Psychological disorders in juvenile offenders

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Abstract

Young persons manifestly suffering from psychological disorders or displaying behavioural abnormalities which alert suspicion to the presence of a psychological illness and individuals who can be diagnosed as being in the preliminary stages of a manifest psychological illness who display abnormal pre-delinquent social behaviour or have already committed an offence present an interdisciplinary challenge across the fields of medicine(particularly child and adolescent psychiatry), education, youth welfare and justice from a variety of aspects and objectives. These young persons do not only come from disrupted family homes, but are also encountered in institutions such as schools or youth welfare facilities or care institutions and in child and adolescent psychiatric units – in certain cases for the purpose of determining a differential diagnosis with a suspected psychological illness, within the framework of a forensic examination – and also in prison should these individuals have reached the age of criminal responsibility. This article provides a concentrated general view of the problem fields encountered in this interdisciplinary challenge from a clinical perspective with a focus on the interfaces between the above-mentioned professional fields.

Introduction

Large-scale epidemiological investigations on the psychological health of children and adolescents in Germany such as the BELLA study as part of the German Health Interview and Examination Survey for Children and Adolescents (German abbreviation (KIGGS) (Ravens-Sieberer et al., 2007) identified indications of psychological abnormalities in over 20 % of children and adolescents between the ages of 7 and 17. Dominating the list of these abnormalities were disorders such as anxiety (10 per cent), disorders relating to social behaviour (7.6 per cent) and also depression. The high rate of social behavioural disorders as a significant preliminary symptom or background to manifested delinquency is a clear indicator of the central core of the issue. How can serious disorders in social behaviour and dissociality be categorised according to the character of the disorder and significance of the illness? What preliminary developmental and behavioural signs are identifiable? What types of treatment and possibilities of intervention already exist and also what methods of prevention? A further problem is that circumscribed psychiatric illnesses such as anxiety disorders, depression, schizophrenic psychoses or obsessive-compulsive disorders can form the direct background to a legally sanctioned act or one with a significant effect on the social fabric. Both perspectives illustrate that young persons who have displayed relevant conspicuous behavioural tendencies can only be adequately targeted through the reciprocal coordination and supervision of the fields of medicine (child and adolescent psychiatry), education and youth welfare and also the judiciary system within the appropriate area of crime perpetrated by the individual. The institutional locations of this dovetailing process are - in view of the largely lacking adequate educational framework provided by the

individual's family – schools, youth welfare through mobile programmes (e.g. family welfare) and inpatient facilities (accommodation in homes and residential groups), child and adolescent psychiatric clinics and outpatient units for diagnosis and/or forensic examination, the institutions of the youth penal system and also hospital treatment orders. Exemplary investigations have established significantly higher psychological disorders among juvenile prison inmates, i.e. substance abuse, impulse control disorders, affective disorders and delayed development (Laucht, 2001).

Adolescence- dissociality- psychological Illness
The following stages and steps indicate the age-dependent legal status of children, adolescents and young adults:

from the age of 6	compulsory school education
from the age of 7	limited legal capacity and civil liability
from the age of 14	limited criminal responsibility, end of criminal law protection of children
from the age of 15	end of compulsory school education/vocational college
from the age of 18	age of majority
from the age of 21	end of application of juvenile criminal law s, end of youth welfare support for young adults over 18

Case vignette 1
Hans was taken by his parents to the educational counselling services for the first time at the age of 12 after he had proved to be educationally almost uncontrollable within a school environment. The integration with children of his own age was unsuccessful and a permanent viscous circle of impulsive action, aggressive disputes with his peers, isolation and disruption of lessons ensued. A mobile youth welfare support service organised following initial contact proved ineffective in preventing further escalation around the age of 15 with a criminally relevant case of theft, smaller break-ins accompanied by alcohol abuse, truancy from school and generally hanging around. Hans additionally displayed a distinct emotional instability: at times he appeared to be anxious and dependent and at other times suddenly arrogantly dismissive and aggressive towards persons of authority and his peers. These phases alternated with periods of complete indifference in which he reacted stubbornly to any form of educational regulation and displayed expansive behavioural patterns. Hyperactive phases and expansive ideas developed on a sub-acute level: Hans expressed the necessity of speaking to politicians, the desire to introduce a new currency and other similar ideas. During his sporadic attendance at school, he made no contribution to lessons and sat with his back to the teacher, but displayed no further signs of aggression and appeared to be apathetic until the onset of an increasingly confused-disorganised behavioural phase which was then evaluated as acute psychotic (schizophrenic) decompensation, resulting in his admission to an inpatient clinic.

