavior throughout adolescence.

There’s need for further research into the factors that contribute to resilience in the face of trauma to inform policy and practice.

References

Amin, M. E. (2005). *Social science research: Conception, methodology and analysis*. Makerere University.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). American Psychiatric Association.

Cernkovich, S. A., Lanctôt, N., & Giordano, P. C. (2008). Predicting adolescent and adult antisocial behavior among adjudicated delinquent females. *Crime & Delinquency, 54*(1), 3-33.

Cohen, J. A., & Mannarino, A. P. (2008). Trauma-focused cognitive behavioural therapy for children and parents. *Child and Adolescent Mental Health, 13*(4), 158-162.

DeLisi, M., Pechorro, P., Gonçalves, R. A., & Maroco, J. (2021). Trauma, Psychopathy, and Antisocial Outcomes among Community Youth: Distinguishing Trauma Events from Trauma Reactions. *Youth Violence and Juvenile Justice*, *19*(3), 277-291.

Eaton, B. (2020). The relationship between trauma and juvenile delinquency. Retrieved from https://www.lcsc.edu/media/2435/eatonjs499trauma-and-delinqency-research2020.pdf

Feiring, C., Miller-Johnson, S., & Cleland, C. M. (2007). Potential pathways from stigmatization and internalizing symptoms to delinquency in sexually abused youth. *Child Maltreatment, 12*(3), 220-232.

Feist, J., Feist, G. J., & Roberts, T. (2018). Theories of personality (9th ed.). Retrieved from https://de1lib.org/book/5394270/207954

Finkelhor, D., Hamby, S. L., Ormrod, R., & Turner, H. (2005). The Juvenile Victimization Questionnaire: Reliability, validity, and national norms. *Child Abuse & Neglect, 29*(4), 383-412.

Flisher, A. J., Kramer, R. A., Grosser, R. C., Alegria, M., Bird, H. R., Bourdon, K. H., … & Hoven, C. W. (1997). Correlates of unmet need for mental health services by children and adolescents. *Psychological Medicine, 27*(5), 1145-1154.

Ford, J. D., Fraleigh, L. A., Albert, D. B., & Connor, D. F. (2010). Child abuse and autonomic nervous system hyperresponsivity among psychiatrically impaired children. *Child Abuse & Neglect, 34*(7), 507-515.

Freyd, J. J. (1996). Betrayal trauma: The logic of forgetting childhood abuse. Cambridge, MA: Harvard University Press.

Freyd, J. J., Klest, B., & Allard, C. B. (2005). Betrayal trauma: Relationship to physical health, psychological distress, and a written disclosure intervention. *Journal of Trauma and Dissociation, 6*(3), 83–104.

Freyd, J. J., DePrince, A. P., & Gleaves, D. (2007). The state of betrayal trauma theory: Reply to McNally (2007) — Conceptual issues and future directions. *Memory, 15,* 295–311.

Gupta, S. (2023). Betrayal trauma: The impact of being betrayed.

Hammer, C. S. (2011). The importance of participant demographics. *American Journal of Speech-Language Pathology, 20*(4), 261.

Human Relations. (2022). Survey response rates: Trends and a validity assessment framework. *Human Relations, 75*(8), 1560–1584. https://doi.org/10.1177/00187267211070769

Kampiringisa National Rehabilitation Centre. (n.d.). Retrieved from [URL]. Uganda Prisons Service.

Kerig, P. K., Bennett, D. C., Thompson, M., & Becker, S. P. (2012). "Nothing really matters": Emotional numbing as a link between trauma exposure and callousness in delinquent youth. *Journal of traumatic stress, 25*(3), 272-279.

Maas, C., Herrenkohl, T. I., & Sousa, C. (2008). Review of research on child maltreatment and violence in youth. *Trauma, Violence, & Abuse, 9*(1), 56-67.

