

Mentally Ill Youths

and the Juvenile Justice System

A Primer on Mental Health Disorders

By Lisa Melanie Boesky, Ph.D.

Sadly, the juvenile justice system has become the default system for many young people with mental health disorders who are not receiving appropriate treatment from the mental health system.

A significant number of youths with mental health disorders are seen in juvenile courts each year, and the numbers seem to be increasing. Because no national studies are available, the exact number of mentally ill juvenile offenders is currently unknown; however, it is clear that the prevalence of mental health disorders is higher among youths involved with juvenile justice than among their peers in the general population (Edens & Otto, 1997). A recent study found up to 25% of incarcerated male youths had a diagnosable mental health disorder that was impairing the juveniles' functioning (Wasserman et al., 2002). Sadly, the juvenile justice system has become the default system for many young people with mental health disorders who are not receiving appropriate treatment from the mental health system.

Identifying mentally ill juveniles can be challenging. Because most judges, attorneys, probation officers, correctional personnel, and law enforcement

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officers have not been trained on mental health disorders, it is easy for them to overlook subtle signs and symptoms of mental illness in juvenile offenders. Further, juvenile and family justice professionals may inadvertently misinterpret juveniles' mental health symptoms as: 1) attempts by youths to avoid an unpleasant task; 2) intentional resistance/opposition toward adult requests; or 3) manipulation on the part of youths to obtain whatever it is they want. When mentally ill children and adolescents are not correctly

identified, they are typically viewed as "bad" kids in need of sanctions instead of "sick" kids in need of assistance or treatment.

When juvenile and family justice professionals are able to identify youths with mental health disorders, strategic, effective, and fair decisions concerning young people are more likely. Judges, attorneys, probation staff, and law enforcement, in particular, are in a key position to refer youths to mental health professionals when mental illness is suspected. During interactions with juveniles, they may observe behavior that is out of the

ordinary and/or bizarre. If they have had previous experience with a particular youth, these professionals may be the first to detect changes in the child's behavior. This information can be critical to decision-makers in court, as well as to clinicians evaluating these youths. There is an increased chance of effective interventions and successful outcomes with youths when juvenile and family justice professionals recognize mental health symptoms as signs of psychiatric disorders versus solely oppositional or manipulative behavior.

Common Mental Health Disorders Found Among Juveniles

The following are brief descriptions of some of the most common mental health disorders seen among youths involved with the justice system. The symptoms are from the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000), the most commonly used source for providing psychiatric diagnoses.

Oppositional Defiant Disorder (ODD)

Juveniles diagnosed with Oppositional Defiant Disorder (ODD) exhibit a pattern of negative, hostile, and defiant behavior that lasts at least six months. These youths typically: argue repeatedly with adults; defy or refuse to comply with rules/adult requests; frequently lose their temper; regularly annoy others in a deliberate fashion; are often spiteful and vindictive; are frequently easily annoyed by those around them; and are often angry and resentful. Although many children and adolescents engage in the above behaviors, they do not all have ODD. Youths who receive this diagnosis engage in the above behaviors more often than peers of the same age and developmental level, and these behaviors significantly interfere with their ability to function (e.g., in relationships and at school or work). Although ODD is a common diagnosis among juveniles involved with the justice system, many youths with this disorder also suffer from one or more additional psychiatric disorder(s) as well.

Editor's Note

The case studies used in this article are from *Juvenile Offenders with Mental Health Disorders: Who Are They and What Do We Do With Them?*, by Lisa Melanie Boesky, Ph.D., and are reprinted by permission of the publisher, the American Correctional Association.

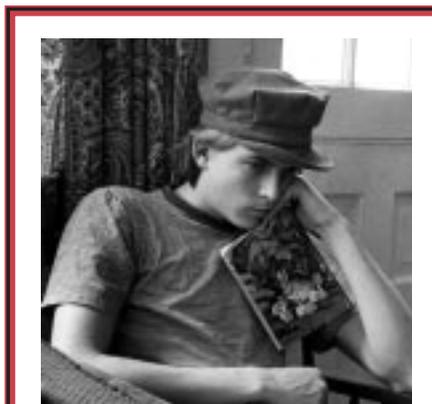
The young people pictured in this article are models. These photographs are used for illustrative purposes only.

