Forensic Psychiatry and Violent Adolescents

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In the 1990s, increasing rates of violence among adolescents spawned a new era of research into the causes and correlates of youth violence. The resultant data on risk factors have provided opportunities for establishing empirically based assessments and risk-focused treatment programs. Community-based treatment programs that demonstrate moderate effect in reducing violence have renewed optimism in the benefit of treatment over punishment. Current research on “adolescent psychopathy” and structured assessments of risk for violence present opportunities for advancing rehabilitation but carry a significant risk of harm. It is essential that forensic psychiatrists are guided by the available evidence and instruments when providing professional opinions on violent adolescent clients to the criminal justice system. In fitting with the evidence-based practice approach, forensic psychiatrists have an ethical responsibility to take into consideration available empirical research relevant to assessing and treating violent adolescents. Current policies that limit the ability to provide treatment in juvenile settings should be challenged by organized psychiatry. [Brief Treatment and Crisis Intervention 8:27–42 (2008)]

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Psychiatrists working with juvenile courts or corrections face unique clinical and ethical challenges. Youth who come before the juvenile court have wide-ranging developmental capabilities, social and family backgrounds, socioeconomic status, and education, resulting in marked variation in psychological sophistication. Young offenders commit a variety of criminal behaviors of varying severity and frequency. While the majority of adolescents charged with criminal offenses commit minor and nonviolent crimes, there is a sizable subgroup of offenders who commit serious or violent offenses. These youth challenge our society’s abilities to protect itself from harm while also providing the rehabilitation and treatment that may assist the youth in establishing a prosocial lifestyle that will reduce the future risk of violence. This paper will provide a brief overview of the changing and, at times, conflicting values within Juvenile justice that may clash with medical values of beneficence. Subsequently, we will review the empirical research on risk factors for juvenile violence, treatment programs with proven efficacy, and prevalence rates of psychiatric illness among juvenile offenders that may shape our approach to dealing with violent youth. We will then focus on current controversies in juvenile forensic psychiatry, including assessment of risk for future violence, assessment of “psychopathy” in adolescents, and the potential role of the forensic psychiatrist as an advocate for rehabilitation within the juvenile justice system.
Juvenile courts have always approached adolescents who come into conflict with the law with ambivalence. Rutter, Giller, and Hagell (1998) describe the changes in European philosophy of justice of juvenile offenders from a welfare model, emphasizing rehabilitation, in the 1950s to a “just desserts” model, emphasizing civil rights, in the 1970s. Rutter et al. coined the term “populist punitiveness” to describe a process that developed over the last 20 years during which arose the belief that punishment would reduce crime through general deterrence and incapacitation while also appealing to the electorate as a solution to juvenile crime.

Authors have noted a similar trend in the United States (Grissio, 2003; Shook, 2005). Traditionally, the courts saw adolescents as being developmentally immature and less responsible than adults and deserving of separate treatment. Rehabilitation, guidance, and training of young offenders were given greater emphasis than punishment. Unfortunately, there developed practices in which efforts at rehabilitation led to lengthy periods of incarceration that were longer than given to adult offenders convicted of similar crimes. He describes the “rights reform” beginning in 1960s, emphasizing establishment of due process rights for young offenders. In Gault (1967) the courts established procedural due process rights similar to those afforded to adult offenders. The courts, however, still insisted on the obligation of rehabilitation for juvenile offenders. Shook (2005) explains that more punitive and control-oriented reforms began in the juvenile justice system beginning in the late 1970’s. Grisso (2003) describes the “punishment reform” beginning in the 1980s in response to increasing rates of adolescent violence. The catchphrase “adult crime–adult time” signaled the trend to treat adolescents as if they were adults despite the substantial developmental differences. This phase increased the likelihood and severity of punishment for young offenders, increased the number of juveniles transferred to adult courts, and emphasized public safety over rehabilitation. Although they were unable to provide significant evidence to support their claim, Poythress, Lexcen, Grisso, and Steinberg (2006) suggested that the relative immaturity of adolescents may impair their competence-related abilities in criminal court. Poythress et al. (2006) state that some courts are beginning to recognize developmental immaturity as an acceptable basis for adjudicative incompetence in juvenile court proceedings. They further suggest that youths who are “direct filed” to criminal court are placed at greater risk of incompetence to stand trial than their adult counterparts (Poythress et al., 2006).

Quinn (2002) notes that the emphasis on retribution in the 1990s has changed the emphasis of the juvenile forensic examination away from global assessments for disposition or treatment purposes in favor of more specific evaluations for fitness to stand trial, competency to waive rights, or insanity pleas. The role of the psychiatrist in juvenile court shifted further from a more traditional medical advisory role to a more strictly forensic role.

