CHAPTER 1

Trends and Processes in Youth Violence

Stephen dressed in black every day, dyed his hair black, and even painted his fingernails black. He was a morose, brooding kid who didn't have any friends at school. Many kids felt uneasy around him, and he was the subject of a lot of gossip and speculation. One day he came in wearing a T-shirt that read, "No one knows where I hid the bodies." He was suspended, and his parents were advised to take him to a psychologist for an assessment before he could return to school.

Alex was a socially inept high school freshman who was routinely picked on and teased by upperclassmen because of his small size and his less-than-cool appearance. One day, as the older boys were taunting him, he pulled out a pocket knife and waved it around. The seniors all laughed, but the school administration was not amused. Alex was arrested for possession of a weapon and expelled for the remainder of the year.

Curt was a junior lacrosse player with a fiery temper and the body of an ox. When a friend told him in the hallway that their English teacher had given their group project a low grade, Curt yelled, "I'm going to kill that bitch!" Overheard by the vice principal, he was sent to the office, where he was suspended for 10 days and required to see a therapist.

Ask yourself which of these students poses a serious risk for actually committing violence in the future. Doesn't Stephen seem frightening? Might Alex be on the brink of doing something major? What about hot-headed Curt? Which of these young men is likely to hurt someone, and how might violence be prevented?

These are situations and questions that confront mental health and criminal justice professionals every day. The stakes are high for everyone involved. The cases often seem ambiguous, and the decisions are difficult. If you were chosen to assess each of these boys, how would you decide their level of risk for future violence? How would you intervene to reduce that risk?

This text outlines a comprehensive approach to assessing and managing violence risk in juveniles. The recommendations are grounded in the best available research in the field and interpreted within a carefully conceived framework. The goal of the book is to equip you to conduct risk assessments that are thorough, fair, helpful, and developmentally and empirically sound.

The first section of the book provides the foundation for violence risk assessments by laying out the research on juvenile violence, risk factors for violence, and the role of behavioral health conditions and antisocial processes in youth violence. The second section provides a comprehensive model for conducting violence risk assessments and communicating the results. Finally, the third section discusses research on the effectiveness of treatment for adolescent aggressive conduct problems and gives guidance for designing effective intervention plans.

CONTEXTS FOR ASSESSMENT

In his first therapy session, Stephen made threatening statements about his ex-girlfriend. Alex went to court for his weapons charge and was ordered to participate in an assessment. Curt participated in a full evaluation, the results of which were sent to the vice principal. All of these young men needed a risk assessment, but each in a different context.

Risk assessments for young people may occur within the context of the juvenile justice system, in therapy sessions where there is a duty to protect, or through direct referrals (Borum, 2000). In some instances, a court orders a young person to complete an assessment (Burnett & Roberts, 2004; Grisso & Schwartz, 2000; Howell, 1997, 2003). At other times, a client makes statements in a session that require a therapist to assess the level of risk (Appelbaum, 1985; Borum & Reddy, 2001; Monahan, 1993; Stone & Isaacs, 2003). Finally, there are times when a juvenile comes in voluntarily—or at least without legal compulsion—for an assessment due to a referral by a concerned parent or professional.

Juvenile Justice

Nearly all juvenile justice referrals come after some serious problem behavior already has occurred (Grisso & Schwartz, 2000; Howell, 1997). Sometimes a juvenile has committed a violent act in the past and the task of the assessment is to determine the level of risk for violence in the future. Other times, the individual has come to juvenile court for a nonviolent offense, but those involved in the case, such as court counselors, judges, or advocates, have concerns about this behavior escalating in the future. In either event, the goal of the referral is to assist the court in formulating an appropriate disposition (Krisberg, 2005). A thorough risk assessment for a juvenile involved in the justice system may inform decisions about treatment needs, prehearing release, the duration and intensity of probation, level of supervision, or discharge from a facility.

Duty-to-Protect Situations

In the landmark case *Tarasoff v. Regents of University of California* (1976), the Supreme Court of California found that when a mental health professional determines (or, by the standards of his or her profession, should have determined) that a client presents a serious risk of violence to another person, the mental health professional incurs a duty to use "reasonable care to protect the victim." In its first hearing of the case, *Tarasoff I* (1974), the Supreme Court of California ruled that mental health professionals had a duty to *warn* third parties about potential risk that their clients presented. *Tarasoff II* (1976) redefined this duty as one to *protect*. Subsequently, other courts across the country have taken on this issue and defined the specific duty either more broadly or more narrowly (Walcott, Cerundolo, & Beck, 2001). Some legal decisions have rejected the *Tarasoff* doctrine altogether, declining to find or impose any such duty on mental health professionals. Whether there is a legal duty to protect and what that duty might be will vary according to state or jurisdiction (Perlin, 1992).

