

The Effects of Visitation on Incarcerated Juvenile Offenders: How Contact with the Outside Impacts Adjustment on the Inside

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Abstract The present study investigates how visitation from parents impacts youths' mental health in the first two months of incarceration in a secure juvenile facility. A diverse sample of 276 male, newly incarcerated serious adolescent offenders (14–17 years) was interviewed over a 60-day period. Results indicate that youth who receive visits from parents report more rapid declines in depressive symptoms over time compared to youth who do not receive parental visits. Moreover, these effects are cumulative, such that the greater number of visits from parents, the greater the decrease in depressive symptoms. Importantly, the protective effect of receiving parental visits during incarceration exists regardless of the quality of the parent–adolescent relationship. Policy changes that facilitate visitation may be key for easing adjustment during the initial period of incarceration.

Keywords Adolescent offenders · Depression · Incarceration · Social support

It is well documented that youth in the juvenile justice system often report mental health problems (Cauffman, Lexcen, Goldweber, Shulman, & Grisso, 2007; Elliott, Huizinga, & Menard, 1989; Potter & Jenson, 2003; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002) with estimates for affective disorder as high as 28–48% (Teplin et al., 2002). Yet relatively little research has examined factors that may improve mental health, particularly depressive symptoms, among youth as they enter an incarceration setting. This is a significant oversight as two important risk factors for depressive symptoms, stressful events and lack of social support, place newly incarcerated youth at an increased risk for developing internalizing problems. Indeed, depression among incarcerated youth is a significant concern that has been related to substance abuse (Elliott et al., 1989), self-harm, and in more extreme cases suicide/mortality (Liebling, 1999). Yet to our knowledge, no research to date has examined how social support, in the form of visitation, helps youth adjust to the stressful initial experience of incarceration: this is the goal of the present study.

As youth report high rates of mental health symptoms upon arrival to a juvenile justice facility, the time period immediately following arrival may have an especially significant impact on determining the course of one's mental health symptoms throughout incarceration. For example, the initial period of incarceration has been characterized as stressful (MacKenzie, Goodstein, & Flanagan, 1995) and has been associated with higher levels of mental health problems (e.g., depression and anxiety) than later periods of incarceration (Brown & Ireland, 2006). Furthermore, suicidal behavior and/or self-harm disproportionately occur within the first month of incarceration (Liebling, 1999), suggesting that the initial period of incarceration is a crucial period to study youth mental health adjustment. Indeed, the

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finding that disproportionate mental health risk occurs during initial periods of incarceration is consistent with the idea that during transitional periods, concurrent stressors (such as separation from family and adjusting to a new restrictive environment) may exacerbate existing emotional and behavior problems (Cicchetti & Rogosch, 2002).

For juvenile offenders, social support may play an especially important role in minimizing concurrent stressors and improving adjustment to incarceration. By definition, incarceration is characterized as a separation from society, enforced isolation from family, friends, and significant individuals in one's life. However, social support can be maintained through face-to-face visits. The majority of research on the impact of social support during incarceration has been limited to adults (Hoffman, Dickinson, & Dunn, 2007; Jiang & Winfree, 2006; Wooldredge, 1999) and has focused on visits from spouses and/or children (Gordon & McConnell, 1999; Grinstead, Zack, & Faigeles, 2001), and the transition out of incarceration (Bales & Mears, 2008). As such, we know very little about how social support in the form of face-to-face visits might impact mental health during adjustment to incarceration among juvenile offenders. Among adults incarcerated in state facilities across the United States, receiving more frequent visits was associated with greater psychological well-being and lower rule-breaking activity (Jiang & Winfree, 2006; Wooldredge, 1999; Woolf & Tumin, 1991). Thus, although the impact of visitation on juvenile mental health during incarceration has not been studied, parallel research in the adult literature indicates that social support may be key to promoting positive adjustment during incarceration among adolescents.