Most states have multiple pathways to determine which juveniles will be tried in adult court (Shook, 2005; Sickmund, 2003). Shook (2005) explains that juvenile transfer to ordinary court can occur through three mechanisms: judicial discretion, statutory exclusion, or prosecutorial discretion. Although youth transfers to criminal court have occurred since the juvenile court’s creation, Shook suggests that drastic increases in transfers are a result of legislative changes in the 1980s and 1990s that have dramatically eased the process. These changes include lowering or removing minimum age requirements, expanding the types of offenses eligible for transfer, modifying transfer criteria, and providing more players in the system authority to decide on transfers.
Shook, 2005). A review of juvenile court statistics in the United States provides data from 1998 (Sickmund, 2003). All states have maintained the traditional juvenile court waiver procedures in which a juvenile judge may decide to transfer a youth to ordinary court, following a full hearing. By 1999, 29 states had enacted statutory transfer provisions in which commission of certain offenses, usually violent, resulted in automatic transfer to adult court. In 13 states, the upper age of juvenile court jurisdiction was reduced to 15 or 16 years. In 15 states concurrent jurisdiction provisions gave prosecutors discretion regarding which juveniles should be tried as adult offenders. There are no data on the number of juveniles who are tried under concurrent jurisdiction provisions. In Florida, a state with broad provisions, prosecutors sent 4,000 juveniles to adult court in 1998–1999. This compares with an estimated 8,100 cases nationwide that juvenile court judges transferred after waiver hearings in the same time period. Among felons sentenced to prison, transferred juveniles were more likely to receive prison sentences than defendants who were adults at the time of the offense.

In the United Kingdom, youth justice reforms in the last several years have focused on reduction of custody use for young offenders with greater emphasis on community management with the goal to reduce the number of youth in custody (Youth Justice Board for England and Wales, 2003). England is proceeding with restorative justice programs, family programs, and intensive supervision programs (ISSP). ISSP is designed for the persistent young offender, providing intense supervision with education, vocational training and programs to reduce offending, as well as reparation for victims. The costs of these community programs are less than one third of a custodial sentence.

In Canada, The Young Offender Act (YOA) enacted in 1984 paralleled other legislation, emphasizing community protection. It was replaced in 2003 by the Youth Criminal Justice Act (YCJA) that returned emphasis to rehabilitation. In the Declaration of Principle, the Act sets out the intent to prevent crime by addressing factors underlying criminal behavior, providing rehabilitation, and also ensuring measured consequences for criminal conduct consistent with the youth’s immaturity. Transfers to adult court were eliminated, although limited adult sentencing is available for serious crimes such as aggravated sexual assault, murder, or attempted murder. Intensive Rehabilitation Custody and Supervision Programs for violent offenders were established and funded as an alternative to adult sentences. This order set a maximum sentence of 6 years in custody and 4 years community supervision for first-degree murder for youth with an emotional disturbance or psychological disorder, where there was reasonable grounds to believe a treatment and rehabilitation plan “might” reduce the risk of a repeat “serious violent offense.” Parliament intended to reduce the number of youth in custody as well as the length of sentences given to individual offenders. The Act places great faith in rehabilitation that may not be yet fully justified. The most recent overview of the youth correctional population in Canada documents the impact of the YCJA in its second year of implementation (Calverley, 2007). The Statistics Canada report indicates that there has been a continued decline of 12% (or 31,700) admissions (Calverley, 2007). As might be expected from the YCJA’s focus on rehabilitation and the decline in the youth crime rate, the majority of young persons in correctional services were on probation (87%), whereas 13% were in youth incarceration (Calverley, 2007).

Public response to the effectiveness of the YCJA has been both encouraging (Barnhorst, 2004; Pulis & Sprott, 2005) and critical (Barnhorst, 2004). Pulis and Sprott (2005) compare the efficacy of the YCJA to its predecessor,
the YOA, in relation to the issue of sentence proportionality. Unlike the YOA, the YCJA explicitly promotes proportionality as a principle of sentencing (Pulis & Sprott, 2005). Their study provided evidence to indicate that judges are more influenced by the nature of the offense in sentencing under the YCJA than they were under the YOA. Barnhorst (2004) presents both the positive directions that the YCJA aims for and several implementation issues that demonstrate the YCJA’s flaws. Among its positive directions, Barnhorst names accountability, protection of the public, and reduced use of the court as some examples of the Act’s effectiveness. However, Barnhorst also highlights the YCJA’s many implementation issues such as the possibility that explicit recognition of the range of extrajudicial measures sometimes leads to more interventions than would have occurred under the YOA, and the possibility that police may misuse community referrals by advising youth that failure to comply will result in a charge. Barnhorst further states that conditions of release can essentially set up youths for failure (because the type and number of conditions may be difficult to comply with and therefore may lead to breaches, new charges, and subsequently a higher chance for custodial sentences) and that there may be a tendency for conferences to overreach in their discussion of a youth’s life, to recommend intervention disproportionate to the seriousness of the offense, and to lack procedural fairness.