Case vignette 2

Matthias displayed numerous developmental disorders of a linguistic, motoric and psycho-social nature. A social behavioural hyperkinetic disorder was diagnosed at an early stage: this was followed by intervention on the part of educational institutions, youth welfare services and child and adolescent psychiatric services including a longer period at a day-clinic and long-term medication with stimulants. His family background was distressing: his mother had a series of frequently changing partners and copious quantities of alcohol and violence formed a regular background to his home environment. Matthias finished school in year 6 of secondary modern school after eight years of attendance; extended phases of remedial education care including a phase in a child guidance school and a placement in a curative educational institution were unable to prevent an extensive record of criminal acts stretching back to his childhood including theft, damage to property and playing with fire which escalated around the age of 16 to include assault, aggravated robbery and sexual coercion leading to imprisonment.

Case vignette 3

The 17-year-old Patrick left secondary modern school without any qualifications and completed his vocational preparation year without succeeding in finding a vocational training placement or potential career. His family background displayed numerous changes of relationships on the part of his separated parents and frequently changing attachment figures. Patrick grew up with his grandparents and felt himself rejected by his parents. Through his own stages of development, no serious conspicuous behaviour on the part of the quiet and conforming child was registered until he reached puberty and made initial acquaintance with delinquent circles (chiefly with drugs) among his peer groups and began to utilise psychotropic substances himself to brighten his moods. He did not display any criminal or conspicuous social behaviour until he was charged with attempted homicide within the context of a dispute about a young woman. The adolescent psychiatric examination by an expert displayed no indication of a forensically relevant influence on the part of any psychological disorder on the ability to control his actions. The highly gifted young man utilised his period of imprisonment to acquire a school-leaving qualification and undertook vocational training.

These biographical sketches already illustrate several facets of the constellation complex young persons, psychological illness and delinquency. Whereas in the first case vignette, it must be assumed that the serious social behavioural disorders displayed were at least in their final phase the long-term preliminary symptoms of psychotic illness, the individual in the second vignette displayed signs of delinquency and a permanent deviation of social behaviour against a highly problematic developmental background stretching right back into childhood which proved impossible to influence despite a series of interdisciplinary intervention. The third young person only resorted to criminal acts during a crisis situation in his adolescence and it was pressures on his development and a lack of maturity which precipitated the psychodynamic derailment leading to the criminal act.

The spectrum of these biographical sketches provides a clear illustration for criminal statistics indicating that over a third of criminal suspects in Germany are under 25 and that delinquency is observed to increase dramatically during puberty and subside just as steeply in young adulthood (statistic survey by the Federal Criminal Police Office [BKA] by Kölch, 2009). Despite the intensified media focus on this problem field, it is by no means a recent phenomenon in any country or culture (Kölch, 2009).

Psychological disorders and delinquency

Before homing in on any tangible definitions, the following interrelationships are possible:

- The psychological disorder causes and/or intensifies a delinquent tendency.
- The psychological disorder reduces and/or eliminates a delinquent tendency.
- There is no link between delinquency and psychological disorders.
- The psychological disorder can in the case of certain young persons minimise the tendency of perpetrating criminal acts whereas in others it can increase this tendency, depending on the situation of the individual.