There is reason to believe that social support from parents in particular may play a key role in reducing youths' depressive symptoms during their initial adjustment to incarceration. In general, higher quality parent-child relationships act as a buffer against mental health symptoms (Patten, Gillin, Farkas, & Gilpin, 1997) and youth who have more positive family relationships are less likely to become depressed over time (Stice, Ragan, & Randall, 2004). Similarly, among adolescents (ages 11–17) on probation in the juvenile justice system, but not incarcerated, social support from parents is linked to greater overall emotional well-being (Caldwell, Silverman, Leforge, & Silver, 2004). Moreover, in a sample of incarcerated male and female adolescents (ages 13–18), higher quality relationships with parents was associated with lower levels of depressive symptoms upon arrival to the facility (McCarty, VanderStoep, Kuo, & McCauley, 2006). While social support and quality parent-child relationships may buffer incarcerated youth against mental health issues, it remains unclear how the opportunity to interact with these loved ones during visitation may impact mental health during incarceration.

Yet while quality parent-adolescent relationships act as a buffer against mental health symptomatology, in general, the familial relationships of youthful offenders are often tumultuous and in some cases may be a negative influence on youths' psychosocial well-being (Glueck & Glueck, 1934; Moffitt, Caspi, Rutter, & Silva, 2001; Wattenberg & Saunders, 1954). In fact, inconsistent parenting is a strong predictor of involvement in antisocial behavior in the first place (Bogenschneider, 2006; Loeber & Stouthamer-Loeber, 1986). It remains unknown, however, if visits from maladaptive sources of support, such as parents who have a low quality relationship with their teenage child, have a different effect than visits from a parent who has a high quality relationship with their teenage child. Alternatively, the stress and isolation of incarceration may make any visit, regardless of relationship quality, valuable to the mental health of an adolescent.

In addition to the parent-adolescent relationship, there is the issue of the facility and its rules for visitation. While the United States Supreme Court has affirmed that individuals have a right to visitation (*Overton v. Bazzetta*, 2003), it is nonetheless the case that facilities can restrict prisoner visitation. In the state of California, where data for the present study are drawn, juveniles in secure facilities are prohibited from receiving visitors during their first week of incarceration. Moreover, visitation privileges are often suspended when a youth is in solitary confinement or temporary detention (e.g., for infractions, fighting, etc.) and when the facility (in its entirety or some specific section) is on a lockdown. To the extent that visits from parents may aid youths' adjustment to incarceration, it remains an important research question whether facilities should actively encourage parent-adolescent visits. Although there will undoubtedly be instances where visitation is not possible due to safety concerns within the facility (i.e., lockdown) or visitation privileges are temporarily suspended (i.e., due to temporary detention), it may be that parent-adolescent visitation is an important tool for promoting youth mental health during the initial period of incarceration. By testing how visitation impacts depressive symptoms over the course of the first two months of incarceration, the present study can inform debate about whether policy changes should be made to encourage early and regular parent-adolescent visitation at secure juvenile facilities.

The present study aims to fill gaps in our understanding of how parental visitation impacts juvenile adjustment to incarceration by answering three research questions. First, does visitation from parents influence juveniles' patterns of depressive symptoms during adjustment to incarceration? Second, do youth who receive more parental visits have lower depressive symptoms than youth who receive fewer parental visits? Third, does the quality of the adolescent-

parent relationship moderate the impact of parental visitation on youth depressive symptoms?