In reviewing juvenile justice legislation in Western nations, it is evident that the tension between the goals of rehabilitation and protection of the public has resulted in a pendulum-like approach to young offenders. The last two decades have witnessed a harsher approach to controlling young offenders that is beginning to swing back to a more rehabilitative model in some jurisdictions. The renewed interest in rehabilitation of young offenders has in large measure stemmed from longitudinal research identifying risk factors and potential treatment options conducted in a number of countries in the last decade.

Psychiatric Disorders in Young Offenders

In the last several years there has been increasing attention paid to the prevalence of psychiatric illness in young offenders (Cocozza & Skowyra, 2000; Feldstein & Ginsburg, 2006). In the United States, this arose from a growing recognition of the unmet mental health needs of young persons in general coupled with studies documenting the inadequacy of mental health services in juvenile correctional facilities. Feldstein and Ginsburg (2006) assert that adolescents involved in the juvenile justice system often face a number of compounding challenges including mental health diagnoses. To address such disorders including substance abuse, there is evidence to support the efficacy of motivational interviewing intervention, which is said to be an appropriate developmental match for adolescents (Feldstein & Ginsburg, 2006). Research has also demonstrated gender differences in psychiatric disorders among adolescents within the juvenile justice system (Wasserman et al., 2005). Wasserman et al. describe a “gender paradox,” whereby females are less likely than males to have psychiatric disorders or be involved in criminal activity, but the minority of females involved in the justice system are at an elevated risk for internalizing disorders. In particular, there is a significantly higher prevalence of affective disorders and anxiety disorders for girls who commit offenses, and this increase is even more distinct where the offense is violent (Wasserman et al., 2005). The empirical literature is limited, but the research data suggested high rates of psychiatric illness in young offenders (Feldstein & Ginsburg, 2006; Thomas & Penn, 2002).
Similar findings emerged in the United Kingdom (Hagell, 2002). Prevalence estimations derived from limited studies suggested rates of mental health problems in 46%–81% of young offenders. The report by The Mental Health Foundation concluded that existing mental health services failed to meet the needs of this population and called upon the government to increase psychiatric services under the National Health.

In Teplin’s (2002) prevalence study, substantial rates of psychiatric morbidity were found in juvenile detainees in Chicago. Even after excluding for the diagnosis of conduct disorder, 60% of males and 67% of females met diagnostic criteria for one or more psychiatric disorders. Bearing in mind the limitations in the research, the rates of psychiatric disorder in young offenders is far greater than previously estimated and exceeds the capabilities of community and institutional mental health services.

**Risk Factors for Adolescent Violence**

In the last 15 years there has been a surge in research into child conduct problems (Connor, 2002; Loeber & Farrington, 1998; Rutter et al., 1998). Longitudinal and cross-sectional studies in different countries and cultures have examined multiple factors to determine their association with subsequent offending and violence. There is a convergence of findings in different studies that confirms the multifactorial nature of serious offending behavior and violence. This has resulted in a wealth of data that can now be used to formulate prevention and treatment interventions for children and youth at different developmental levels.

Self-report rates of criminal behavior and violence by adolescents in England demonstrate high frequency of behavior that would result in criminal charges if discovered (Flood–Page, Campbell, Harrington, & Miller, 2000). In the United States the “Monitoring The Future” project has demonstrated stable levels of self-reported violent behavior over the last 25 years with approximately 30% of adolescent’s affirming at least one violent act in the previous year (Johnston, Bachman, & O’Malley, 1995). Given the high rates of antisocial and assault behavior, one could consider this almost normative in adolescence. Most adolescents, however, discontinue antisocial or violent behavior by late adolescence, and only a small percentage of them go on to become chronic adult offenders.