Between the two poles of manifested psychiatric disorders and delinquency, behavioural abnormalities within the dissocial and delinquent spectrum are conceivable which arouse and/or confirm a suspicion of psychiatric illness, for example if the criminal act is completely beyond the context of a recognisable biographical or developmental continuity. On the other hand, a criminal act can demonstrate a competence for action and a situational orientation which can put other observed or suspected impairments of ego functions through a potential psychological disorder into perspective. Behavioural abnormalities within the dissocial spectrum can also be precursors to psychiatric illness, as not infrequently observed chiefly in adolescents prior to the onset of psychotic, i.e. schizophrenic, illnesses (Case vignette 1). What also should be mentioned here are developmental and age-dependent abnormalities in social behaviour which are not subject to judicial measures, either because the individual is below the age of criminal responsibility or due to the form and nature of the deviation from social expectations.

It is however only a relatively small group of juvenile delinquents whose criminal activity takes place against the background of manifest psychiatric illness. The forms of these disorders range from clear motivational contexts which can also be evaluated by experts (e.g. a young man suffering from a compulsive disorder breaks off and collects an immense number of Mercedes stars motivated by a destructive desire; a psychotic young man commits an assault under the orders of imperative voices and/or delusional experiences) to sometimes complex specific constellations which can only be clarified within the context of thorough forensic-psychiatric investigation, motivational derivatives and their possible influence on the situational disposability of individual action competences and intrinsic controlling mechanisms. In addition to the establishment of the presence or absence of medical reasons for a reduced or even nullified criminal responsibility, the degree of maturity of the young person or young adult must also be evaluated as this will have far-reaching consequences in legal proceedings.

What is far less well defined and more controversial – not only within the field of child and adolescent psychiatry – is the evaluation of those children and adolescents who have displayed conspicuous behaviour which is chiefly or even exclusively manifested through the violation of social and legal norms. These types of behaviour do not per se constitute a psychological disorder. In the classification system for psychological disorders in children and young adults (ICD-10 according to the World Health Organisation and DSM-IV-R according to the American Psychiatric Association), there is no specific classification for delinquency (Remschmidt & Walter, 2010). In children and adolescents, this type of conspicuous behaviour is attributed to social behavioural disorders. If the field of intersection between child and adolescent psychiatry, youth welfare, school and the educational sector is broad in the case of this type of disorder, the field of child and adolescent psychiatry will claim the priority of their area of responsibility with regard to diagnosis and the detection of accompanying disorders and developmental characteristics, not least within the context that these disorders display characteristics of independent degrees and categories of illness (Schmidt, 2008). According to this concept, dysfunctional social behaviour generally displays a consistent group of symptoms, a consistent aetiology or at least pathogenesis, a consistent course of progress and reacts to consistent forms of intervention. The term dysfunctional social behaviour encompasses long-term patterns of dissocial, aggressive and rebellious behaviour which grossly violate the social expectations of the relevant age group. This behaviour goes substantially beyond mere childish mischief and adolescent insubordination and is not purely limited to individual dissocial or criminal acts. Other psychological disorders should not form the background for this conspicuous behaviour which should be observed over a minimum period of over six months. The list of characteristics in the International Classification of psychological disorders (ICD-10) includes extraordinarily frequent and intensive outbreaks of rage, oppositional behaviour, anger, blame shifting, sensitivity, resentment, hate, lying and unreliability, a disregard for the physical integrity of others, the use of dangerous weapons, staying out in the evenings, physical cruelty, cruelty to animals, damage to property, starting fires, stealing, truancy from school, running away, frequent tyrannising and other forms of bribery, robbery, sexual coercion and break-ins. The key points determining the degree of affliction and the duration of individual symptoms are provided in this list. According to Kölch (2009), seven per cent of all male children and adolescents and three per cent of girls suffer from social behavioural disorders. In specialised youth welfare institutions and schools providing educational support, this figure rises to a peak of 48 per cent, although in 22 per cent of these cases a comorbid hyperactivity disorder is also observed.