Conduct Disorder

Conduct Disorder is one of the most commonly diagnosed mental health disorders among youths involved with the juvenile justice system. These youths display a *recurring* and *enduring* pattern of behavior in which the basic rights of others or major age-appropriate societal norms/rules are violated. Juveniles with Conduct Disorder typically: are aggressive toward others (e.g., physical fights, intimidation, robbery, rape, weapon

use, physical cruelty toward people and/or animals); are destructive with property (e.g., deliberate fire-setting, property defacing); engage in theft or deceitfulness (e.g., lies, forgery, shoplifting, car/house/building break-ins); and violate important rules (e.g., school truancy, curfew violations, running away from home).

Conduct Disorder is diagnosed when these behaviors significantly interfere with a juvenile's ability to function in school, work, or interpersonal relationships. Although many youths experiment with such behaviors during pre-adolescent and/or adolescent years, juveniles with Conduct Disorder engage in these behaviors on a repetitive basis. In comparison to the general population of young people, the negative and problematic behaviors of juveniles with Conduct Disorder tend to be more intense, frequent, and chronic. Their symptoms are usually not a reaction to a short-term stressor (e.g., break-up of a romantic relationship, moving to a new school), but instead reflect a persistent *pattern* of behavior. A significant percentage of juveniles diagnosed with Conduct Disorder also suffer from one or more additional psychiatric disorders as well.



Devon, 17, threatened his mother with a knife during an argument about school. He has no history of aggression. Lately, Devon has been sleeping 16 hours a day. When awake, he mostly stays in his room, listening to music. He occasionally spends time with friends, but they have noticed he has become quiet and guarded. He used to love basketball, was always in a good mood, and seemed to enjoy school. Devon's parents are concerned because his grades have slipped due to missed classes, he is increasingly irritable at home, and he has not played basketball in weeks. He was overheard saying, "I wish I could go to sleep and never wake up."

Attention-Deficit/Hyperactivity Disorder (ADHD)

Juveniles with Attention-Deficit/Hyperactivity Disorder (ADHD) display a continual pattern of difficulties related to inattention, hyperactivity-impulsivity, or both. Their symptoms are more frequent and severe than other youths of the same age and developmental level, and these symptoms cause significant problems in their everyday lives.

Children and adolescents with *inattention* problems tend to: be easily distracted; be disorganized; lose things; find it difficult to pay attention to one task or activity for a significant period of time; forget things; appear as if they are not listening; avoid tasks requiring sustained mental effort; not follow

through on instructions; and make careless mistakes. These juveniles frequently have a hard time completing chores or responsibilities. Although it may appear that they are behaving in an intentionally disobedient manner, this is often not the case. It is common for these youths to forget scheduled activities (e.g., court dates, probation appointments). In addition, juveniles with ADHD may attempt to avoid written assignments (e.g. requested by the court or school) because it is too difficult for them to pay attention long enough to complete it. They frequently misplace their belongings—both trivial objects and those important to them.

Children and adolescents who have problems with *hyperactivity-impulsivity* tend to: move around excessively; fidget with their hands or feet; find it difficult to remain seated for long periods of time; have difficulty quietly engaging in activities; talk constantly; appear “revved up” and full of energy; interrupt others; call out answers before a question is finished; and have difficulty waiting for their turn. Sitting through long court proceedings can be torture for these youths, and they can be disruptive due to being noisy, overly energetic, and restless.

Major Depression

Juveniles with Major Depression experience several of the following symptoms for at least two weeks and the symptoms represent a change from the youths’ typical functioning: depressed and/or irritable mood; lack of interest or pleasure in most activities; significant change in appetite and/or sleep patterns; noticeable restlessness or slowed body movements; loss of energy/feelings of fatigue; feelings of worthlessness; excessive or inappropriate feelings of guilt; indecisiveness/difficulties with thinking and concentration; and repeated thoughts of death and/or a suicide attempt.