Youth who commit serious violent behavior usually also commit other serious nonviolent crimes such that it is difficult to separate violent offenders from other chronic severe delinquents. Violent adolescents are a heterogeneous group with variable social and psychological profiles. Despite the variability of traits, certain patterns of behavior help identify those youth at higher risk for violence. Moffitt’s (1993) characterization of the “life course-persistent offender” versus “the adolescent-limited offender” identifies a group of offenders who carry a higher risk of violent behavior. The life course-persistent offender generally first demonstrates persistent conduct problems in early childhood and escalates the behavior through adolescence and into adult years. Although they make up only approximately 5% of the population, they commit a disproportionate number of offenses. This group had higher rates of difficulties in temperament, social alienation, poor parenting, as well as difficulties in cognitive deficits, hyperactivity and attention problems, impulsivity, and aggressiveness. More than 50% continued showing serious conduct problems through adolescence. Although this group presents a higher risk of continued antisocial behavior than the “adolescent-limited” group, the fact that many desisted antisocial behavior in adolescence highlights the complexity of predicting violent
behavior during the rapid shifts in psychological development inherent in adolescence. This process is further complicated by the fact that youth who begin and likely discontinue their antisocial behavior in adolescence are a far larger group with the result that they commit an overall higher number of violent offenses. Although adolescent-limited offenders are more likely to discontinue antisocial behavior in young adult years, they are often caught in the web of mandatory waiver to adult court, resulting in potentially lengthy sentences that may not be required to assure public safety.

In response to increased violence among adolescents, The Surgeon General of the United States examined youth violence from a public health perspective (Satcher, 2001). A public health approach demands identification of risk or protective factors, determination of how factors work, public education regarding the findings, and designing programs to prevent violence. Results from Lipsey and Derzon’s (1998) meta-analysis of longitudinal studies, were augmented by further longitudinal studies in the United States. Risk factors were defined as anything that increased the probability for violence with the condition that there was an underlying theoretical rationale to support the factor. The factors were categorized into early-onset and late-onset and divided into individual, family, peer, community, and school factors. Risk factors were demonstrated to have different effects at different ages of development. Within the late-onset or adolescent group, most risk factors had only a small individual effect. In keeping with adolescent development, however, peer group factors had a strong effect such that association with antisocial peers, belonging to a gang or lacking social ties strongly predicted antisocial behavior. Individual, family, and community factors had less specific individual impact, but the additive effect was predictive. The majority of risk factors were consistent with social learning theory. Biological factors did not demonstrate statistical significance in large group data.

The report cautioned that no individual factor or group of risk factors was powerful enough to predict which individual will become violent. Most youth with evidence of some risk factors would never become violent, but risk factors could be used to predict rates of violence in groups with certain characteristics. Cumulative risk factors were not able to account for an individual’s specific situational or social factors given that these were not easily researchable.

Current research has also examined risk factors from the ecological perspective by considering individual, family, school, and community characteristics (National Institute of Health [NIH] State-of-the Science Conference Statement, 2006). Panels of health professionals at the NIH conference endorsed Moffit’s (1993) distinction between violence that persists from adolescence to adulthood and limited-duration adolescent violence that typically ceases with the transition into adulthood (NIH, 2006). Individual-level risk factors may include child fighting, crimes, victimization, and childhood substance abuse (Blitstein, Murray, Lytle, Birnbaum, & Perry, 2005; NIH, 2006). There is significant evidence to support the claim that family-level risk factors play a key role in predicting adolescent violence (Blitstein et al., 2005; Herrenkohl, Hill, Hawkins, Chung, & Nagin, 2006; NIH, 2006; Nofziger & Kurtz, 2005). Parenting style (Blitstein et al., 2005; NIH, 2006), family management practices (Herrenkohl et al., 2006), violent victimization or child abuse (Nofziger & Kurtz, 2005), and family conflict (NIH, 2006) are demonstrated to be family-level risk factors. Having a nonauthoritative father (demanding and controlling) can lead to adolescent violence for both boys and girls, whereas authoritative mothering (warm and responsive) can be a protective factor, reducing risk of adolescent violence,
for girls (Blitstein et al., 2005). Similarly, a low level of family management during early adolescence poses a risk of increasing violence, whereas a normal or high level of family management buffers the risk of adolescent violence (Herrenkohl et al., 2006). School or community risk factors include poor peer relations, involvement in gangs, lack of connection to school, living in a violent neighborhood, association with violent peers, and exposure to violence (NIH, 2006; Nofziger & Kurtz, 2005; Wright & Fitzpatrick, 2006). Petras et al. (2005) suggest that early levels of aggressive behavior identified by teachers during elementary school years are strong predictors of later criminal court violence among girls (Petras et al., 2005).

In 1998 the National Institute of Mental Health initiated a process to identify risk factors for child and youth exhibiting externalizing behavior problems and describe the types of further research needed in the field (Hann & Borek, 2002). They selected a consensus process with a group of experts asked to identify factors supported by key research studies. Factors were divided into “correlates,” “predictive risk factors,” and “causal risk factors.” They conducted a critical review of the literature and identified a number of significant causal risk factors including child hostile attribution processes, parental engagement and discipline patterns, and peer rejection and association with delinquent peers. In addition they identified many more predictive risk factors and “concurrent correlations,” which required further research to determine if they had potential causal effect. They argued the need to move beyond examination of simple risk factors to develop a more complex view of how these factors interact within a developmental and contextual perspective. As an example, child temperament interacts with parenting style in a bidirectional relationship, such that each will affect the other. Similar findings can be seen in other interactions, for example, Moffitt (1990) found in the Dunedin study that the aggression seen in youth with low neuropsychological functioning coupled with family adversity was four times higher than that in boys with either factor alone.

