Properly Diagnosing Adolescents

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Ethical Guidelines

- American Academy of Psychiatry and the Law Ethical Guidelines for the Practice of Forensic Psychiatry
- Specialty Guidelines for Forensic Psychologists

**The guidelines set forth in these documents are aspirational.*

Clinician Competency

"Capable forensic examiners who work with adults should be cautious about evaluating a juvenile without adequate training or supervision. It is possible to conduct a seemingly competent evaluation but fail to obtain the data necessary to construct a complete picture of the developmental and familial context for the youth's clinical presentation and delinquent behavior."

(Heilbrun, Marczyk, and DeMatteo, 2002)

What is all the Fuss About?

"At a recent meeting of the states' administrators of juvenile correctional programs, the host asked one of them, "In your opinion, what are the three most pressing issues in juvenile justice facilities today?". The administrator answered without hesitation, "Mental health, mental health, and mental health."

(Grisso, Vincent, and Seagrave, p. 3, 2005)

Little John

15 y.o. male. Has hx of substance use, associating with negative peers, family issues/conflict, academic difficulties, and "anger management issues". Is characterized as impulsive, moody, guarded/defensive, and is said to have "problems" with authority (perhaps for good reason) – presents as cold, distant, egocentric, and lacking in empathy (sound familiar?)

ADHD?	Parent-Child Relational Problem?
Mood Disorder?	Substance Abuse?
Conduct Disorder?	Borderline IQ or MR?
Psychopath?	Anxiety Disorder?
ODD?	IED?
Asperger's/Autism?	Teenager?

Don't forget about Little Jane, as research consistently shows a greater prevalence of psychiatric disorders in girls than boys (in juvenile justice system).

DATA, DATA, DATA

Don't let psychologists fall in love with their all-knowing, all-telling psychological tests (How about those inkblots?) A thorough assessment is a much an investigation as it is an evaluation.

We MUST make every attempt to collect relevant collateral data. Assessments of juveniles should include conversations with parents and/or caregivers (as well as probation officers and attorneys), a review of academic records, probation/detention records, and treatment notes, as well as consideration of previous psychological evaluations, a comprehensive clinical interview, *and* the utilization of age-appropriate psychological tests.

The Juvenile Brain

A variety of environmental and psychosocial factors, in conjunction with developmental influences, affect the way a child/adolescent processes their world and, as a result, how they make decisions. The prefrontal cortex, known as the "CEO" of the brain, is responsible for executive functioning and advanced cognition (reasoning, advanced thoughts, planning, impulse control, judgment of consequences). This is the final area of the brain to mature. Not only does the frontal lobe fail to mature until age 25 or so, but it's connections to the other parts of the brain continue to improve until that age as well.

More Juvenile Brain

Younger children and adolescents are generally less likely to think strategically about their decisions…When they find themselves in an emotionally charged situation, the parts of the brain that regulate emotions, rather than reasoning, are more likely to be engaged. As adolescents mature (this may take a while), they typically become better problem solvers, are less influenced by peers, less impulsive, and more sophisticated in the way they think.

Some Brain Terms in Case You Want to Know

Research on brain development tell us that young people have much greater activity than adults in the emotional and reactive brain regions [limbic system], and much less activity and maturation in the planning and inhibitory areas [frontal lobe]. Adolescents rely more on the amygdala and other areas of the limbic system (areas of the brain associated with impulse and aggression) in part, because the frontal regions of the brain are not fully developed. This, in part, is responsible for delinquent behavior and high overall morbidity rates.

As mentioned, adolescents are more likely to engage in risky, thrill-seeking behavior. At least part of the reasoning behind this is biological, as ineffective dopamine levels in adolescents impacts memory, concentration, problem-solving, and other mental capacities.

For the Mechanically-Inclined in the Audience

"As Steinberg sees it, a teenager's brain has a well-developed accelerator but only a partly developed brake…By around 15 or 16, the parts of the brain that arouse a teen emotionally and make him pay attention to peer pressure and the rewards of actions – the gas pedal – are probably all set. But the parts related to controlling impulses, long-term thinking, resistance to peer pressure and planning – the brake, mostly in the frontal lobes – are still developing."

"It's not like we go from becoming an accelerator to all brake," Steinberg said. "It's that we go from being heavy-foot-on-the-accelerator to being better able to manage the whole car."

USA TODAY article, 12-02-07
Dr. Robert Steinberg, Temple University

Bad News

At some point, the majority of teenagers engage in behavior(s) that, if observed by the discerning eye of the law, would result in their arrest. As such, those adolescents who we refer to as "delinquents" are often merely those who have been caught.

Good News

Most of those same individuals do <u>not</u> continue their "offending" into adulthood. This, it should be noted, holds true for both violent offenders and sex offenders.

Common Referral Issues for Juveniles

Psychological evaluation with no specific forensic question

Fitness to proceed

Evaluation of sex offenders, Risk assessment

Transfer to adult court

Mental retardation

Consulting

Assessment – Areas of Emphasis

-Family
-Substance Abuse
-Psychiatric History
-Peer Relations
-Community/Support
-Academic History
-Abuse/Trauma
-Developmental/Medical
-Personality Functioning
-Relationships/Sex
-Response to Mandatory Supervision
-Insight into Past Problems and Current Situation
-Behavioral History (weapons, fire, animal cruelty, violence)

Adolescent Development

There is significant intra-age variability among adolescents. Development is not linear, as all adolescents develop at different rates, and oftentimes in spurts. Social and/or emotional functioning is often situational. Personality traits are often experimented with and are frequently not permanent. While this may be conducive to work/change in psychotherapy, it can make a forensic evaluation quite challenging.