Major Depression is one of the most misunderstood mental health disorders among youths involved with the justice system. Therefore, it can be challenging to recognize. Most adults associate depression with sadness, crying, and social withdrawal. Many children and adolescents manifest Major Depression in an *irritable* mood instead of a sad, gloomy mood. Juveniles suffering from Major Depression often appear agitated, angry, and aggressive. Because many adults do not recognize these symptoms as signs of depression, these irritable youths can be misdiagnosed with Oppositional Defiant Disorder or Conduct Disorder—and referred to juvenile court. This dynamic often results in depressed youths receiving sanctions for their aggressive behavior, but never being referred for treatment services. If juvenile and family justice professionals observe extreme



Marcie, 16, was picked up for trespassing. She hates school and often refuses to go because “it’s boring.” She was in special education classes throughout junior high, but completely dropped out of school in the tenth grade. Although she says the schoolwork was “easy” for her, she rarely completed class assignments. She enjoys reading, but it takes her a long time to complete a book. She frequently mixes up words and letters, regardless of whether she is reading silently or aloud.

irritability or aggression in a child, as well as a lack of interest and pleasure in activities he or she used to enjoy (e.g., friends, sports, television, school, hobbies), depression is a possibility and should be further explored.

Depressed youths (with a sad or irritable mood) are at high risk for serious suicide attempts. Because adults do not always recognize aggressive juveniles suffering from Major Depression, they often do not take these youths’ threats of suicide as seriously as those who are visibly upset. This can have tragic consequences. Although confinement is often used as a management strategy for aggressive youths, incarceration (especially seclusion/isolation) is one of the most high-risk situations for suicidal (depressed) juveniles.

Dysthymic Disorder

Juveniles diagnosed with Dysthymic Disorder also suffer from a depressed or irritable mood. These mood states are typically less intense than among individuals suffering from Major Depression, but they last for a significantly longer period of time (at least one year). There is also the presence of: fatigue/low energy; feelings of hopelessness; indecisiveness/concentration difficulties; lack

of appetite or overeating; sleeping too little or too much; and/or low self-esteem.

Rather than being a change from how youths usually appear (as in Major Depression), the irritability and sadness typical of youths with Dysthymic Disorder is how the youths usually appear. Dysthymic youths with a predominantly irritable mood seem to be continually annoyed by everyone and everything around them. Everything gets on their nerves. Dysthymic youths with a predominantly sad mood usually appear in a continual state of mild depression. They rarely get excited about anything.

Bipolar Disorder

Juveniles diagnosed with Bipolar Disorder suffer from severe changes in mood that cause them significant distress and/or interfere with their ability to function in everyday activities. This disorder has been referred to as “Manic-Depressive Disorder” in the past because individuals usually experience episodes of *mania*, as well as episodes of *depression* (as described earlier).

Juveniles suffering from a manic episode are consistently overly happy or extremely irritable for one week or more. Their manic mood state is so extreme and excessive that these children and adolescents often require psychiatric hospitalization. During their intense mood state, juveniles with mania also exhibit some of the following symptoms: more talkative than usual/very rapid speech; increase in activity/physical agitation; grandiosity/inflated self-esteem; racing thoughts/accelerated speech with abrupt topic changes; distractibility; excessive involvement in pleasurable activities with a high potential for painful consequences; and a decreased need for sleep without the use of drugs and alcohol (e.g., able to go several nights without sleep, feeling rested after only 3-4 hours of sleep).

The pattern of mood changes among youths with Bipolar Disorder is very individualized. Some juveniles experience manic episodes immediately followed by episodes of depression. Other youths experience a significant time period between episodes of mania and depression (e.g., weeks, months, years) where their mood state is fairly stable. Intense emotions and wide ranges of mood can be common during the teenage years. These should not be confused with Bipolar Disorder, which is a serious, often disabling disorder that interferes with juveniles’ ability to function in important daily activities.

Mental Retardation

Juveniles with Mental Retardation have significantly below-average intellectual
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functioning (IQ of approximately 70 or less). They also are deficient in their ability to cope with the everyday demands of life and the ability to function independently. Mentally retarded youths typically cannot take care of themselves, interact with others, communicate, and/or keep themselves safe at the level expected for someone of their age. The onset of this disorder must occur prior to the age of 18. Depending on the youth's level of intellectual impairment, the disorder can be mild, moderate, severe, or profound.