The promise that increased knowledge regarding the interaction of different risk factors will lead to the development of improved prevention and treatment programs has already been demonstrated in treatment programs described below.

### Treatment Approaches for Violent Adolescents

In the modern history of juvenile justice, there have been multiple attempts at treatment and rehabilitation of juvenile delinquents. The substantial failure of most of these attempts led to a sense of therapeutic nihilism by the 1980s. Over the last several years, however, there has been renewed optimism in the efficacy of treatment and rehabilitation of juvenile delinquents. Several comprehensive meta-analyses of studies have examined the effectiveness of various treatment types in reducing future violent behavior among adolescents (Carr, 2005; Lipsey & Wilson, 1998; Littell, Popa, & Forsythe, 2005). After reviewing randomized controlled trials of multisystemic therapy (MST), Littell et al. (2005) state that there is inconclusive evidence of MST’s effectiveness as compared with other interventions. However, other researchers suggest that there is a wealth of evidence to support the effectiveness of MST and other treatments in significantly reducing the risk of future violence (Carr, 2005; Lipsey & Wilson, 1998). Carr (2005) found that MST leads to a significant reduction in violent offending among male and female youths aged 12–17. In their extensive meta-analysis of 200 treatment studies, Lipsey and Wilson (1998)
concluded that there was statistically significant overall treatment effect with some approaches showing great promise. Within the meta-analysis, the best treatment outcomes had a 30% recidivism rate in the first year, compared with a 50% rate of recidivism in control groups. Treatment programs focusing on interpersonal skills, cognitive behavioral techniques, individual counseling, and multiple services were the most effective for community groups. Although a modest treatment effect could be demonstrated, the authors concluded that given the array of treatment program combinations, even 200 studies were insufficient to derive any firm conclusions.

The report of the Surgeon General on youth violence highlighted the historical development and continuation of violence prevention and treatment programs with no proven efficacy (Satcher, 2001). In review of proven programs, they selected Level 1 programs that demonstrated reduction of violence or serious delinquent behavior and Level 2 programs that demonstrated reduction of known risk factors for violent behavior. Determinations were based on rigorous experimental designs, evidence of significant deterrent effects, and replication of results at multisite or clinical trials. Programs were divided into primary, secondary, or tertiary prevention. Tertiary prevention programs were aimed at adolescents already demonstrating violent or serious delinquent behavior. The review reached two major conclusions. First, treatment could divert a significant proportion of violent youth from future violent behavior. Second, there was marked variability in the effectiveness of different types of programs.

The Surgeon General Report outlined “model programs” that employed rigorous experimental design and resulted in significant and replicated deterrent effects on violence. Tertiary prevention model programs aimed at youth already demonstrating antisocial or violent behavior included “functional family therapy,” “multisystemic therapy,” and multidimensional foster care. “Promising programs” employed rigorous experimental design that demonstrated replicated deterrent effects on any risk factor for violent behavior. Ineffective tertiary programs were also identified. These included “boot camps,” residential programs, and social case work. In contrast to the stated goals of reducing crime, waiving adolescents to adult court was shown to increase subsequent recidivism among those youth who had been waived while also exposing them to increased rates of physical harm by other adult prison inmates. Waived youth had much higher rates of attempted and successful suicide in custody compared to adult defendants.

Although, to date, empirical studies demonstrate only a modest treatment effect for violent adolescents, progress in pediatric psychopharmacology will likely increase treatment effectiveness by targeting specific risk factors including impulsivity, attention deficits, and underlying psychiatric disorders associated with violence. Connor (2002) summarizes the pharmacological approaches to adolescent aggression. There is strong empirical support for the use of neuroleptics for disruptive behavior disorders and psychotic disorders and for the use of stimulants in conduct disorder and attention-deficit hyperactivity disorder. Promising results have also been obtained for mood stabilizers. Although it would be reductionistic to believe that pharmacological treatments by themselves would have a profound effect on individual aggression, there is reason to expect that combining psychosocial treatments with targeted pharmacological interventions will lead to improved compliance and ultimate efficacy.