Method

Sample

Participants in the current study were a subsample of 373 males incarcerated in a secure juvenile facility in Southern California. Youth ranged from ages 14 to 17 and were ethnically diverse (53% non-Caucasian Hispanic, 29% African American, 6% Caucasian, and 12% reported a bi- or multi-racial ethnicity). This diversity was consistent with the ethnic background of youth in the California juvenile justice system (Snyder & Sickmund, 2006). Parental education was used as a proxy for socioeconomic status; 7% of parents had less than a high school education, 24% of parents had some high school; 43% of parents had a high school diploma or GED, and 36% of parents reported some college. The analytic sample was limited to 276 youth for whom visitation records were available from the facility. While Chi-square tests indicated that the analytic sample was more likely to be Hispanic than would be expected by chance ($\chi^2(3) = 13.69, p < .01$), *t*-tests indicated that there were no significant differences between the full and analytic sample in age ($t(371) = .497, p = .62$) or parental education ($t(264) = -1.83, p = .07$).¹

Procedure

Youth under 18 years of age who were newly admitted to the facility over the course of 2 years (Spring 2005 to Spring 2007) were eligible for enrollment. Each day the facility was contacted to determine how many new youth had been placed in the facility. Each potential participant was informed of the nature of the study (both verbal and written explanations), told that participation was entirely voluntary, and that they would not be penalized for declining to participate. Confidentiality was ensured and was only broken in the event that the youth reported he had plans to hurt himself or somebody else, or that someone was hurting him. Informed consent was obtained from the parent/guardian via a tape-recorded telephone conversation and assent was obtained from the youth. Of parents contacted, 97% provided consent; among adolescents, there was a 95.5% assent rate. To be enrolled in the study, youth

were required to have parental consent and to have also assented to be involved in the study.

Once appropriate consents and assents were obtained, youth participated in a baseline interview (within 48 hours of arrival to the facility), a weekly follow-up interview for the subsequent 3 weeks, and a monthly follow-up thereafter. The baseline interview took approximately 2 hours and consisted of numerous environmental, behavioral, and attitudinal measures. Questions were read aloud to control for differences in reading comprehension. Follow-up interviews lasted approximately 1½ hours. Differences between the baseline interview length and the follow-up interview length were due to addition questions about lifetime history at the baseline interview; follow-up measures typically only addressed emotions, behavior, and environment since the prior interview. In appreciation for their participation, youth were given a snack at the end of each interview.

Measures

Of interest to the present study were demographic information, depressive symptoms, visitation records, and quality of the parent–adolescent relationship. Measures were selected on the basis of their internal and external validity, broad use in the field, and relatively quick time to administer.

Background Characteristics. Youth self-reported their age and race/ethnicity and home address prior to incarceration was determined using official court records. Home addresses were geocoded and the miles between home address and the facility location were calculated.

Depressive Symptoms. The Center for Epidemiological Studies-Depression Scale (Radloff) assessed psychological and somatic symptoms of depression within the recall period. Individuals responded to 20 statements (e.g., “I thought my life had been a failure,” “I had crying spells,” and “I felt that people disliked me”), rating them from “never” to “almost every day.” Responses were summed, with higher scores indicating greater self-reported depressive symptoms (possible range 0–60). Studies conducted with clinical populations suggest that individuals scoring 16 or higher on the CES-D are considered to be depressed (Radloff, 1977). Although the CES-D was initially developed to assess the severity of depression, it is now often used to estimate the prevalence of depression or screen for depressive symptomatology across many populations and settings (Santor & Kazdin, 2000). In the present study, the measure was found to have adequate reliability over time ($\alpha_{\text{baseline}} = .82, \alpha_{\text{week2}} = .82, \alpha_{\text{week3}} = .77, \alpha_{\text{week4}} = .79, \text{ and } \alpha_{\text{month2}} = .77$).

¹ With a sample of 276 youthful offenders, we had the power (1-B) to detect the difference between conditions as small as $d = .10$, generally considered small effects.

Visitors. Official facility records were used to determine whether or not a youth had received a visit from a parent in a given recall period. Facility policy prohibited visitors during the first week of incarceration, but visitors were allowed thereafter. Although records were collected on all visitors (e.g., aunts, friends, significant others), parents were by far the most prevalent of visits, accounting for more than 54% of the visits that youth received. After parents, the most prevalent types of visitors were sisters (16% of all visits), brothers (13% of all visits), girlfriends (7% of all visits), grandparents (6% of all visits), children (1%), and other types of visitors (3%).

