Adolescent Psychopathology in a Family Court

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This paper presents the findings of a one-year study of psychopathology in 304 court-involved adolescents referred for psychiatric evaluation in a New York Family Court. The Family Court deals with all juvenile cases and is a court for the ghetto poor. Of the individuals served by the court, 56% are black, 23% hispanic and 18% white. Only 21% are from intact families and 59% are on welfare. These individuals represent a spectrum of disturbed juvenile behavior, ranging from minimally asocial to grossly antisocial. Over 50% have a history of prior court appearances, and 10% have had psychiatric hospitalization. It has been reported that only 16% of court involved adolescents have an I.Q. of more than 100 and that 75% are chronically truant. Since 1963 juvenile delinquency has been increasing at a faster rate than the juvenile population, with the rate of court involvement for juveniles going from 2% to 12% in ten years. In New York City, violent crime by adolescents has increased from 1279 robberies and 30 murders in 1964, to 4449 robberies and 94 murder cases in 1974.[1,2]

Approximately 168,500 families with children under 18 in New York City had poverty level incomes. Almost 60% of these families were headed by a single female parent or surrogate.[2] A higher degree of emotional instability among the poor, deprived and one-parent households has been well documented. It is estimated that there are potentially 20,000 to 40,000 mentally ill children and another 160,000 to 200,000 children with serious emotional disturbance in New York City.[2] These are some aspects of the population from which the 304 adolescents in this study came. They come to court because they have been neglected or abused by adults, or because their own behavior or antisocial acts have brought them into conflict with the law, their institutions, or their parents.

Solutions to the major child health problem of emotional and mental illness must be rooted in empirical knowledge. There are many myths as well as conflicting theories about the relationship between crime and mental illness. Social laboratories like the courts must be used to study relationships between social behavior and mental illness. Delinquency problems seem to reflect severe ego pathology with complex interactions with social environmental influences; yet there is also strong opinion that most crime does not derive from mental illness and is not a mental health problem.[3] What and how much children can tolerate in the way of bad homes, poor schools, defective communities, traumatic experiences, learning disabilities, antisocial peer pressure and organic disease, and still maintain defenses against mental illness, must be studied. This author has pointed out that the mental health professional is being looked to for solutions to complex problems which may well be beyond his limits of expertise. However, the responsibility to study them and to inform others is clearly there.

Method

All referred cases were evaluated as to mental status, diagnosis, and response to

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particular questions asked by the court judge. Diagnosis had to conform to an A.P.A. Diagnostic Statistical Manual II classification.[5] The examiner was a psychiatrist or clinical psychologist (Ph.D.) under the supervision of a senior psychiatrist. Details of court processes and the manner of arrival for evaluation have been fully described by this author elsewhere.[4] All evaluations were reviewed by this author and required to meet DSM II criteria. Diagnosis of schizophrenia was required to meet criteria described by Carpenter,[6] developed from the International Pilot Study on Schizophrenia,[7] in addition to the DSM II description, for greater accuracy. The category of No Definable Psychiatric Illness includes Undiagnosed Psychiatric Illness, as described by Woodruff *et al.*, [8] and those diagnosed as normal. Cases not meeting diagnostic criteria were reclassified after conferences between the author and examiners.

Each court case had a docket number which defined the type of court case, and included a probation folder containing all the data available to the court, including past hospital records, school reports, agency studies, and prior court records. The categories of cases were as follows:[9]

DELINQUENT – Any individual under 16 years of age who did any act which if done by an adult would constitute a crime. Supervision, treatment or confinement is required.

A PERSON IN NEED OF SUPERVISION (PINS) – Individual under 16 who is habitually truant, or incorrigible, ungovernable or habitually disobedient, and beyond lawful control of his parents, guardian, or custodian. Supervision or treatment is required.

NEGLECT – 1. Individuals under 16 whose parents inflict or allow the infliction upon the child of physical injury by other than accidental means, which causes or creates risk of death, or serious disfigurement, or protracted impairment of physical or emotional health, or protracted loss or impairment of any bodily organ, or creates or allows creation of substantial risk, or commits or allows the commitment of sexual act to a child.

2. An individual under 18 whose parents or others do not adequately supply basic needs, or suffers or is likely to suffer serious harm from improper supervision, or has been abandoned or deserted.