Current Controversies

Juvenile justice legislation is the measure of our approach to dealing with violent adolescents.
Within different jurisdictions, there is different emphasis placed on the goals of rehabilitation versus protection of the public. As a result, there are marked differences in the way violent juveniles are managed. In some jurisdictions, adolescents convicted of a violent crime are exposed to harsh penalties that in other jurisdictions would merit comparatively limited incarceration or intensive supervision and treatment. Accordingly, different jurisdictions place variable ethical and clinical demands of forensic psychiatrists. Central to ethical concerns are determinations of which adolescents meet statutory criteria for waiver to adult court. Courts generally apply the “public safety standard” and the “amenability to treatment standard” (Grisso, 2003) that demand assessments for risk of future violent behavior and potential to reduce that risk through specific treatment and rehabilitation.

The assessment of risk of violent behavior in adult offenders has been the subject of extensive debate (Monahan, 2003; Monahan et al., 2005; Rogers, 2000). Despite many legitimate concerns regarding the methodology, process, and accuracy of the probability assessments and the purposes for which they are used, there has at least been developed empirical data to guide the process. Assessment of risk of violence among adolescents shares the same concerns but lacks validated risk assessment instruments and must also account for the fluid state of adolescent development. Grisso (2003) describes the assessment as employing known risk factors, actuarial factors, base rates of violent behavior, and assessments of the social context in which the violence occurred. Conditional, short-term risk estimates are possible with some degree of accuracy, but estimates of long-term risk are more problematic. Although it is reasonable to assume that youth exhibiting the extremes of either few or many risk factors would more likely be accurately assessed, we are currently unable to accurately predict future violent behavior in the larger middle group. At this point, the forensic psychiatrist is able to give to the court a generic description and analysis of proven risk factors and protective factors in a specific situation and guide the court as to the significance of the information (O’Shaughnessy, 2003). Definitive statements as to an individual’s risk for future violence should only be offered in broad statements that highlight the limitations in the research.

At the current time, specific structured risk assessments of youth violence (Borum, Bartel, & Forth, 2002; Grinberg, Dawkins, Dawkins, & Fullilove, 2005; Hoge, 2002; Raine et al., 2006) are being tested in offender populations. The Structured Assessment of Violence Risk in Youth (SAVRY) is a work in progress utilizing a structured professional judgment approach (Borum et al., 2002). The SAVRY was created by employing risk and protective factors derived from existing research, operationalizing them and scoring them on a scale with each item rated from 0 to 2 based on the extent of fit with the description. Preliminary research in adolescent offenders treated in our violent offender program showed moderate ability to predict which youth reoffended in the 12-month follow-up period (Catchpole & Gretton, 2003). Although preliminary results are encouraging, there is insufficient research at this time to affirm this instrument for court purposes. The structured professional judgment approach, however, has much to offer as a general guideline in the clinical assessment of violent offenders and serves as an aide de memoir in ensuring relevant factors are considered in the assessment. It also focuses the assessment process on those areas that may be amenable to intervention and thus guides treatment planning.

Grinberg et al. (2005) sought initial validation for the Life-Challenges Questionnaire-Teen Form (LCQ-TF), a 120-item risk assessment tool.
for violence in youth. The LCQ-TF assesses many of the risk factors for adolescent violence discussed earlier. The survey was administered to youth in a detention facility, and the Risk Assessment Index scores calculated were compared to a control group of high school students. Results indicated that violent adolescents were more likely to score high on the family environmental, peer relationship, school and community, and personality risk factors (Grinberg et al., 2005). The study provided initial support for the reliability and validity of the LCQ-TF as a risk assessment tool for violence in adolescents (Grinberg et al., 2005).

Raine et al. (2006) constructed the Reactive–Proactive Aggression Questionnaire (RPQ) and studied the correlates that exist for these two forms of aggression. Proactive aggression is parallel with violent adolescents because it is characterized by a psychopathic personality, delinquency, and serious violent offending, whereas reactive aggression involves less intense characteristics of impulsivity, hostility, and social anxiety (Raine et al., 2006). This study found that proactive aggression could be accurately assessed in children aged 7 by factors including initiation of fights, strong-arm tactics, delinquency, poor school motivation, hyperactivity, and poor peer relationships (Raine et al., 2006). Raine et al. demonstrate the efficacy of the RPQ in assessing risk of violence and emphasize the importance of differentiating the different forms of aggression.