This duty to protect may require the mental health professional to take one or more steps, depending on the particulars of the case, including such possible actions as alerting the intended victim of the danger or notifying law enforcement. The professional may also need to take other steps that might be reasonable given the specific circumstances, such as pursing hospitalization or other forms of intervention (Monahan, 1993; Stone & Isaacs, 2003).

In the course of a therapy session with a juvenile, the client might make threatening statements or imply the possibility of violence. At that point, the therapist has a professional—and in some cases a legal—responsibility to determine if the client poses a serious, foreseeable risk of vio-

lence. If the result of that assessment suggests that another identifiable person is at risk, the therapist should consider what actions might be taken to protect that other person. In this context, a risk assessment is required, often with little or no preparation.

Direct Referrals

Sometimes an attorney, educator, physician, pastor, or other professional will refer a child for a risk assessment. These referrals are occurring with increasing frequency from schools, as in the examples of Curt, Alex, and Stephen. Typically, this follows some behavior or communication by the young person that has caused someone to be concerned. It can be as clear as a student who has created a working explosive device and written a specific plan with a hit list of victims at school or as ambiguous as an isolated teenage boy who gives menacing stares to the girls at his youth group. The aim of these referrals is to prevent the possibility of some future violence.

TRENDS IN YOUTH AND SCHOOL VIOLENCE

It is difficult for any professional to discern accurate patterns in the nature or prevalence of youth violence based solely on media accounts and public concern. Since the mid-1980s, youth violence has gained increasing prominence as a significant public health problem (Chan et al., 2005; Durant, 1999; Hamburg, 1998; U.S. Department of Health and Human Services, 2001; Zimring, 1998). The public perception over the past decade has been that juveniles are getting more violent and dangerous. So what percentage of violent crime do they actually commit? When Gallup asked a representative sample of Americans that question, the results indicated that they believed juveniles were responsible for nearly half (43%) of all violent crime. The truth is that according to most reliable crime statistics, it actually is closer to 13%. Juveniles are believed to be responsible for much more violent crime than they actually are (Snyder & Sickmund, 1999).

The public concern, however, is not completely without a basis in fact. As Figure 1.1 illustrates, beginning around 1985, rates of violence committed by juveniles rose sharply. The trend was consistently observed in prevalence estimates derived from official arrest records, youth self-reports, and victimization surveys (Snyder & Sickmund, 1999). Between 1987 and 1992, the number of Offenses Against Person handled by juvenile courts increased by 56% (Snyder & Sickmund, 1999). Although most of these cases (76%) were for assault the number of homicides committed by youth and the number they committed with guns doubled between 1985 and 1992 (Blumstein, 1995).

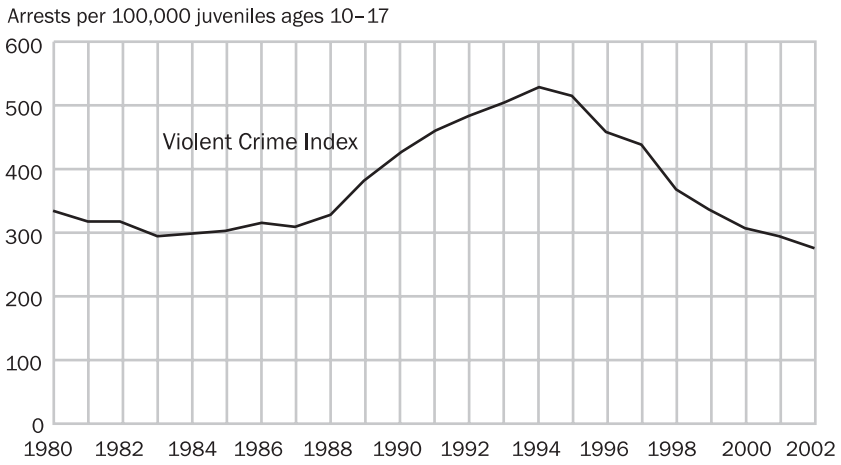

FIGURE 1.1. The juvenile Crime Index arrest rate in 2002 was lower than in any year since at least 1980 and 47% below the peak year of 1994. Data source: Analysis of arrest data from the FBI and population data from the U.S. Bureau of the Census and the National Center for Health Statistics. In comparison with the juvenile violent Crime Index Arrest rate, the rate for young adults (persons ages 18–24) that peaked in 1992 had fallen only 28% by 2002, remaining above the rates of the early 1980s.