Most mentally retarded youths in the justice system fall into the mild range and typically function at about a sixth-grade level. These juveniles usually need additional guidance and supervision in comparison to same-aged peers. Juveniles whose IQ and level of adaptive functioning place them in the moderate range of Mental Retardation usually function near a second-grade level and need a tremendous amount of adult supervision and support. Even with additional support and structure, moderately mentally retarded youths often have an extremely difficult time adjusting to a correctional environment. The majority of youths in the severe and profound range of Mental Retardation reside with their families or in specialized residential facilities.

Juveniles with Mental Retardation comprise a heterogeneous group of youngsters. Some affected children and adolescents are gentle, compliant, and dependent on adults; others are aggressive, impulsive, and oppositional; and some will display a combination of these behaviors. It is common to see juveniles with Mental Retardation become hostile or aggressive when having difficulty communicating their wants and needs. These youths may not always understand court proceedings and/or how certain consequences are related to specific behaviors. Mentally retarded youths can be frustrating for juvenile court personnel, since it is often difficult to determine if these juveniles' negative behavior is purposeful and planned or associated with the youths' cognitive limitations.

Learning Disorders (LD)

Juveniles with a Learning Disorder demonstrate a significant discrepancy between how they *should* perform and how they *actually* perform on standardized school-based tests (given their IQ and education). For example, if a juvenile's IQ is above average and he has received adequate schooling, one would expect him to perform fairly well on a test of reading, written expression, or mathematics. It would be surprising for this particular youth to perform poorly, given his above average intellectual ability and educational experience. Juveniles with average,



Karen, 14, was picked up for prostitution. She has a history of sexual abuse by two family members and was raped on the streets two months ago. Karen becomes extremely angry or depressed for days at a time. Adults describe her as constantly being “keyed up” and hypersensitive. Her continual focus on others and questions about what they are doing can be annoying to those around her. Karen has accused her probation officer of looking at her in “sex-crazed” ways or of trying to “feel her up.” Although she appears confident and tough, she feels damaged and disgusting. She cuts and carves on her arms when she gets upset because it helps to calm her down.

above average, or below average IQs can be diagnosed with a Learning Disorder as long as a substantial discrepancy exists between their intellectual ability (IQ) and scores on individually administered standardized school-based tests. The youths' difficulties must interfere with academic achievement or everyday activities that require reading, writing, or mathematical skills. Many youths involved with the justice system suffer from more than one Learning Disorder.

Problems related to information processing are common among children and adolescents with Learning Disorders. These youths are often bright, and many are of at least average intelligence. However, transferring what is in their brain onto a piece of paper can be difficult, especially under time constraints. Some youths need to receive information in written form rather than just hearing it. Others know what they want to say, but have difficulty translating their thoughts into speech. Some juveniles with Learning Disorders do not comprehend what someone is saying in the way the speaker intended it, resulting in problems with miscommunication (e.g., upon arrest, in court, during community supervision).

Information-processing difficulties can interfere with youths' ability to be successful within interpersonal relationships, and many juveniles with Learning Disorders have poor social skills. Many of these youths do not understand the “give and take” of relationships, can be slow to pick up on subtle social cues, and may misinterpret what peers or adults are saying to them. Because of this, their interpersonal style can inadvertently irritate or offend others.

Posttraumatic Stress Disorder (PTSD)

Posttraumatic Stress Disorder is an *anxiety* disorder. In order for a juvenile to be diagnosed with PTSD, the youth must be exposed to trauma (witnessing or experiencing

an event that involves threatened or actual serious injury or death). His or her response at the time of the trauma typically involves intense fear, horror, or helplessness.

Youths with PTSD repeatedly *reexperience* a traumatic event with frequent intrusive and upsetting thoughts and/or repeated nightmares about the event. They may actually experience flashbacks—feeling as though the traumatic event is happening all over again. Juveniles with PTSD tend to avoid things that remind them of the trauma and become less responsive in general. They typically avoid places, people, or activities associated with the traumatic event and often do not want to talk about what happened to them. They may lose interest in activities they used to enjoy and often display a restricted range of emotions (e.g., unable to feel happy, feel “numb”). It is common for youths with PTSD to describe feeling “different” and separate from others because of the negative event(s) that have happened to them. Many of these youths have a sense of a foreshortened future and do not see the point in making long-term goals.