In adult forensic settings, the concept of psychopathy as measured by the PCL-R (Hare, 1991) has become a well-established instrument used in predicting risk of future violent behavior. Groups of individuals with high psychopathy scores have higher rates of violent offenses than offenders with lower scores. Like all instruments used for assessment of risk, however, the PCL-R is unable to establish the specific risk for a given individual (Hempill & Hart, 2003). As well, the PCL-R has been criticized to lack predictive ability among females because it does not take into consideration gender-related factors such as exposure to sexual abuse, psychiatric comorbidity, threat to interpersonal relationships, and insecure attachment (Odgers, Moretti, & Reppucci, 2005; Odgers, Reppucci, & Moretti, 2005). Odgers et al. suggest that adolescent girls exposed to harsh victimization may be manifesting features that appear to be psychopathic traits but are not actually related to psychopathy. Psychopathy has been defined as a specific form of personality disorder. Psychopaths are arrogant, superficial, and manipulative, with shallow and labile affects and who are unable to form strong emotional bonds. Behaviorally, they tend to be irresponsible, impulsive, and sensation seeking and are prone to criminal behavior (Cleckley, 1976). Generally, these traits are evident in adolescence and continue through the adult years. The diagnosis of psychopathy generally has severe consequences for the offender and may affect their classification within correctional settings and limit their opportunities for parole. To date, there has been no proven treatment for adult psychopathy, although the literature is characterized by significant methodological weaknesses.

Personality traits consistent with psychopathy are recognized in adolescent offenders, but there is heated debate as to whether psychopathy is an appropriate concept for adolescents. The first measurement of psychopathy in adolescents utilized a modified PCL-R that eliminated two items and modified two further items (Forth, Hart, & Hare, 1990). High psychopathy scores were able to predict reconvictions for violent offenses. Subsequent studies utilizing the PCL-YV (Forth, Kosson, & Hare, 2003) have found good internal consistency and interrater reliability in adolescent populations (Dolan & Rennie, 2006a; Forth & Mailloux, 2000). High psychopathy scores correlated with age of first arrest, seriousness of
offense, number of convictions (Brandt, Kennedy, Patrick, & Curtin, 1997; Kosson et al., 2002), reoffense rates in adolescent sexual offenders (Gretton, McBride, Hare, O’Shaghenessy, & Kumka, 2001), reoffense rates in violent offenders treated in the community (Catchpole & Gretton, 2003), and institutional misconduct and infractions (Dolan & Rennie, 2006b; Edens & Campbell, 2007). A factor analysis of the PCL-YV suggests that, in particular, high scores on the interpersonal portion of the instrument, characterized by a grandiose sense of self-worth, impression management, and deceitfulness, positively correlate with violent and aggressive behavior (Vitacco, Neumann, Caldwell, Leistico, & Van Rybroek, 2006).

Other measurements of psychopathy in children and adolescents include the Psychopathy Screening Device (Frick & Hare, 1994) and the Childhood Psychopathy Scale (Lynam, 1997). Limited research is available on these instruments. The CPS was used in the middle group of the Pittsburgh Youth Study (Loebber, Farrington, & Stouthamer-Loebber, 2001). Youth with high scorers demonstrated the most impulsive, severe, frequent, and aggressive conduct difficulties and provided incremental accuracy in predicting antisocial behavior over and above other known risk factors. Lynam (1996) argues that youth with conduct problems combined with hyperactivity, impulsivity, and attention difficulties are “fledgling psychopaths.”

Early identification of psychopathy may have profound impact if treatment and support resources can be applied to these youth and their families early in their development. Childhood personality traits interact with the environment in a manner that may perpetuate or exacerbate their development (Caspi, 1997). Disruptive youth may evoke harsher discipline or reaction from parents or teachers that may serve as a rationalization for subsequent oppositional or antisocial behavior. They often associate with other youth with similar behavioral problems that predictably reinforce the antisocial traits. Early intervention may disrupt this reinforcement, resulting in amelioration of the development of adult psychopathy. Although further research on specific treatment is needed, evidence has shown that youth with psychopathy features who receive intensive residential treatment have significantly lower rates of violent recidivism than those in juvenile correctional institutions (Caldwell, Skeem, Salekin, & Van Rybroek, 2006). This supports the line of thought that rehabilitation, rather than punishment, may be a crucial component in reducing youth violence.

Although recognizing the potential benefits of early identification and intervention, a number of critics have raised substantial concerns regarding the use of the construct of psychopathy in adolescents. Seagrave and Grisso (2002) raise concerns that psychopathy may be diagnosed in adolescents who may be going through a transient development phase that mimics similar traits, for example, self-centeredness or rule-breaking behavior, resulting in false-positive diagnoses. The temporal stability of psychopathy from adolescence into adulthood has not been demonstrated empirically, thus limiting its predictive ability. Further, concerns were raised about the lack of certainty regarding base rates of psychopathy, cutoff scores used to determine psychopathy, and the potential for examiners to fail to consider temporal and contextual information. Ultimately, the authors feared that a psychopathy diagnosis would be used as a screening device to transfer youth to adult court.

Other authors (Hart, Watt, & Vincent, 2002) wonder whether juvenile psychopathy actually exists or, if it does, whether it is the same as adult psychopathy, given the lack of longitudinal research on the temporal stability of the construct. The same group of researchers, however, agrees that there is good interrater
reliability in measures of psychopathy and that the same traits are found in both adolescents and adults (Hempill & Hart, 2003).