Within the framework of the dominance of biological etiologic paradigms in child and adolescent psychiatry, the risk factors were postulated as including dissocial developments (Vloet 2006), morphological disorders (lesions in the central nervous system: predominantly hypothalamus, amygdala und prefrontal cortex), a series of further somatic disorders (diminished vegetative reacting capacity and disorders relating to endocrine regulation mechanisms between the pituitary and the adrenal cortex) and a serotonergic dysfunction from a neurochemical perspective: all these diagnoses must be considered and subsequently classified according to their specific aetiological dignity for the primary descriptive clinical picture of social

behavioural disorders and dissocial development respectively. Less speculative and closer to the behavioural forms observed in institutional environments are temperamental and personality factors observed in these children and adolescents: abundant explorative and impulsive behaviour, a style of interaction which is characterised by a lower level of internal and social inhibition, conspicuous affective indifference, lack of empathy and a deficient emotional regulation in correlation to age. In most cases, these children and adolescents possess a lower threshold for conspicuous behaviour, particularly situation-induced impulsivity which can become problematic in all social environments. This type of personality and/or behavioural style has been particularly linked to post-traumatic developments which are easily comprehensible in view of the simultaneously existing psycho-social risk factors (Vloet 2006). Risks originating within the original family or individual environment such as low social-economic status, belonging to an ethnic minority, frequent changes of attachment figures with consecutive attachment disorders, delinquent and/or mentally ill parents, physical and psychological maltreatment and an inconsistent style of parenting styles with too few or too many rules all lead to the development of deficient strategies in the processing of social information which is considered to have an essential pathogenetic function within the sketched behavioural structure. In the case of young males, aggressive role models also play a particularly vital role.

Moffit (1993) describes two distinct types of phases for these social behavioural disorders and/or dissocial developments: an episodic phase type (limited to adolescence) and a persistent phase form (remaining stable throughout the individual's life).
Characteristics of the episodic type include oppositional and delinquent behavioural patterns initially developing at the onset of puberty which are largely observed as not behaviourally stable and gradually disappear once the individual has reached adulthood. Adolescents displaying this form of development possess a largely inconspicuous personality structure, are normally socially well integrated, do not as a rule exhibit further psychiatric abnormalities and the social behavioural disorder manifests itself with less aggressive forms of delinquency. Should psychiatric symptoms (such as depression) be observed, these can more be categorised as the result of dissocial behaviour and the social reactions to this behaviour. Substance abuse, i.e. alcohol and drugs, increases the risk of this behaviour pattern subsequently developing into the persistent form. Generally, these dissocial abnormalities have at least temporary consequences for integration at school and work and social and family integration. This type of developmental phase was primarily considered as an excessive form of behaviour for overcoming specific challenges at certain developmental stages and was therefore interpreted as resistance to the maturity gap, particularly in western cultures (gulf between psychological maturity and socio-economic independence). Epidemiological statistics show the incidence of this type of behaviour in up to 25 per cent of all adolescents (Vloet, 2006). The persistent behavioural phase form must be evaluated as being significantly more severe. Affected adolescents have drawn attention to themselves through their aggressive, oppositional and delinquent behaviour which has manifested itself since early childhood and normally continues to escalate beyond adolescence into adulthood. These individuals display

neuropsychological deficits, i.e. an attention-deficiency disorder and psychopathic personality characteristics, frequently also physical aggression and their social integration is inadequately or non-existent (except within dissocial peer groups). In these cases, psychiatrically relevant abnormalities are observed such as attention deficit disorders, elements of post-traumatic stress disorders, early social behavioural disorders, states of depression progressing as far as to suicidal syndromes and are accompanied by substance abuse, anxiety disorders and psychotic syndromes. Concomitant with the already abnormal temperamental characteristics of the child which shape the early stages of interaction, other factors such as an adverse family environment, individual cognitive deficits, early traumatisation and maltreatment resulting in an altered anxiety threshold and the development of a personality disorder also play a role here. This unfavourable course of development is observed in between five and ten per cent of primarily male adolescents. Should this persistent type of development following the presence of the factors above described produce the tendency towards a personality development disorder at an early stage, the episodic type supports the developmental theory of juvenile delinquency. The cerebral restructuring processes within the neurobiological time window of adolescence cause an increased susceptibility towards environmental influences during this developmental process which in turn contribute to typical adolescent behavioural characteristics such as increased impulsiveness, a higher intensity of affectivity and risk behaviour. Discrepancies during the maturing process have already been mentioned: dissociality is here primarily viewed as being an expression of adaptive difficulties and problems in coping with the demands of particular developmental phases, particularly during the critical developmental time window. Nevertheless, adolescents affected in this manner display a far greater number of so-called protective factors – in comparison to those affected by a persistent disorder – such as better social skills. They fare better at school at least during the initial phase of abnormality, display fewer accompanying psychological disorders, appear capable of relationships and bonding and are capable of a higher level of performance due to their cognitive abilities (Vloet, 2006; Laucht, 2001).