Results

Neglect, PINS, and Delinquent cases represent a continuum of asocial juvenile behaviors, being minimal in Neglect, intermediate in PINS and clearly antisocial in Delinquent juveniles. Figure I shows the referral rates of the types of juvenile cases. The overall referral rate was 11%. PINS cases, which were the least prevalent court cases, showed the greatest rate of referral. Distribution of diagnostic impressions among the adolescents is shown in Figure II. Schizophrenia occurred in 10% of the adolescents evaluated. Behavior Disorder of Adolescence was the impression in 47% of the cases. 22% of the adolescents had no diagnosis of mental disorder, while 14% were considered to have a Transient Situational disorder. Drug dependence cases were infrequent findings among the referrals.

Figure III shows the distribution of the major diagnostic impressions among the three types of court cases. Schizophrenia was relatively constant in all three types of court cases (Fig. IV). Behavior Disorder of Adolescence (Fig. V) increased from Neglect to PINS to Delinquent cases, while No Definable Psychiatric Illness (Fig. VI) decreased in those respective court cases.

Statistical analysis of the data reveals the difference between Neglect, PINS and Delinquent cases to be significant as the P is less than .05 level.

Discussion

The population served by the Family Court is predominantly in the lower socioeconomic range and represents a subgroup of that class. Many of the referrals had an extensive history of mental illness and prior contact with mental health services as part of their court record. The prevalence of psychosis and emotional disturbance has been found by many investigators[10] to be higher in the lower socioeconomic class. The Midtown Study[11] revealed an 8.3% prevalence of schizophrenia in this group. The White House Conference on Children in 1970 estimated severe emotional disorder in one-third of children from poverty groups.[12] Hollingshead and Redlich[13, 14] found a 12% frequency of schizophrenia for social class V individuals. Arieti reported,[15] in a review of epidemiologic studies, that the centers of cities, which also have the highest incidences of delinquency, addiction and crime, are the areas with the highest incidence of schizophrenia. In consideration of these factors, it can be concluded that the individuals evaluated in this study did not show a high prevalence of psychopathology.

The findings of this study, which show a relatively low prevalence of psychopathology, are consistent with the findings of other studies of psychopathology in court settings.[16-20] Guze *et al.*[20], in studying psychiatric examinations for courts, concluded that schizophrenia and other psychosis occurred no more frequently than in the general population, with findings of psychosis almost three times greater than found in this study. Weiner and Del Gaudio,[21] in a large scale study of adolescent psychopathology in an upstate New York State county, reported findings of schizophrenia in 12% of adolescents, compared to 10% in this study in the comparable social class.

Cooke *et al.*,[18] in considering factors for psychiatric referral, concluded that referral is frequently based on a legal strategy rather than on legitimate concern for mental status. Drug cases, being simple disposition cases, were infrequently referred for evaluation in this study. PINS cases are generally the most difficult disposition problems for the court because these youngsters are often involved in asocial behaviors that do not clearly constitute crimes and therefore restrict the court's ability to institute controls (*e.g.*, confinement or training school). PINS cases represented 64% of the referrals while representing only 21% of the total adolescent court cases. The adolescents sent for psychiatric referral by the Family Court were no more disturbed than the general population from which they were drawn, and they do not show a clear correlation between psychiatric diagnosis and the behavior bringing them to court. The basis for referral seems to have an agenda other than concern for mental status, an agenda which seems related to disposition and other needs of the legal institution.

Psychiatric categories reflecting maladaptive behavior patterns and responses were the most frequent findings in this study. Categories like Behavior Disorder of Adolescence, Transient Situational Disturbance, and No Definable Psychiatric Illness represent compromises between the pressure of inner drives and demands of reality. The influence of social setting and value judgments introduces contaminants into the objective appraisal of these entities. Psychiatric referral is sought for solutions to these most difficult problems of living and disposition. Psychiatric treatment for these non-psychotic disorders is most difficult, since they frequently contain individuals poorly motivated and refractory to change.

The proposition that criminal behaviors are a product of or clearly associated with mental illness, particularly psychosis, is not supported. A relatively constant degree of schizophrenia may simply be endemic in all populations and is not an indication of a relationship to criminal behavior. The mentally ill population may in fact be less likely to perform such behaviors, and when involved may just be more likely to be discovered. The more psychiatry accepts the charge of dealing with "antisocial problem adolescents," the more it will deemphasize the real need for it to be dealt with elsewhere – by parents,

society, schools, and courts. The more psychiatry permits itself to be used as an institution for control, the more it tacitly encourages other institutions not to deal with problems of control. The solutions to antisocial behavior problems must be derived from empirical studies conducted by multi-disciplinary investigations. Present utilization of mental health professionals by the court system must be further studied, along with the influence and distribution of psychopathology on court populations. Screening by trained mental health professionals in pre-court investigation and evaluation phases might well provide for a more effective application of such services. When indicated, extensive psychiatric evaluation would, in the opinion of this author, be optimally conducted in affiliated major university hospital centers.