Existing research findings on risk assessment and juvenile psychopathy have potential for great benefit and great harm. In large measure, the harm versus benefit is determined by the context and purposes of the assessment. In those jurisdictions emphasizing a retribution and punishment approach, one could easily envision a youth given the label “psychopath” or the designation “high risk” to be summarily transferred to adult court and denied any opportunity for rehabilitation. Given the current state of research, such summary determinations would not be justified. In adults, the diagnosis of psychopathy connotes the image of a ruthless, callous, and dangerous individual who is unamenable to treatment. It is easy to understand how courts would perceive an adolescent psychopath in a similar vein and react with a punitive response to protect the public. In fact, PCL-YV scores have been found to predict certification status of an adolescent into adult court (Marczyk, Heilbrun, Lander, & DeMatteo, 2005). This punitive response would be inappropriate on two grounds. First is the lack of empirical support for the temporal stability of adolescent psychopathy. Second, research into specific treatment aimed at the core features of adolescent psychopathy has not yet been conducted. Research in our forensic service compared 61 violent adolescents treated in our cognitive behavioral violent offender program with a comparison group of 58 untreated violent adolescents followed for average of 3.5 years (Catchpole, Gretton, & Hempill, 2003). Violent reoffenses occurred in 26% of the treated group versus 48% of the comparison group \( (p = .007) \). In the overall group, youth with high PCL-YV scores (above 30) had a 68% recidivism compared to 38% in the moderate group (PCL 20–29) and 18% in the low group (PCL <20; \( p < .001 \) consistent with other research noting increased rates of violence in youth with high PCL scores. In the treatment comparison, however, high PCL youth treated in our violent offender program had a 43% recidivism rate compared to 80% in untreated group \( (p < .01) \). This preliminary study requires replication and expansion, but it suggests that it would be premature to assume adolescent psychopathy is an untreatable condition. Although clearly youth with high PCL scores remained a significant risk to reoffend, longer term follow-up is required to determine what degree of risk persists after treatment.

I would agree with the position that use of the concept of adolescent psychopathy should be restricted to research settings and not used in court proceedings until the issue of temporal stability and treatability has been resolved. Removal of the term “adolescent psychopathy” from forensic use will not prevent the potential misuse of the construct, however. Forensic clinicians describing an adolescent offender as callous, self-centered, impulsive, aggressive, lacking empathy, and prone to impulsive violence will likely have the exact same effect as if they diagnosed psychopathy.

In research and treatment settings, assessment of adolescent psychopathy adds an important element to the evaluation process. This subgroup of offenders can be reasonably identified with good interrater reliability, and comparisons across different treatment settings are reasonable. Adolescents with high PCL scores are identified as high-risk youth who should receive increased treatment and supervision services. At this point there is no definitive treatment yet developed and this must be a priority for future research. Whether we can significantly alter the trajectory of adolescent psychopathic-like traits and behaviors into adult psychopathy remains to be determined.

In an ideal world, juvenile offenders with psychiatric difficulties would receive appropriate...
treatment and resources in a juvenile setting. In the real world resources are limited, and many juveniles are transferred to adult court and prisons where no treatment is available and they are exposed to abuse and violence. Many youth transferred to adult court are indeed violent and dangerous and may not be amenable to intervention or treatment. Although far from perfect, the comprehensive risk-focused assessment process is able to identify within reason those youth who present the highest risk from those who are less likely to continue offending. The civil rights of the accused are protected through the due process of the waiver hearing, and the evaluation of the forensic psychiatrist or psychologist is open to cross-examination. The process is designed to be fair and transparent.

In contrast to the waiver hearing are automatic transfer provisions in which the nature of the crime or the opinion of the prosecutor determines whether a youth will be tried in adult court. While, no doubt, many of these offenders pose a significant risk to reoffend, we have no way of determining which of these youth shares the risk factors that indicate a likelihood of future violent offending. Adolescents who may have committed a violent offense, but who would not be evaluated as a high-risk offender on a comprehensive assessment, are exposed to a process that has been demonstrated to likely cause harm without necessarily reducing the risk of subsequent recidivism. The genesis of this legal doctrine was at least in part driven by rising levels of youth violence that shocked communities coupled with our lack of knowledge about prevention and treatment of violent behavior in adolescents. These factors are no longer as relevant. The rates of youth violence as measured by crime statistics have declined in virtually all Western countries. We are now at a point where we can offer moderate abilities to predict higher risk youth and construct prevention and treatment programs. Although these programs are far from ideal at this point, the public health prevention and treatment approach is superior public policy to automatic transfer provisions that incarcerate without rehabilitating.

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References


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