The good news is that these alarming rates of juvenile homicide have declined significantly since 1993, and by 2000 were the lowest they had been since the 1960s (Harms & Snyder, 2004; U.S. Department of Health and Human Services, 2001). Better yet, a similar downward trend was seen for most forms of juvenile violence (Snyder & Sickmund, 1999), and contrary to popular perception, that trend is also true of school violence.

The Bureau of Justice Statistics and the National Center for Education Statistics jointly publish a yearly tally called "Indicators of School Crime and Safety" that draws information from a number of large national surveys of youth, school officials, and crime victims. These data show that the number of homicides at school fell from 34 during the 1992–1993 school year to 14 during the 2001–2002 year. The number of serious violent crimes in U.S. schools dropped by more than 70%, from 306,700 in 1993 to 88,100 in 2002. The rate of serious violent crimes similarly dropped by 75%, from 12 per 1,000 students in 1993 to 3 per 1,000 students in 2002.

Despite these encouraging trends in the community and in schools, there is good reason to temper our optimism with caution. Although the overall number of juvenile homicides was at a 30-year low, there were still

about 1,360 juveniles arrested for murder or non-negligent manslaughter in 2002 (Snyder, 2004). As Figure 1.2 illustrates, adolescents' self-report and arrests for aggravated assault have declined much more modestly since the peak in 1993, with 61,610 juvenile arrests recorded in 2002. That aura of caution has kept violence prevention as a high priority in forensic mental health services and in juvenile justice (Hoge, 2001, 2002; Howell, 2003; U.S. Department of Health and Human Services, 2001; Zimring, 1998).

WHY VIOLENCE?

There is no universal and accurate answer to the question of why people engage in violence (Andrews & Bonta, 2002; Hoge, 2005; Reiss & Roth, 1993). Usually many different factors contribute to any given violent act (Hann & Borek, 2002). Sometimes biological factors, such as frontal lobe dysfunction, play a key role (Reiss & Roth, 1993). Other times, psychological or social/environmental influences contribute more strongly (Dodge, Bates, & Pettit, 1990; Felson, Liska, South, & McNulty, 1994). Violence, like nearly all human behaviors, has multiple causes (Elliott & Tolan, 1999; Fagan, 1993; Hann & Borek, 2001; Stattin & Magnusson, 1996). We advise, however, that having a coherent framework for understanding violence will be helpful on many levels (Pepler & Slaby, 1994; Roitberg &

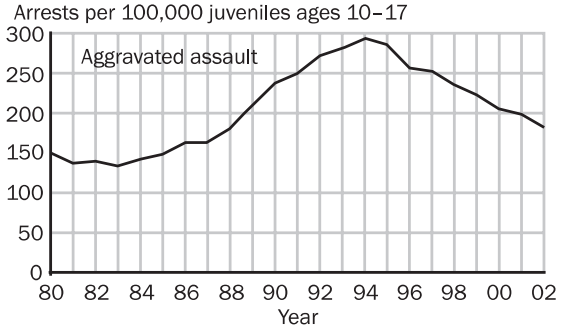

FIGURE 1.2. The juvenile arrest rate for aggravated assault doubled between 1980 and 1994, generally paralleling the arrest rate trends for murder and robbery. Unlike the juvenile arrest rate trends for murder and robbery, the decline (of 37%) in the juvenile arrest rate for aggravated assault between 1994 and 2002 did not erase the increase that began in the mid-1980s. The juvenile arrest rate for aggravated assault in 2002 was still 27% above the 1980 level. Data source: Analysis of arrest data from the FBI and population data from the U.S. Bureau of the Census and the National Center for Health Statistics. From Snyder (2004).

Menard, 1995). We believe the framework we offer in this book will lead to clearer thinking, more focused assessments, and more effective interventions.