Mueser, K. T., & Tuab, J. (2008). Trauma and PTSD among adolescents with severe emotional disorders involved in multiple service systems. *Psychiatric Services, 59*(6). https://doi.org/10.1176/ps.2008.59.6.627

National Child Traumatic Stress Initiative. (2024).

Quinn, D. (2023, August 3). Types of trauma: The 7 most common types and their impacts. *Sandstone Care Newsletter*.

Schoenfeld, C. G. (1971). A psychoanalytic theory of juvenile delinquency. *Crime & Delinquency, 17*(4), 469–480. https://doi.org/10.1177/001112877101700412

Schultz, D. P., & Schultz, S. E. (2017). Theories of personality (11th ed.). Retrieved from https://de1lib.org/book/3658067/4e2789

Shufelt, J. L., & Cocozza, J. J. (2006). Youth with mental health disorders in the juvenile justice system: Results from a multi-state prevalence study (pp. 1-6). Delmar, NY: National Center for Mental Health and Juvenile Justice.

Smith, D. K., Leve, L. D., & Chamberlain, P. (2006). Adolescent girls' offending and health-risking sexual behavior: The predictive role of trauma. *Child Maltreatment, 11*(4), 346-353.

Stupar et al. (2021). Child Adolescent Psychiatry Mental Health, 15, Article 26. https://doi.org/10.1186/s13034-021-00378-2

Terr, L. C. (2003). Childhood traumas: An outline and overview. *Focus, 1*(3), 322-334.

Uganda. (1950). *The Penal Code Act, Chapter 120*. Retrieved from ULII

Vaughn, M. G., Salas-Wright, C. P., DeLisi, M., & Maynard, B. R. (2014). Violence and externalizing behavior among youth in the United States: Is there a severe 5%?. *Youth violence and juvenile justice*, *12*(1), 3-21.

Wilson, H. W., Stover, C. S., & Berkowitz, S. J. (2009). Research Review: The Relationship Between Childhood Violence Exposure and Juvenile

Antisocial Behavior: A Meta-Analytic Review. *Journal of Child Psychology and Psychiatry*, *50*(7), 769-779.

Yadav, S., & Ranaut, A. (2023). Juvenile Justice Reforms: Evaluating the Effectiveness of Rehabilitation Vs Punishment. *International Journal for Multidisciplinary Research*, *5*(6).

Appendix A

UCLA PTSD INDEX FOR DSM IV (Adolescent Version) Page 1 of 3

Name _____ Age _____ Sex (Circle): Girl /Boy

Today's Date (**write day, month, and year**) _____ Class _____ School _____ Teacher _____District_____

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED or could have been. Some people have had these experiences; some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

FOR EACH QUESTION: Tick "Yes" if this scary thing **HAPPENED TO YOU. Check "No"** if it **DID *NOT* HAPPEN TO YOU**

S/N	Statement	Yes	No
1	Being in a big earthquake that badly damaged the building you were in.		

2	Being in another kind of **disaster**, like a fire, storm, flood, or hurricane.		
3	Being in a bad **accident**, like a **very serious** car accident.		
4	Being in place where a **war** was going on around you.		
5	Being **hit, punched, or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).		
6	Seeing a family member being **hit, punched, or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).		
7	Being **beaten up, shot at, or threatened to be hurt badly** in your town or village		
8	Seeing someone in your town or village being **beaten up, shot at, or killed.**		
9	Seeing a **dead body** in your town (do not include funerals).		
10	Having an adult or someone much older touch your **private sexual body parts** when you did not want them to.		
11	Hearing about the **violent death or serious injury** of a loved one.		
12	Having **painful and scary medical treatment in a hospital** when you were very sick or badly injured.		
13	**OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to you that was **REALLY SCARY, DANGEROUS OR VIOLENT?**		
14 a	If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank		
14 b	If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOU THE MOST NOW** in this blank		
14 c	About how long ago did this bad thing (your answer to [a] or [b]) happen to you?		
14 d	Please write what happened ……		

	…… …… ……

FOR THE *NEXT* QUESTIONS, please **TICK [YES] or [NO]** to answer **HOW YOU FELT during or right after** the bad thing happened that you just wrote about in Question 14.