Risk evaluation and its earliest possible identification constitute a vital concern within the field of psychological disorders. Epidemiological studies have generally shown that social factors such as poverty, broken homes, migration, educational career and social status are biographical characteristics which can increase the risk of psychological disorders. Aspects of our life today which have been apostrophised as modern such as excessive media consumption, the frequently invoked high degree of mobility and flexibility and the raising of children and adolescents in partially or completely restructured families all contribute to the structural weakening of the core caring fabric of the family which cannot in any way be sufficiently compensated for in institutions. For the relevant special adolescent age-group, there is a modicum of truth in the fact that development thresholds are generally considered to increase risks, even if the long held concept of adolescence as a crisis in itself could not be sufficiently validated (Kapfhammer, 1995 et al.).

Diagnosis and intervention

In view of the numerous overlapping of different progressive forms of generally frequent “vaguer” clinical pictures during adolescence and also certain partially trivial and partially clichéd fundamental assumptions (“puberty!”), the establishment of a framework enabling the earliest possible intervention in the case of children displaying abnormal behaviour appears from the child and adolescent psychiatric viewpoint to be an urgent issue which will enable adequate forms of diagnosis to identify risk factors for dissocial delinquent development and its preceding and accompanying symptoms. Adequate diagnosis will also help to differentiate between phenomena which are caused by development or dissocial factors and unambiguously psychopathological phenomena and would constitute the first essential contribution of adolescent psychiatry in the above outlined interdisciplinary challenge. The high figure of undiagnosed cases of psychological disorders in offenders, the lack of identification of risk factors and the low percentage of expert assessments demanded in the case of an already existing criminal record all highlight potential opportunities for intensified action and the undertaking of measures for improvement within this area (Brünger & Weissbeck, 2008).

Intervention of any sort always depends on the institutional framework, the nature of the original disorder and other individual criteria such as age, stage of development and cognitive skills. It is however possible to establish general core areas of therapeutic activity for adolescents with psychological disorders and dissocial/delinquent tendencies (Weissbeck & Brünger, 2008).Treatment objectives in which remedial, social pedagogic and child and adolescent psychiatric competences must complement each other are always rooted in the improvement of the reality check including the anticipation of active consequences, the improvement of communicative abilities with the development of socially adequate strategies for conflict solution, the improvement of relationship skills with openness and the creation of trust, the socially adequate approach to the improvement of frustration tolerance, emotional stability and the control of impulsiveness, the improvement of orientation towards norms and the encouragement of alternative satisfaction strategies and also the improvement of family relationships. Additional specific treatment objectives are also vital according to the nature of the fundamental disorder. Depending on the institutional and/or therapeutic environmentand the fundamental disorder, supplementary measures could include psycho-pharmaceutical therapeutic strategies, social competence training, relaxation techniques, creative therapies, work and independence training, behavioural therapeutic strategies for the modification of behaviour patterns and psycho-educational measures in individual and group therapy structures, which would perhaps also be feasible within the framework of a step-care therapy programme (Weissbeck & Brünger, 2008).Schooling, vocational training and pre-vocational measures as a practical support in the recognition of individual development options also generally prove to be a stabilising factor independent of the institutional environment which will also have a positive prognostic influence.