We are not really proposing a new theory, at least not in the formal sense. Rather, our framework builds upon a set of guiding principles that are drawn largely from and informed by the following perspectives:

- Developmental psychopathology (Cicchetti & Cohen, 1995; Sroufe & Rutter, 1984)
- Social learning theory (Bandura, 1986)
- Social-interactionist theory (Tedeschi & Felson, 1994)

We do not mean to suggest that this framework is the only proper way to think about violent behavior in adolescents. We simply want to outline the principles here so that you can understand our foundation for certain recommendations and the reasons we included or excluded certain factors in our analysis.

FOUNDATIONAL PRINCIPLES

Violence Is Multidetermined

Violence has multiple causes rather than a single cause (Agnew, 2005; Hoge, 2005; Lahey, Moffitt, & Caspi, 2003; Reiss & Roth, 1993). A gossiping neighbor might say of a jailed teenager, "Why, he was the sweetest child there ever was! His daddy must have turned him mean. I bet the boy was so frustrated at living with an Army sergeant and all his military rules, it's no wonder he stole that car and robbed a bank! If his sweet mama was still alive, you can bet that child would not be sitting in jail today." This neighbor would be leaning heavily on the "nurture" aspect of the age-old "nature versus nurture" debate. Unfortunately, relying completely on either one or the other to explain any form of human behavior, including violence, is outdated and inconsistent with the current state of research in the field. Some causes will be more prominent than others for certain individuals and for certain types of violence and aggression, but nearly always there will be more than one identifiable cause (Grisolia, Sanmartin, Lujan, & Grisolia, 1997; Lahey et al., 2003; Reiss & Roth, 1993).

Violence Is Transactive

The cause of violence is transactive, which means it does not result from a linear process of cause and effect. Rather, violence is caused by a complex

interaction of biological, social/contextual, cognitive, and emotional factors that may change and affect one another over time (Durant, 1999; Englander, 2003; Grisolia et al., 1997; Scarpa & Raine, 1997; U.S. Department of Health and Human Services, 2001). Our aforementioned gossiping neighbor might just as easily have used the "nature" argument and said, "Why, I knew that boy was going to wind up an alcoholic; his daddy was a drunk, and his granddaddy was a drunk! I'm just glad his mama didn't live to see her boy end up in jail." A given risk factor or cause does not typically act in isolation on a particular adolescent to produce violence; rather, the causes are a part of an ongoing, reciprocal interaction between a young person and his or her environment.

Some have argued—based mostly on psychoanalytic theory or animal research and models of aggression—that human aggressive behavior is instinctual. Instinct has been defined as "natural inward impulse; unconscious, involuntary, or unreasoning prompting to any mode of action, whether bodily, or mental, without a distinct apprehension of the end or object to be accomplished" (*Webster's Revised Unabridged Dictionary*, 1998).

The notion that human aggression is driven by instinct is virtually devoid of any empirical support (Tedeschi & Felson, 1994). Humans have a behavioral and motivational complexity that has not been demonstrated in any other species, so it is not appropriate to make direct inferences about human behavior based on studies of other species, particularly rats and monkeys (Scott, 1970). Indeed, empirical evidence suggests that humans do not inherit instinctual behavior. Tedeschi and Felson (1994) write, "Genetic factors may affect mood states, emotions, and other internal conditions that may indirectly affect the likelihood of aggression under certain conditions. In general, we view biological factors as playing a remote causal role, often moderating aggressive behavior in humans" (p. 36).

Violence Is Purposeful

Most violence is instrumental at some level. It is chosen by the actor as a means to an end or a way of accomplishing some goal. There is a purpose to most violent and aggressive behavior in humans. Certainly, there are exceptions. One can conceive of circumstances where an individual might have some brain dysfunction and/or emotional instability that could result in undifferentiated aggression or violence (Blair, 2004; Borum & Appelbaum, 1994). Most violent behavior, however, is the product of a choice, even if that choice is ill considered. The behavior itself is goal-directed and meant to achieve some valued outcome for the actor. The goal is not necessarily money or financial gain. The valued outcome may be material, but its often more social—for example, to exert influence over an-

other person, to assert or develop a particular identity, or to avenge or correct some perceived injustice (Tedeschi & Felson, 1994).