S/N	Question	Yes	No
15	Were you scared that you would die?		
16	Were you scared that you would be hurt badly?		
17	Were you hurt badly?		
18	Were you scared that someone else would die?		
19	Were you scared that someone else would be hurt badly?		
20	Was someone else hurt badly?		
21	Did someone die?		
22	Did you feel very scared, like this was one of your most scary experiences ever?		
23	Did you feel that you could not stop what was happening or that you needed someone to help?		
24	Did you feel that what you saw was disgusting or gross?		
25	Did you run around or act like you were very upset?		
26	Did you feel very confused?		
27	Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?		

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened to you that you wrote about in Question #14 on page 2. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 3 to help you decide how often the problem has happened in the past month.

PLEASE BE SURE TO ANSWER ALL QUESTIONS

HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
1_{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2_{B4} When something reminds me of what happened, I get very upset, afraid or sad.	0	1	2	3	4
3_{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4_{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5_{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6_{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7_{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4
8_{C5} I feel alone inside and not close to other people.	0	1	2	3	4
9_{C1} I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10_{C6} I have trouble feeling happiness or love.	0	1	2	3	4
11_{C6} I have trouble feeling sadness or anger.	0	1	2	3	4
12_{D5} I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13_{D1} I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14_{AF} I think that some part of what happened is my fault.	0	1	2	3	4
15_{C3} I have trouble remembering important parts of what happened.	0	1	2	3	4
16_{D3} I have trouble concentrating or paying attention.	0	1	2	3	4
17_{C2} I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18_{B5} When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	0	1	2	3	4
19_{C7} I think that I will not live a long life.	0	1	2	3	4
$20_{D?}$ I have arguments or physical fights.	0	1	2	3	4
21_{C7} I feel pessimistic or negative about my future.	0	1	2	3	4
22_{AF} I am afraid that the bad thing will happen again.	0	1	2	3	4

Appendix B

Structured Interview Questions for Juveniles in FGDs

1.What kind of violence or traumatic events did you experience during your childhood?

2.What is the relationship between you and the perpetrators of the violence?

3.How long were you exposed to the violent situation?

4.How often did the violence happen?

5. What was the cause of the violence?

6. How did that violence affect you?

7. What behavior got you into trouble?

8. How often has this behavior been happening?

9. When did this behavior start?

10. How many times have you been to KNRC?

11. What was the reason for your return?

12.How can a Counseling Psychologist support you to change your behavior such that you can live peacefully when you return to your community?

Appendix C

Structured Interview Questions for KNRC Staff in FGD

1. What kind of violence did the juveniles at KNRC experience during their childhood?
2. What is the relationship between the juveniles and the perpetrators of the violence?
3. How long were the juveniles exposed to the violence?
4. What is the relationship between violence and delinquency?
5. What are the delinquent behaviors exhibited by the juveniles?
6. What is the commonest behavior for which juveniles are brought to KNRC?
7. Are there juveniles who have been to KNRC more than once?
8. If yes, what behaviors brought them back to the centre?
9. How can a Counseling Psychologist support behavioral change among the juveniles at KNRC?

Appendix D

Key Informant Interview

1. What is your name?
2. What position do you hold at KNRC?
3. How long have you worked with KNRC?
4. How many juveniles are at KNRC? (Boys and girls)
5. What is the most predominant offence for which juveniles are committed to KNRC?
6. What is the behavior of the juveniles when they have just arrived at KNRC?
7. How do you deal with a juvenile who is violent?
8. What services are offered to juveniles while at KNRC?
9. How long does a juvenile spend in rehabilitation?
10. How often are juveniles visited by their caregivers?
11. How many juveniles have been committed to KNRC more than once?
12. What services are offered to juveniles who are coming to KNRC for the second time?
13. What traumatic experiences have juveniles experienced in the past?
14. What is the relationship between violence and delinquency?
15. How can a Counseling Psychologist support behavioral change among the juveniles at KNRC?