For the purposes of the present study, results focused on visits from mothers and fathers.² The number of individuals who visited a participant was calculated each week from baseline to month 2; data from weeks 5–8 were aggregated to reflect the month level data available for the outcome variable. At any given week, the majority of the participants did not receive a visitor (from 45 to 55% across time). Across all of the time points, 33 youth (12% of the sample) never received a parental visit. Among individuals who did have visitors, most individuals received 1 visitor a week (32–37% of youth per week) followed by 2 visitors a week (11–13% of youth per week), and less than 3% of youth had 3–4 visits from parents in a given week.

Two measures of parental visitation were calculated. The first index was a time-varying covariate which reflected a value of “0” when youth had no visitors in a given period (weekly for the first 3 weeks; monthly for the last month) and a value of “1” when youth received at least one visit from a parent in a given time period. The second index of visitation was a time-varying covariate, which assesses the number of visits (ranging from 0 to 4) received in a given time period. Because facility policy prevented that any youth receive a visit for their first week of incarceration, the values for visitation were set to “0” for the baseline interview (arrival date) and the first week of incarceration.

Relationship Quality. The quality of the parent–adolescent relationship was assessed using the Warmth and Acceptance scale (Greenberger & Chen, 1996). Responding from “strongly agree” to “strongly disagree,” youth responded to eight statements about their relationships with their parents (“He/She lets me know through words or actions that he/she really cares about me.”). Higher scores indicated more warm and

accepting parents. The measure showed good reliability in the sample ($\alpha = .77$).

Control Variables. Two variables were used as controls in all analyses. As prior experiences in a given facility might impact mental health, each model controlled for whether or not the individual had been incarcerated in the facility before (only 10 youth reported being previously incarcerated in the facility). Second, because there was slight variation in timing of interviews (e.g., some youth had interviews that were 6 days apart, others had interviews that were 8 days apart), the number of days from baseline interview to the 2 month follow-up was used as a control. On average, the number of days from the baseline interview to the 2 month-follow-up was 53 days ($SD = 22$).

Results

Analytic Plan

As the goal of the present study was to examine how visitors would impact depressive symptoms, we began by testing if there were qualitative differences in youth who did, and did not, receive visits from parents. Second, we examined the descriptive information of our measure of depressive symptoms (i.e., mean, range of scores, and percent of youth above the clinical cut-off). Third, we examined patterns of depressive symptoms over the first two months of incarceration using growth curve modeling from a multilevel modeling perspective (SAS Institute Inc, 2004). Unconditional models (Model 1) determined the average pattern of change over time and whether there was significant variability within the sample in level (intercept) and change in depressive symptoms by time (slope). If sufficient variability was found in these parameters (either intercept, slope, or both), conditional models were used to predict this variance. Growth curve modeling was ideal for the present analyses because it allowed for a test of differences in both level (intercept) and change (slope) in each domain. Since we were interested in how visitation might impact adjustment to incarceration, analyses were run by length of time in the facility. For purposes of analyses, time was centered at the first week that youth could receive a visit. Thus, the intercept was interpreted as the mean level of depression at the time when youth could first receive a visit from a parent.

After determining the general pattern of development in unconditional models, conditional models were estimated in which covariates were used to predict differences in the intercept and/or slope of depressive symptoms over time,

² Two indices of parents were calculated. The first was limited to biological parents; the second measure accounted for biological and stepparents. There were no differences in results.

controlling for variation in the timing of interviews as well as whether or not a youth had previously spent time in the facility. Remember that the goals of the study were threefold: (1) test if having visitors or not impacted adjustment to incarceration; (2) test if there was an additive effect of visitation (e.g., whether the quantity of visitors matters); and (3) test if the effect of visitation varied as a function of the quality of the relationship with the person visiting. As such, after identifying unconditional patterns of growth (Model 1), we tested three additional models. In Model 2, we examined the impact of receiving a visit or not in a recall period on one's depressive symptomatology. In Model 3, we examined the additive effects of visitation by testing how the number of visitors one had in a given period impacts depressive symptomatology. Finally, in Model 4, we examined if the impact of visitation varied as a function of the quality of the parent–adolescent relationship, testing for an interaction between visitation and relationship quality on depressive symptomatology.