THE ROLE OF DEVELOPMENT IN UNDERSTANDING VIOLENCE

When considering violent behavior committed by juveniles, understanding the role of development is crucial. Two-year-old children are known to have public tantrums, hit the dog, and even bite other kids. This is because they have yet to develop some of the required mechanisms for generating prosocial solutions for getting their needs met and for inhibiting behavior. By contrast, it would be uncommon for most 7-year-olds to engage in these behaviors.

A 15-year-old may affiliate with aggressive and antisocial teenagers and adopt these behaviors because of the increasingly important role of peers, while younger children or adults may not be as easily influenced by negative peers in this manner. Not only must violence be understood in its interpersonal context, but it needs to be considered in light of its intrapersonal context as well. The ultimate goal for the clinician is to conduct a developmentally informed assessment.

The study of human development has yielded some important findings that help our understanding of how developmental issues interact with a young person's decision making and risk for violence (Kazdin, 2000). Those findings include the following:

- The range of what is considered "normal" for attaining certain milestones in each domain varies widely among children and can be substantially affected by environmental factors. The reality of human development is that there is great variability in the age and rate at which different cognitive, social or emotional capacities develop (Grisso, 2004; Steinberg & Cauffman, 1996, 1999). Although developmental psychology textbooks and other reference sources may publish charts that display a "typical" or "average" progression, those normative estimates often are based on white, middle-class children. Minority youth living in poverty, however, are the population most disproportionately represented in the justice system. Research has demonstrated that economic disadvantage may delay or inhibit certain developmental capacities, so the average trajectory of less privileged youth may be expected to differ from the overall average (Grisso, 1998, 2004).
- The rate of progress or trajectory for any given domain is not necessarily the same as for any other. It may be tempting to assume that on-level or advanced abilities in one domain—or even in a particular capacity within a domain—indicate a similar level of attainment in other abilities or do-

mains. For example, a child with an above-average IQ score might be expected to have above-average social skills. This kind of assumption is one of the greatest potential sources of error in developmental assessments. Relevant capacities should be assessed directly, not simply inferred from other characteristics.

- Developmental progress does not always move forward. It is quite common to see "spurts" (periods of rapid advance), "delays" (periods where advances are not occurring at the expected rate), and "regressions" (periods where developmental progress is lost or returns to an earlier state) in different areas of development (Grisso, 1998).
- Inconsistency is normal. It is not uncommon for certain capacities to be evident in one context or circumstance but not in others. Researchers studying human development have concluded that personality traits are far less stable and consistent in children than they are in adults. Everything from extraversion to impulse control to altruism is demonstrated less consistently in children. The expression of these traits depends a great deal on context. For example, a child may be extraordinarily shy in some settings but highly animated and lively in others. Another child may be kind and quick to share at home but verbally cruel and selfish around certain peers. The social context often determines what the child's personality looks like for the moment. Psychologist Thomas Grisso has aptly characterized youth in the developmental period as "moving targets." What may be true about a child physically, cognitively, emotionally, or socially today may not be true a month from now. This variability may be magnified during pubertal changes (Beaver & Wright, 2005). This makes it especially difficult for an evaluator who must assess a child's developmental capacities several weeks or months after an event. Assessing these capacities in a different context at a different point in time can present a challenge for an evaluator.

A developmentally informed assessment begins with an understanding of the key issues that are likely to be relevant for the juvenile's current stage of development. Developmental psychopathologists refer to these key developmental tasks as "stage-salient issues" (Cicchetti, Toth, Bush, & Gillespie, 1988). The ways in which a young person navigates and resolves each developmental task will influence his or her future adaptation. Although prior developmental experiences may predispose, push, shape or constrain future adaptations in certain ways, past experiences do not absolutely *determine* the nature or direction of growth.

If it is true that a juvenile's age, physical development, and index offense do not reveal his or her level of maturity and developmental status, how should that status be measured? Grisso (2005, p. 18) has aptly noted that developmental maturity should not be regarded as a dichotomous,

monolithic construct. He recommends that clinicians think of "immaturity" as a concept that:

- Refers to incomplete development (having not reached one's adult level of maturation) or delayed development (in relation to one's age peers).
- Describes specific abilities or characteristics, not an overall condition of the youth.
- Depends on actual functioning, not simply on age.
- Can be expressed in degrees and in relation to one's peers.