Prevention

The significance of delinquent behaviour of all origins both for the individual juvenile delinquent and the social community heightens the need for the development of preventative strategies which must be utilised in a consistent manner. In view of the epidemiological relevance, the integration of families with children displaying problematic behaviour in screening programmes would be beneficial as a primary preventative measure. It has however been repeatedly experienced that these types of families display a particularly low level of acceptance when offered these forms of support and are therefore not easy to target on a voluntary basis (Brünger & Weissbeck, 2008). Ambivalence on the part of general public awareness for an elaborate interlinked registration system for these types of disturbed children is understandable. It would however in principle be advantageous to be able to identify predictor variables for dissocial disorders and delinquent behaviour such as developmental disorders, hyperkinetic disorders, developmental delays, adverse family circumstances and dissocial disorders in children, irrespective of whatever method is utilised during this process.

Exemplary for the level of secondary prevention, the diagnosis and adequate treatment of an attention deficit disorder syndrome (ADHD) should be mentioned, as this goes hand in hand with a significantly increased development risk according to longitudinal studies. Between 30 and 80 per cent of all children diagnosed with ADHD fail to achieve a school leaving qualification and 60 per cent do not become adequately socially integrated: 45 per cent of this group also displays antisocial behaviour. 25 per cent of these children develop depression and 20 per cent personality disorders (Kölch 2009). There is also a high rate of substance-related dependency among these individuals. Alongside the recommended medication with stimulants (including methylphenidate and atomoxetin) following a careful diagnosis with a simultaneous respect for other pathogenetic elements – and it is imperative that medication should only be prescribed following this thorough degree of investigation – the prescription of further supportive measures should be considered within the framework of schooling, behavioural therapeutic strategies and day-care or in-patient measures according to relevant child and youth welfare laws. It must however be admitted that the prognosis will still remain poor for a particular high-risk group displaying relevant conspicuous behaviour despite all intervention measures.

The primary task of tertiary prevention is subsequently the provision of suitable treatment and support for offenders with psychological illnesses in prison, or – should a de- or exculpation have been ordered within the framework of a forensic examination – within a hospital treatment order which would create at least potential pre-conditions for the improvement of their positive prognostic influence.

A summary of consequences for child and adolescent psychiatry, youth welfare, schools and judiciary bodies

Despite the doubtful prospects for the high risk group, the provision of an adequate diagnosis to set the course in the right direction where possible would appear to be a matter of great importance. In view of the above-described development of risks, psychiatric disorders and comorbid disorders with dissocial developmental stages must both be identified at an early stage in order to be able to implement an evaluated course of treatment, if necessary an adjuvant pharmaceutical therapy. Early originating social behavioural disorders – irrespective of their individual nature – frequently assume the character of a mental handicap, as these disorders can threaten or disrupt the social participation of an individual. This is the point at which youth welfare services and the affected family's entitlement to support can play a decisive and significant role in setting the future course of development and allotting appropriate support, also through low-threshold initial help, for example through clearing measures. Particularly in the case of adolescents with a high risk background, supervision during the "potential breaking point" school and planning for post-school approaches towards vocational training would make real sense: this would provide these endangered young persons with an entry into a training environment which would in turn potentially minimise the risk factors and offer the opportunity for social integration. Once these young persons have crossed the threshold into the age of majority, numerous public support opportunities are no longer available; the legal status of adolescents must also be radically reappraised, and time is running out.

Concluding remarks

Depending on the individual etiological and/or motivational background and course of development, the structure of tasks to be undertaken within the fields of child and adolescent psychiatry, youth welfare, school and the judiciary display a substantial imbalance in their weighting and accentuation due to the frequently widely varying demands originating from the problematic situation of these young persons. Whereas judicial bodies are customarily the penultimate station in a disturbed young person's development which has previously been burdened with numerous problem areas and frequently displays an unsuccessful course, and despite the relativising longitudinal studies, the above-mentioned disciplines are confronted by essential tasks which, despite all obstacles strewn in the way, will have a decisive prognostic, preventative, therapeutic and supervisory and caring function which can only be achieved through interdisciplinary cooperation.

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