In our analyses, missing data on the outcome variable (depressive symptoms) ranged from 12 to 30% at the follow-up interviews. Youth with missing data were included in the model. Specifically, we used full-information maximum likelihood methods which include all available data in the analyses and have been shown to provide nonbiased results (Graham, 2009).

Differences Between Visited and Non-visited Youth

Preliminary analyses were conducted to determine if youth who received visitors were qualitatively different from youth who did not receive visitors. Specifically, visited vs. non-visited youth were compared on race/ethnicity, age, parental education, and proximity of their home address to the facility. *T*-tests indicated that visited and non-visited youth were not significantly different in their age ($t(274) = 1.27, p = .206$), parental education ($t(204) = -1.623, p = .110$), or how many miles their family lived from the facility ($t(264) = .198, p = .843$). Chi-square tests indicated that African American and Hispanic youth were less likely to receive visits during the first 2 months

of incarceration ($\chi^2(3) = 9.321, p = .03$) than would be expected by chance.

Patterns of Change in Depressive Symptoms

Descriptive Analyses of Depressive Symptoms. Mean levels of depressive symptoms over time are presented in Table 1. Results suggest that on average, youth levels of depressive symptoms declined over the first two months of incarceration. Moreover, the number of youth reporting levels of depressive symptoms above the clinical cutoff on the CES-D declined over time. Upon arrival to the facility, 47.1% of youth reported levels of depressive symptoms above the clinical cut-off. By the second week of incarceration, however, 41.4% of youth reported clinical levels of depressive symptoms. This number continued to decline over time, with 31.1% of youth reporting clinical levels of depressive symptoms at week 3 and 23.2% of youth reporting clinical levels of symptoms at week 4. From week 4 to month 2, there was a slight increase in youth depressive symptoms, with 27.6% of youth reporting clinical level depressive symptoms.

Growth Curve Analysis of Depressive Symptoms. Growth curve models indicated that depressive symptoms was found to follow a quadratic form (see Model 1, Table 2). The average level of depressive symptoms across the sample in the second full week of incarceration was 14.3. Notably, the predicted average depressive symptoms score upon baseline arrival to the facility was 17.6. Consistent with much research, a large number of youth were predicted to be above clinical levels of depressive symptoms (scores greater than 16 on the CES-D) upon admittance to the facility. Youth exhibited declines in depressive symptoms over the first few weeks of incarceration; over time, however, the rate of this decline slowed, with depressive symptoms leveling off in the second month of incarceration. Importantly, significant variation was found in the intercept, linear slope, and quadratic slope; subsequently, covariates (visitation and quality of the parent–adolescent relationship) were used to

Table 1 Depressive symptomatology over time

	Depressive symptomatology				
	Baseline	Week 1	Week 2	Week 3	Month 2
Mean (<i>SD</i>)	17.19 (9.00)	16.59 (9.20)	14.70 (7.89)	12.49 (7.35)	13.66 (7.42)
Range of scores ^a	0–44	0–46	0–48	0–40	0–38
% above clinical cut-off ^b	47.1	41.4	31.1	23.2	27.6

^a Range of scores on the CES-D is from 0 to 60

^b Clinical cut-off value on the CES-D is scores over 16

Table 2 Unconditional model and effects of having a visitor of not on depressive symptomatology