Adolescence is a time of major change. Teenagers are undergoing change physically, intellectually, emotionally, and socially. Their bodies are growing and developing while their brains are undergoing significant reorganization. At the same time, they are negotiating new social and relational structures and attempting to form a clearer sense of personal identity. Adolescence, then, is a critical formative period in which lifetime patterns are established. These involve patterns of achievement, relationships, and judgment. It is a time when most individuals are maturing psychosocially and developing the critical capacities that will guide them into and throughout adulthood.

One common way of thinking about the major domains of youths' development is to divide them into biological, cognitive, and psychosocial. They are all constantly moving and affecting each other. Without recounting all the lessons of Developmental Psychology 101, we will briefly review here some key research findings in each domain that bear relevance to a developmental assessment of violence risk.

Biological Development

Perhaps the most significant physical changes affecting young people occur during puberty. Not only does the body endure a serious overhaul, but those changes also affect the way the young person thinks, feels, and behaves toward him- or herself and others. These effects may, in turn, affect decision making and behavior.

Some of the effects are due to surges and changes in hormones, particularly the effects of testosterone and androgen in boys and estradiol and estrogen in girls, which can increase feelings of irritability or aggressiveness. But they are only part of the constellation of changes that can affect adolescents' behavior. Adapting to major changes in one's body is inherently stressful, and adolescents are normatively more vulnerable and reactive to stresses than adults. Moreover, those changes affect their self-image and perceptions of how they are viewed by others precisely at the time in their lives they are most self-focused and most self-conscious about others' judgments. It is difficult to imagine how that situation could not have sig-

nificant effects on one's behavior. The "moodiness" of the teen years is not merely a cliché, but a biologically based reality of human development. Adolescents do indeed "experience emotional states that are more extreme, more variable, and less predictable than those experienced by children or adults" (Steinberg & Cauffman, 1996, p. 261).

Cognitive Development

Cognitive development describes the maturational process of a person's mental and intellectual functions. It recognizes that abilities such as memory, information processing, and reasoning are not fully developed at birth and accounts for how they are acquired over time. Jean Piaget's (1953) theory of cognitive development has had one of the strongest and most lasting impacts on the field. Although subsequent researchers have criticized the tasks and methodology he used to develop his ideas (particularly his failure to consider cultural factors), many of the basic concepts have stood the test of time.

We will not provide here a detailed account of Piagetian theory, but a couple of basic ideas are worthy of reflection. First, Piaget saw cognition (and its development) as an active process in which an individual attempts to organize and make sense of the world. Advances in development were not solely—or even mainly—a product of acquiring new knowledge or facts, but rather of gaining new ways of understanding.

He believed we learn about our environment in infancy mainly by the "hands-on" experience of seeing, hearing, and touching. Very little happens internally (mentally) or symbolically. In early childhood, a young person begins to develop the ability to represent an idea—often through images or drawing—that is not in his or her immediate experience. This is the beginning of symbolic representation and thought. In later childhood (~7–11 years), a remarkable development occurs as the child becomes able to perform tasks in his or her head. This is what Piaget calls an "operation." What is important is that this represents a change in the child's way of thinking and reasoning toward the use of and reliance on basic logic. By early adolescence (~11–15 years), the capacity to perform internal operations does not require a specific stimulus or example; the thought process can be more abstract or hypothetical (including what *might* happen in the future). Piaget did not claim that all youths reached the operations stage at any specific age, but rather that for most youths the capacity began to appear within the early adolescent years, then proceeded to grow and mature across adolescence until it reached the level of functioning that would be characteristic for that individual.

Some of the higher-level cognitive functions such as reasoning and problem solving are strongly linked to brain development. In fact, the part of the brain most responsible for many complex cognitive abilities (and,

incidentally, for inhibiting risky impulses and choices) is the last area of the brain to develop fully (Casey, Giedd, & Thomas, 2000; Spear, 2000). Moreover, cortical and subcortical structures responsible for emotion — including the amygdala and other structures in the limbic region—are more active in children and adolescents than in adults. Yet, current evidence in cognitive neuroscience suggests that areas of the frontal cortex (which governs behavioral inhibition, planning, and emotional regulation) are less active in children and adolescents than in adults, and these structures continue to develop even into early adulthood (e.g., early 20's) (Giedd et al., 1999; Sowell, Thompson, Holmes, Jernigan, & Toga, 1999; Sowell et al., 2003). Essentially, then, the nature of brain development is such that young people have much greater activity than adults, in the emotional and reactive brain regions and much less activity and maturation in the planning and inhibitory ones. Accessible reviews of this research can be found in Strauch (2003) as it applies to adolescents in general and in Beckman (2004) as it applies to issues of delinquency.