Social and emotional stressors significantly impact an adolescent's ability to take advantage of their capacities/strengths (particularly newly acquired strengths), as unlike adults, they have not had the opportunity to display and develop such capacities under a variety of circumstances. Adolescents are still developing their overall cognitive abilities, particularly those relating to executive functioning.

More Development

Increase in risk-taking, sensation-seeking, and experimentation (research suggests that our impulse control is relatively stable from time we begin school until about age 16; adolescents become more impulsive and engage in riskier behavior from ages 16 to19). Less likely to weigh the consequences (particularly long-term) of their decisions. More likely to overlook alternative courses of action. Also more likely to focus on (and overestimate) short-term payoffs of actions.

More Development

-Increase in emotionally-driven behavior. Reactive to stress.

-Increase in erratic/inconsistent behavior *(what may be true about an adolescent physically, cognitively, emotionally, or socially today may not hold true a month from now).*

-Various deficits in judgment, planning, and decision-making.

-Vulnerable to peer pressure/influence (peaks around age 14). While we all hear the "hanging out with the wrong crowd" defense/excuse, remember that biologically, juveniles are indeed more vulnerable to peer pressure.

Sexual Development

In regards to sexual behavior/activity in juveniles, effort should be made to view behaviors that we characterize as sexually inappropriate (or deviate) within the developmental pathway.

For example, voyeurism, exhibitionism, obscene phone calls, sexual hand/body gestures, while inappropriate and sometimes illegal, are not that unusual in "normal" and "healthy" adolescents.

Particular attention should be paid to the circumstances in which such sexual behavior occurs.

Adolescent or Psychopath?

-Impulsive
-Egocentric
-Prone to boredom/Need stimulation
-Irresponsible
-Failure to accept responsibility
-Lack of realistic goals
-Disregard for social norms, rules, obligations
-Promiscuous sexual behavior
-Many short-term relationships
-Limited frustration tolerance
-Lack of remorse, lack of guilt
-Poor behavioral controls

Adolescent Offenders

Keep in mind that delinquent behaviors are fairly common in the general adolescent population, as the majority of adolescents engage in behavior which, if caught, could lead to their arrest. As such, those adolescents we refer to as delinquents are, at times, merely those who have been caught.

Most individuals arrested as an adolescent do not continue offending as adults (this also holds true for violent offenders).

Individuals with higher rates of criminal/violent recidivism are more likely to have initiated their illegal, aggressive, or antisocial behaviors prior to the age of 14.

Significant risk factors for delinquency include family conflict, financial limitations, social/neighborhood difficulties, educational difficulties, substance abuse, and association with delinquent peers.

Adolescent Psychopathology

<u>Most Common Psychiatric Diagnoses in Juvenile Justice System</u>

-Mood Disorder
-Anxiety Disorder
-Thought Disorder
-Disruptive Behavior Disorder
-Substance Abuse Disorder
-ADHD
-MR or Borderline Intellectual Functioning

A Few Things on Diagnosis

Studies generally find that approximately 2/3 of youths in juvenile justice system meet criteria for one of the aforementioned diagnostic categories (roughly half of those in the system are thought to meet criteria for at least 2 diagnoses). This is roughly 3 times greater than what would be expected in the same-age general population.

According to the *DSM-IV*, in a majority of adolescents meeting criteria for CD, "the disorder remits by adulthood", with "many" of the individuals going on to "achieve adequate social and occupational functioning".

Clinical research and experience suggest it is harder to accurately diagnosis (or Not diagnosis) children/adolescents than adults. Mental health professionals may also over-pathologize "normal" adolescents (be aware of base rates/developmental issues).

DSM-IV Comment on Diagnosis

"The fact that an individual's presentation meets the criteria for a *DSM-IV* diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time" (p. xxxiii).

When to Raise the Issue of Fitness to Proceed

1. The individual is 12 years old or younger.
2. There is a history of mental illness diagnosis/treatment.
3. Borderline IQ (70 to 85), MR or established learning disability.
4. Evidence/observations suggesting deficits related to attention/concentration, memory, and/or reality testing.

Grisso, 1998

MacArthur Study Findings

Findings from *The MacArthur Juvenile Adjudicative Competence Study* (Grisso and Steinberg) include the following:

-Juveniles age 11 to 13 were "more than three times as likely as young adults (individuals age 18 to 24) to be seriously impaired on the evaluation of competence-relevant abilities".

-Juveniles age 14 to 15 were twice as likely as young adults to be seriously impaired.

-Juveniles with below-average intelligence (FS IQ < 85) "were more likely to be significantly impaired in abilities relevant for competence to stand trial than juveniles of average intelligence" (FS IQ > 85). In fact, over 1/2 of all "below average" 11- to 13 year olds, and "more than 40% of all below-average 14- and 15 year-olds fell in the significantly impaired range on abilities related to competence".

Diagnoses Impacting Fitness

Most likely?

A thought disorder or MR.

Others to consider?

ADHD
Bipolar Disorder
Depressive Disorder
Borderline IQ
Asperger's Syndrome
Immaturity

Where Does Immaturity Fit?

The Texas Fitness to Proceed statute indicates that a juvenile can be found Unfit to Proceed if, as a result of mental illness or mental retardation, he/she lacks the relevant trial-related capacities. 55.31 does not take into account the very real possibility that a juvenile may be Unfit to Proceed to trial for reasons relating primarily to immaturity in psychosocial development.

Immaturity can significantly impact an adolescent's decision-making and judgment as they relate to Fitness to Proceed. In general, adolescents are less likely to identify risks (or the probability and/or consequences of those risks), though they are more likely to engage in risky choices/behaviors. Adolescents are also more likely to focus on short-term consequences (as opposed to long-term consequences) and are more susceptible to peer influence (Woolard & Harvell, 2005).