Effects	Depressive symptomatology			
	Model 1		Model 2	
	Coefficient (SE)	95% CI	Coefficient (SE)	95% CI
Fixed effects				
Intercept (Mean)	14.27 (.45)**	[13.39, 15.15]	14.74 (.47)**	[13.81, 15.67]
Prior incarceration	–		–.05 (.04)	[–.12, .02]
Days in facility	–		1.05 (.43)**	[.20, 1.88]
Visit dummy	–		–.38 (.55)	[–.15, .69]
Visit*quality	–			
Linear slope	–1.25 (.13)**	[–1.51, –.99]	–1.07 (.15)**	[–1.37, –.77]
Visit dummy	–		–1.84 (.80)*	[–3.41, –.27]
Visit*quality	–			
Quadratic slope	.22 (.03)**	[.15, .28]	.16 (.04)**	[.08, .25]
Visit dummy	–		.38 (.15)*	[.08, .68]
Random effects				
Intercept	45.94 (4.70)**	[36.72, 55.15]	44.42 (4.55)**	[35.50, 53.34]
Linear slope	1.95 (.44)**	[1.08, 2.82]	2.01 (.44)**	[1.14, 2.87]
Quadratic slope	.08 (.03)*	[.03, .13]	.08 (.03)**	[.03, .13]
Level-1 error	19.24 (1.30)**	[16.93, 22.05]	18.72 (1.27) **	[16.47, 21.47]
Model fit				
–2 Log Likelihood	7609.6		7584.4	
AIC	7629.6		7614.4	
BIC	7665.8		7668.7	
R square	–		6%	

* $p < .05$, ** $p < .01$

predict differences in level and change over time, in depressive symptoms.

In the next step of the analyses, we examined if receiving visitors predicted differences in the level of depressive symptoms and in how depressive symptoms changed over time (both linear and quadratic growth; see Model 2, Table 2). In the first week of receiving visits from parents, youth who received visitors were no different in depressive symptoms than youth who did not receive visitors. However, over time, youth that received visits from their parents showed more rapid declines in depressive symptoms and a more stable pattern of depressive symptoms compared to those who did not receive visits from parents. Parental visitation accounted for 8% of the variance in depressive symptoms among youth; significant variance remained in the intercept and slope of depressive symptoms.

In Model 3, we tested if there was an additive effect of having more visitors compared to fewer visitors (see Model 3, Table 3). Results mimicked the same pattern yielded by Model 2: the more visitors one received had positive effects on depressive symptoms over time, leading to more positive adaptation in the initial weeks of incarceration.

These positive effects of visitation on depressive symptoms were linear, such that the more parental visits a youth received, the stronger the rate of decline in depressive symptoms over the course of the first two months of incarceration (see Fig. 1). Because the pattern of results was identical to those reported with the dummy coded index of visitation (yes or no), we present the figure for the current model to illustrate the additive effect of having more visitors. Estimating the effect of visitation as a continuous variable accounted for 8% of the variance in depressive symptoms. Significant variance remained in intercept and slope.

Finally, we tested if the effects of visitation differed as a function of the quality of one's relationships (see Model 4, Table 3). Youth with higher quality relationships with their parents showed consistently lower levels of depressive symptoms. Yet, the impact of having a good quality relationship with one's parents did not moderate the effect of parental visitation. Thus, the protective effects of a quality relationship with parents and parental visitation on adolescent depressive symptoms are independent. Inclusion of both visitation and parent-adolescent relationship quality

Table 3 Effects of number of visitors and relationship quality on depressive symptomatology