Psychosocial Development

Psychosocial development is perhaps the most central and least studied domain likely to affect a juvenile's risk of violence. Historically, the most fundamental problem in this area as it relates to forensic assessment has been the absence of a clearly articulated model, or even definition, of psychosocial maturity.

Scott, Reppucci, and Woolard (1995) and Cauffman and Steinberg (2000; Steinberg & Cauffman, 1996) have made some of the most important advances on this front. Using Cauffman and Steinberg's (2000) conceptualization, psychosocial maturity is "the complexity and sophistication of the process of individual decision making as it is affected by a range of cognitive, emotional, and social factors" (Cauffman & Steinberg, 2000, p. 743). Specifically, they outline three developmental capacities that combine to shape that decision-making process. The first is *responsibility*. This is the ability to be self-reliant and unaffected by external pressure or influence in making decisions. The second is *perspective*. This has two components. One is temporal (i.e., the ability to see and consider both short- and long-term implications of a decision); the other is interpersonal (i.e., the ability to take another's perspective and understand a different point of view). The third developmental capacity is *temperance*. This is the ability to exercise self-restraint and to control one's impulses.

Research on responsibility shows that by late adolescence, most young people are capable of being largely independent and self-reliant in decision making (Cauffman & Steinberg, 2000). Significant decisions can be made without consultation of parents or peers. Self-reliance increases as the teenager progresses through adolescence, while parental influence de-

clines. Peer *pressure* steadily increases from late childhood through adolescence; however, peer *influence*, which begins to increase in early adolescence, peaks around the age of 14, then gradually declines in the later high school years.

While adolescents are capable of making autonomous decisions and accepting responsibility for their actions, the maturity of their judgments is strongly affected by identity development. This is especially true for teenagers who are 15 years old and younger when self-concept is not yet well consolidated. Adolescents with a poorly developed sense of personal identity may be more susceptible to peer influence and tend to make more impulsive and imprudent decisions.

Perspective taking, as we have noted, has both temporal and interpersonal (role perspective) facets. It is a developmental task that improves over the course of adolescence for most individuals. During adolescence, teenagers begin to weigh the relative costs and benefits of consequences in their behavioral decision making. While younger children can do this with some guidance and direction, adolescents often can do it autonomously and without external prompting. Bad decisions result not just from youths' failures to conduct sophisticated, adult-like cost–benefit analyses, but from fundamental differences in the "subjective values that they attach to various perceived consequences in the process of making choices" (Halpern-Felsher & Cauffman, 2001, p. 268). Specifically, before adulthood, greater weight is given to acquiring potential gains than to avoiding potential losses, and to short-term than to long-term consequences.

Finally, with regard to temperance, current research indicates that an adolescent's degree of self-restraint and impulse control changes as he or she ages. This is consistent with evidence in neuroscience that the frontal lobe is still maturing and, accordingly, that "response inhibition, emotional regulation, planning and organization continue to develop between adolescence and young adulthood" (Sowell et al., 1999, pp. 859–860). Children tend to be relatively stable in their overall impulse control from the time they are school aged until about the age of 16. Around that time, the research suggests that adolescents actually become more impulsive and engage in more sensation-seeking and risk-taking behavior (through about age 19) (Steinberg & Cauffman, 1996). In this regard, older adolescents are actually less temperate and typically exercise less control over their impulses.

In summary, child and adolescent behavior is best understood and assessed in its developmental context. This maxim is as important in the therapy office as in the courtroom. Young children understand how to follow rules and have a rough understanding of right and wrong. To them, something is wrong if it likely leads to punishment. They do not tend to have a grasp of the deeper issues involved in moral reasoning. By approxi-

mately age 9, children begin to develop greater capacity for intentional behavior and have a more complex understanding of what is right and wrong. Most children 13 and younger still lack certain psychosocial capacities that tend to affect their behavior and judgment. They are more likely to be impulsive, easily frustrated, and easily led than older adolescents and adults. By the age of 17, on the other hand, most adolescents have adult-like judgment and psychosocial capacities. These developing capacities have vital implications for behavioral expectations, judgments of culpability, and intervention strategies.