Because PTSD is an anxiety disorder, these juveniles typically experience symptoms of increased arousal, including: an exaggerated startle response; problems falling or remaining asleep; concentration difficulties; irritability or outbursts of anger; and/or a need to be excessively attentive or watchful regarding what is going on around them.

A significant number of juveniles involved with the justice system have witnessed or directly experienced one or more traumatic events in their lives (Steiner, Garcia, & Matthews, 1997). Physical abuse, sexual abuse, parental abandonment, and neglect are common among this population. Some of these young people have been sold into pornography or prostitution at very early ages; some have been raped repeatedly, shot, or severely beaten. Sadly, witnessing the death of a parent, relative, or close friend is not an infrequent occurrence in the lives of

justice-involved youth. Because the rate of traumatic experiences is so high among this population, it is not surprising that many of these children and adolescents suffer from PTSD. However, just because youths have experienced a traumatic event does not automatically imply that they are suffering from PTSD. This diagnosis is only given when youths experience several of the above symptoms for more than a month. The symptoms must also cause significant distress and/or impairment in their ability to function within important areas of their lives (e.g., school, work, relationships).

Many juveniles with PTSD have tremendous difficulty regulating their emotions. They often exhibit severe mood swings (e.g., becoming angry and hostile with minimal provocation), as well as impulsive behavior. They may be very defensive, believing they are constantly being threatened in some way. Once emotionally upset, juveniles with PTSD often find it difficult to calm themselves down. Stomachaches, headaches, and vague muscle or joint pain are common among youths with anxiety disorders (including PTSD). Juveniles (particularly males) who are concerned about looking tough and in control, may be reluctant to report feelings of anxiety or fear related to a traumatic incident. Therefore, their anxiety manifests itself in more physical, health-related symptoms.

Self-injury/self-mutilation (cutting, carving, or burning one's own body) is frequently associated with youths suffering from PTSD. Some juveniles with PTSD use self-injury as a way to release built-up tension; others use it as a way to punish themselves. Self-injury helps some of these youths feel a sense of grounding and calm, even if only temporarily.

Psychotic Disorders

Individuals suffering from psychosis have difficulty differentiating what is real from what is not real. Psychotic individuals typically experience and exhibit hallucinations, delusions, disorganized speech and behavior; and "negative" symptoms.

Hallucinations are false sensory perceptions not associated with real external stimuli. Although youths can experience hallucinations with any of the five senses, auditory hallucinations (hearing voices/sounds that others cannot hear) are the most common. Psychotic youths do not perceive these voices as their own thoughts, but as someone else talking to them or about them. The voices may tell juveniles to behave in certain ways, such as killing themselves or others. The voices may comment on the youths or the youths' behavior (e.g., telling them they are stupid or ugly, ridiculing them for something they have done). Although less com-

mon, some psychotic juveniles will see things, such as people or animals, that others cannot see.

Delusions are personal beliefs that an individual rigidly holds onto despite obvious proof that the belief is false and/or irrational. Examples of delusional beliefs held by psychotic juveniles include thinking that other people are: plotting against them; talking negatively about them; or trying to steal or control their thoughts. Psychotic juveniles may believe that: certain adults are trying to poison them; court personnel are in a conspiracy against them; parts of their body are diseased or rotting away even though all medical tests are normal; or they have special/magical gifts or talents.

Disorganized thinking and speech are also common among youths suffering from psychotic disorders. Psychotic juveniles may: speak in sentences that do not make sense or are only loosely related; use words that do not make sense; talk in rhymes or with a sing-



Terrence, 17, has recently been charged with assault. Although adults and peers used to describe him as "odd," they now describe him as "weird," "crazy," and "totally out of it." Terrence has always kept to himself and was known as a loner, but lately he has become agitated and angry when in group situations. He has accused peers of stealing his belongings and believes that the police are conspiring to conceal the thievery. When watching television, he believes subliminal messages are being transmitted over the airwaves. He is also fearful that the host of one of his favorite shows is trying to steal his thoughts. Terrence has not told anyone about his experiences with the television for fear that people would think he is crazy.

song tune; or repeatedly parrot back what others have said. What comes out of their mouths may sound strange and confusing, or they may completely stop talking in the middle of a sentence for no apparent reason. Some psychotic youths will take a very long time to answer questions or they may have little or no speech at all. Even when asked to elaborate, some psychotic juveniles may only provide one- or two-word answers or sentences.