Effects	Depressive symptomatology			
	Model 3		Model 4	
	Coefficient (SE)	95% CI	Coefficient (SE)	95% CI
Fixed effects				
Intercept (Mean)	14.63 (.47)**	[13.71, 15.55]	14.64 (.48)**	[13.70, 15.58]
Prior incarceration	-.04 (.04)	[-.12, .03]	-.04 (.04)	[-.11, .03]
Days in facility	1.04 (.43)**	[.19, 1.88]	.96 (.44)**	[-.09, 1.83]
Number of visitors	-.09 (.38)	[-.84, .66]	-.07 (.40)**	[.85, .71]
Relationship quality	-		-1.08 (.55) **	[-2.15, -.01]
Visit*quality	-		.31 (.49)	[-.65, 1.27]
Linear slope	-1.10 (.15)**	[-1.39, -.81]	-1.12 (.15)**	[-1.4, -.82]
Number of visitors	-1.33 (.54)*	[-2.39, -.27]	-1.34 (.55)*	[-2.42, -.26]
Relationship quality	-		.06 (.17)	[-.28, .40]
Visit*quality	-		-.10 (.64)	[-1.34, 1.15]
Quadratic slope	.18 (.04)**	[.11, .26]	.18 (.04)**	[.11, .26]
Number of visitors	.26 (.10)**	[.07, .46]	.27 (.10)**	[.06, .47]
Relationship quality	-		-.02 (.04)	[-.10, .06]
Visit*quality	-		.01 (.11)	[-.22, .23]
Random effects				
Intercept	44.77 (4.58)**	[35.78, 53.75]	44.10 (4.65)**	[34.98, 53.22]
Linear slope	1.98 (.44)**	[1.12, 2.84]	2.16 (.46)**	[1.26, 3.05]
Quadratic slope	.08 (.03)**	[.03, .13]	.08 (.03)**	[.03, .13]
Level-1 error	18.74 (1.27)**	[16.48, 21.49]	18.36 (1.25)**	[16.13, 21.08]
Model fit				
-2 Log likelihood	7584.5		7280.2	
AIC	7614.4		7322.2	
BIC	7668.7		7397.1	
R square	8%		11%	

* $p < .05$, ** $p < .01$

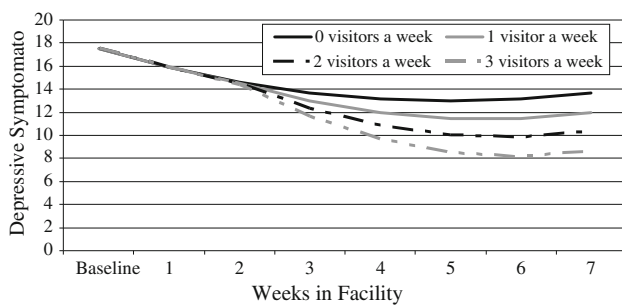


Fig. 1 Impact of visitors on depressive symptomatology

accounted for 11% of the variance in depressive symptoms in the first two months of incarceration.³

³ Results of the present study did not change when the number of days spent in temporary detention/solitary confinement was controlled nor when we controlled for youth anti-depressant medication. Consequently, we report the findings without these variables in the model for parsimony.

Discussion

Youth in the justice system are disproportionately likely to have mental health issues (Cauffman et al., 2007; Elliott et al., 1989; Potter & Jenson, 2003; Teplin et al., 2002) and the stress of incarceration accentuates these problems (Grisso, 2004; Toch, 1977; Zamble & Porporino, 1988). The present study investigates how naturalistic factors, whether or not one is visited by parents, impact the mental health of young, incarcerated offenders. Among incarcerated youth, parental visitation is associated with better mental health during their initial adjustment to incarceration. The positive impact of parental visitation on mental health is aggregate, such that more visits from parents are associated with more rapid declines in depressive symptoms over time. Moreover, to the extent that the protective effects of parental visits on depressive symptoms become stronger over time, allowing parental visits as soon as youth become incarcerated may produce earlier declines in depressive symptoms among incarcerated adolescents.

Most notably, however, it appears that any parental visits, regardless of parent–adolescent relationship quality, serve to reduce depressive symptoms during the first two months of incarceration. Therefore, the present study suggests that one mechanism for promoting successful adaptation to incarceration is to facilitate early and continued parent–adolescent visits.