FIGURE I
REFERRAL RATE OF COURT CASES

	Total Number Court Cases	Percent of Total Adol. Cases	Adol. Cases Referred	Percent Referred
Delinquent	1461	46%	120	8%
PINS	563	21%	131	20%
Neglect	1036	33%	85	8%
Total	3160	100%	336	11%

FIGURE II
PREVALENCE OF DIAGNOSIS

	No. Adols.	Percent Adols.
*O.B.S. – Psychotic	1	1%
O.B.S. – Non Psychotic	11	4%
Schizophrenia	30	10%
Affective Disorder	1	1%
Paranoid State	0	–
Neurosis	1	1%
Sex Deviation	1	1%
Personality Disorder	0	–
Alcoholism	0	–
Drug Dependence	4	1%
Psychophysiologic Disturbance	1	1%
Special Symptoms	1	1%
Transient Situational Disturbance	41	14%
Behavior Disturbance Adolescence	144	47%
No Definable Psychiatric Illness	68	22%
Total	304	

**O.B.S. – Organic Brain Syndrome*

FIGURE III
DISTRIBUTION OF MAJOR DIAGNOSTIC CATEGORIES

	Total No.	Schizophrenia	Adol. Behavior Disorder	No Definable Psych. Illness
Delinquent				
Minor	114	11 (10%)	68 (60%)	15 (13%)
PINS				
Minor	134	14 (10%)	59 (44%)	30 (22%)
Neglect				
Minor	56	5 (9%)	17 (30%)	23 (41%)

FIGURE IV
SCHIZOPHRENIA

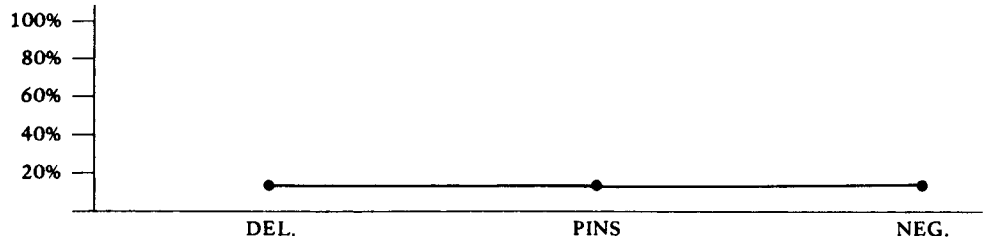


FIGURE V
BEHAVIOR DISORDER
OF ADOLESCENCE

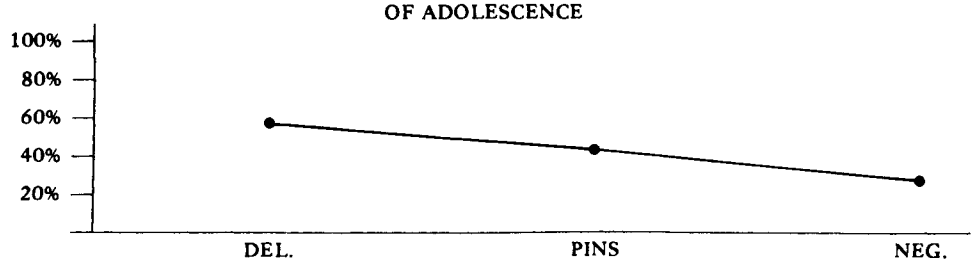
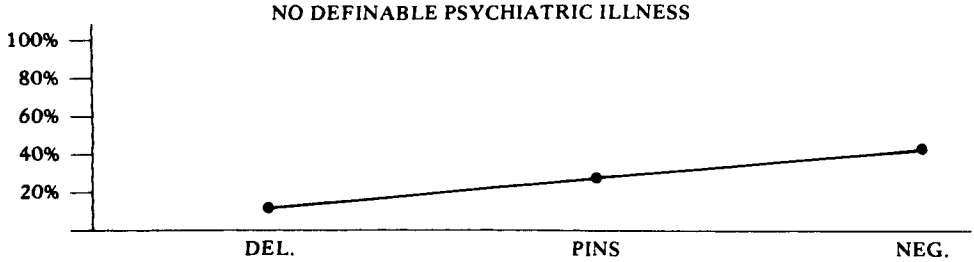


FIGURE VI
NO DEFINABLE PSYCHIATRIC ILLNESS



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