Youths with **disorganized behavior** usually exhibit: a messy appearance; restless/agitated behavior; bizarre movements or posturing; pacing; or rocking. Poor hygiene is common. Psychotic youths may appear odd or strange to juvenile and family court personnel. These youth may repeatedly engage in unusual and strange movements with their arms, legs, or neck, or they may rock back and forth for hours. Within juvenile justice facilities, some psychotic youths like to crawl into tight spaces when in their room (e.g., under their bed, in-between the toilet and the wall). Some psychotic youths may be unable to remain still and feel like they have to constantly keep moving. Yet, others will remain still, without any movement, for extended periods of time.

Symptoms of psychosis can be associated with a variety of different mental health disorders. Youths with Schizophrenia typically exhibit psychotic symptoms. However, youths suffering from Major Depression or Bipolar Disorder can experience symptoms of psychosis as well, as can juveniles who use large quantities of drugs (e.g., methamphetamine, LSD, PCP).

Co-Morbidity

Most mentally ill juveniles suffer from more than one of these mental health disorders simultaneously. In fact, it is common for youths involved with the justice system to be diagnosed with three or four mental health disorders at the same time. For example, a juvenile may have been diagnosed with Attention-Deficit/Hyperactivity Disorder, a Learning Disorder, and Conduct Disorder in the past. This youth may then develop Major Depression when detained. If the youth has recently been raped or severely beaten, he or she may also develop Posttraumatic Stress Disorder. As one can imagine, the assessment and treatment of mentally ill youths becomes more clinically complex with each additional diagnosis.

Conclusions

Juvenile and family justice professionals play a critical role in the identification of youths with mental health disorders.

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Although recognizing mental illness among juveniles can be challenging, juvenile court personnel have many opportunities to observe and interact with these youths. They are in a key position to refer juveniles in possible need of treatment to mental health/medical professionals. When unidentified or misclassified, juveniles with mental health disorders not only can receive significant sanctions, but also do not receive the appropriate mental health treatment they need. Some symptoms of mental illness look similar to adolescent behavior that is intentionally oppositional and defiant (e.g., disruption at school, repeated conflict with family members, irritability, violation of adult directives, aggression). Therefore, it is common for juvenile and family justice professionals to misinterpret such behavior and become more restrictive or punitive with these youths. Although mentally ill juveniles should be held accountable for negative behavior, they should also receive treatment for their mental health disorder. Providing education and training to juvenile court personnel on recognizing juveniles with mental health disorders (as well as practical strategies to use when working with these youths) can lead to more strategic and effective referral and intervention decisions.



About the Author

Lisa Melanie Boesky, Ph.D., Clinical Psychologist, specializes in the identification and management of juveniles with mental health disorders, including suicidal and/or self-injurious youth. She has designed several mental health training programs and will serve as faculty at the National Council's upcoming program, "Mental Health Issues in Juvenile Court," scheduled May 18-21, 2003 in Indianapolis, Ind. She has helped develop a mental health screening tool for juvenile correctional facilities and consults on mental health policy and programming to juvenile justice agencies across the country. She can be reached at (206) 979-5792 or www.drlisab.com.

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For more detailed information on the identification and management of mentally ill juveniles, please refer to Dr. Boesky's new book, *Juvenile Offenders with Mental Health Disorders: Who Are They and What Do We Do With Them?*

Published in 2002 by the American Correctional Association, the book expands upon the disorders addressed here and also discusses issues related to suicide, self-injury/self-mutilation, cultural factors, gender, mental health screening and assessment, mental health treatment, and juveniles who have co-occurring mental health and substance abuse disorders. This publication is appropriate for any professional who comes into contact with juveniles, whether working in the community or a residential setting. (To order, contact the American Correctional Association at 1-800-222-5646, ext. 1860.)