An especially interesting result from the present study is that the quality of the parent–adolescent relationship does not moderate the effect of parental visitation on youth mental health. This suggests that for incarcerated youth, the mere presence of a parent has positive effects on their adjustment on the inside. Thus, it may be that encouraging parental visitation for all youth, regardless of their relationship with their parents, will improve mental health among incarcerated youth. Whether this finding is unique to parent–adolescent visitation, and perhaps does not hold for other visitors (e.g., grandparents, aunts, uncles, romantic partners, peers), is an important question for future research.

Facilitating visitation for adolescents raises a number of important policy issues. As previously noted, the United States Supreme Court has affirmed that individuals have the right to visitation while incarcerated (*Overton v. Bazetta*, 2003) but facilities can set rules about a number of different aspects of visitation (e.g., when youth can receive their first visit). In the present study, per facility rules, youth were prohibited from receiving visitors until their second full week of incarceration. Another issue is the termination of visits. For instance, even after visits were initially allowed, facilities can prohibit youth from receiving visits for a number of reasons.

The findings of the present study have important implications for these visitation policies. Foremost, it may be the case, as our findings suggest, that facilities should allow visits earlier to more rapidly capitalize on the positive effects of visitation on youth mental health over time. Second, although rules/punishments are undoubtedly needed at times to maintain order within the facility, to the extent that these situations prohibit visitation, and consequently, prohibit the protective effects of visitation on mental health, they should be minimized. As youth with greater difficulties are more likely to be given solitary confinement or temporary detention, it is precisely these youth, who are prohibited from visits, who may benefit from visits the most. Given the benefits of prison visitation on youth psychological adjustment, it is imperative that policy assists in overcoming barriers to prison visitation such as geographic distance and lack of resources (e.g., finances, time off from work, transportation, child care, etc., Arditti, 2003). Finally, qualitative research on adult prison visitation suggests that prison visitation is very stressful for the individual coming to visit, and that failure to clearly communicate facility rules regarding visitation,

the lack of information from prison officials, and the stress of passing through security that are often reported by prison visitors may serve as a barrier to encouraging prison visitation (Christian, 2005). Particularly in a juvenile setting where youth may be more vulnerable to separation from family and friends, it is important that facilities work to ensure that visitation experiences are pleasant, safe, and as streamlined as possible.

While the present study is strengthened by its focus on a unique population, it is nonetheless limited. First, while individuals who receive visitors are not from different geographic regions than non-visited youth, it may be that other factors (e.g., financial or work) impact whether or not a youth receives visitors. Many of these youths come from single parents households and/or may have parent who is incarcerated. Unfortunately, we have no way of systematically determining if visitation was simply easier for some families as compared to others. Second, our assessment of relationship quality is based on youth self-report of the quality of their relationship with their parents at the baseline interview. It is possible that youths' perceptions of the quality of their relationship with their parents changed over the course of incarceration, perhaps based on whether or not they received visits from their parents. This remains an interesting question requiring further inquiry. Third, the present study focuses on the role of parental visitation. Although we were unable to examine the effects of visits from other individuals in the present study due to a lack of clarity about whether or not the visitors were the same over time (i.e., if the same girlfriend visited more than once) and a low number of other types of visitors, it is important to understand if visits from other sources of social support promote positive mental health across initial periods of incarceration. Finally, the ethnic make-up of our sample is consistent with the California prison system in general (i.e., a large number of Hispanic youth), but it is unclear how the results of this study may generalize to other juvenile facilities with different ethnic populations.

The juvenile justice system is built on the premise that young offenders are more amenable to treatment and rehabilitation efforts compared to adult offenders. Many youth in the justice system report co-morbid mental health issues, and it is key to provide youth with appropriate mental health services. The results of the present study suggest that, in addition to more formal mental health treatment, encouraging visitation may diminish mental health problems among incarcerated youth. Promoting and maintaining early and sustained contact with one's parents while incarcerated acts as a significant protective factor against mental health issues. As such, the mental health needs of young, incarcerated individuals would be well served if policy and practice would support parental visitation.

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