Appendix E

Informed Consent and Ascent Form

Title of Research: Post Traumatic Stress Disorder Symptoms and Delinquent Behavior among Juveniles at Kampiringisa Rehabilitation Centre

Principle Investigator: Nantabo Winnie Kisakye; Tel. contact +256-782 006747
Affiliated to Uganda Christian University, Department of Social Sciences P.O Box 4, Mukono, Uganda.

1. Introduction and Purpose of the Study

This study seeks to explore if youths who suffered continuous abuse during their childhood commit crime during their adolescence. The general objective of the study is to examine the relationship between the experience of childhood traumatic violence and delinquent behavior among juveniles. The information you give us, will be confidential and only used for purposes of this study. In the process of report writing, your name will never be used and so everything you tell us will remain anonymous. We shall ask questions about the nature of the violence that you experienced and the behavior that led you to Kampiringisa National Rehabilitation Center. If you do not want to respond to a particular question, you can simply say so, and we will not insist.

2. Description of the Research

This is a mixed methods study involving qualitative research methods to describe the nature of an individual's experience and quantitative research methods to examine the relationship between the experience of traumatic violence and delinquency at Kampiringisa Rehabilitation Center.

3. Subject Participation

Participants will be children, the principal, and counselors or social workers at Kampiringisa National Rehabilitation Center.

4. Potential Risks and Discomforts

This is a study involving two-way conversation between the researcher and the respondents on their experience of childhood trauma and consequent delinquent behavior. Minimal risk is expected.

5. Potential Benefits

The findings will inform the decisions of stakeholders in the Justice, Law, and Order Sector (JLOS) including Probation Officers, the Principal of KNRC, Judges and Magistrates in the Family and Children Court (FCC), psychologists, counselors as well as police officers. The Ministry of Gender, Labor, and Social Development (MGLSD) will be able to use the results of

the research to design interventions that address behavioral change among delinquent juveniles.

6. Confidentiality

The information you give us, will be confidential and only used for purposes of this study. In the process of report writing, your name will never be used and so everything you tell us will remain anonymous. We shall ask questions about the nature of the violence that you experienced and the behavior that led you to Kampiringisa National Rehabilitation Center. If you do not want to respond to a particular question, you can simply say so, and we will not insist.

Every participant will be asked to sign a written study informed consent form before participating in the study as this ensures voluntarism and acceptability to participate in the study.

7. Authorization

By signing this form, you will be authorizing us to use the information from this research, for example, for designing interventions to address behavioral change among juveniles.

8. Participation

Your decision to participate in this study is completely voluntary. If you decide to not participate in this study, it will not affect your work or your stay here in any way.

9. Withdrawal from the Study and/or Withdrawal of Authorization

As a participant in this study, you can withdraw at any point if you choose not to continue.

10. Reimbursements

Reimbursement which is equivalent to a soft drink and a snack has been budgeted for you.

11. Whom to contact in case of ethical related concerns.

This study was Approved by Uganda Christian university Research Ethics Committee (UCU-REC) and cleared by Uganda National Council for Science and Technology (UNCST). In case of any Ethical related concerns or inquiries, you can contact UCU-REC chairperson; Prof. Peter Waiswa on 0772 405 357, pwaiswa@musph.ac.ug or UCU-REC Secretariat, Mr. Osborn Ahimbisibwe on 0775737627 or oahimbisibwe@ucu.ac.ug

I voluntarily agree to participate in this research program; to tick appropriately.

Yes **No.**

I understand that I will be given a copy of this signed consent and ascent Form.

Name of Participant (Optional): ……

Signature: …… Date: ……..

Name of Researcher: ……..

Signature: ……. Date: ……