UNDERSTANDING SUBTYPES OF AGGRESSIVE BEHAVIOR

Not all aggression is the same. Aggressive behavior can differ not only in its intensity, but also in its underlying causes and motivations. Although there are many ways to classify aggressive behavior (Connor, 2002), research consistently points to two broad categories: reactive and proactive (Connor, Steingard, Cunningham, Anderson, & Melloni, 2004; De Castro, Merk, Koops, Veerman, & Bosch, 2005; Kempes, Matthys, de Vries, & van Engeland, 2005; Weinshenker & Siegel, 2002).

Generally, speaking, reactive aggression tends to be angry and impulsive, while proactive aggression is more deliberate and goal-directed. Some clinicians use the term "instrumental" rather than "proactive" (Atkins & Stoff, 1993). One could even argue that there are subtle distinctions between them. We prefer not to use "instrumental" to label a distinct type of violence because we believe—as noted earlier—that most violent behavior is instrumental in some way. It is purposeful (even if impulsive) and intended to achieve a desired outcome, although the goal may simply be to stop another's behavior or to retaliate for an injustice. Both types of aggression can be serious, even deadly, but it is useful to distinguish between the two. Each type has different cognitive, affective, and behavioral mediators and a different mechanism for development.

Reactive Aggression

Reactive aggression is an angry, retaliatory response to a real or perceived provocation. This is the most common type of aggression in youth. Juveniles who engage in this type of aggression typically rate high on measures of trait anger. They are often chronically angry kids who tend to perceive that others are acting with hostile intent, even when no such motivation is present. They misread social interactions through a filter of perceived affront or threat and act in response to this.

Behaviorally, these acts of aggression tend to be impulsive. Youths who commit them tend to act and react impulsively, without considering

the implications of their behavior ahead of time. The extent of their aggression is often only limited by the circumstance, including, for example, the comparable strength of their opponent, the immediate availability of weapons, and the presence of outside intervention.

Their perception of being persecuted and treated with hostility often has roots in their early experiences. Juveniles who are prone to reactive aggression often have been victims of physical abuse and harsh discipline. They have grown up with a sense that people will hurt them, and they have learned to protect themselves by being vigilant in searching for cues of hostility and negativity in their interactions.

Proactive Aggression

By contrast, proactive aggression is unprovoked and goal-directed. The individual is not acting out of an emotional burst of anger, but out of a belief that violence is an effective and acceptable way of accomplishing some objective. To him or her, aggression is a legitimate, justifiable, or necessary means to an end.

This nonimpulsive form of aggression is usually accompanied by a belief that violence will likely produce some desired result. The young person also believes that he or she will be able to implement the aggressive strategy successfully. It is often the mindset behind such violent behavior as muggings, carjackings, rape, and school shootings.

Those who engage in this type of aggression frequently have been exposed to aggressive role models. These are children and adolescents who have seen adults get what they want through the use of force and violence. Others who engage in this type of violence have had the experience of feeling weak, inferior, or powerless.

One reason to understand this distinction is that interventions for reactive and proactive aggression are likely to be quite different. For example, it may not be very effective to prescribe anger management training to reduce risk of violence in a youngster with an exclusive pattern of proactive aggression. Likewise, interventions to enhance empathy or diminish antisocial attitudes may meet with less success in an impulsive youngster whose only acts of aggression are angry and reactive.

PATTERNS OF JUVENILE OFFENDING

It is not uncommon for teenagers to engage in a range of criminal activity from shoplifting to assault to property destruction. In fact, rates of criminal and delinquent activity during adolescence are so high that it is statistically normative (Elliott, Ageton, Huizinga, Knowles, & Canter, 1983; Hirschi,

1969; Moffitt, Lynam, & Silva, 1994). For example, in 2003, the U.S. Centers for Disease Control and Prevention (2004) examined a national sample of more than 15,000 high school students—not a particularly high risk group—in their Youth Risk Behavior Survey and found that approximately 33% reported being in a physical fight one or more times in the prior 12 months. It is critical to keep in mind that engaging in violent behavior as a juvenile does not predestine a young person to a life of violence. Most kids who are violent in adolescence do not continue to offend into adulthood. In fact, 80% quit (or desist) by age 21.

Official crime rates tend to peak at age 17, then drop off sharply in young adulthood. The graphic display of this pattern is often referred to as the *age–crime curve*. The earlier a youth begins engaging in some form of violent behavior, however, the more likely he or she will be to commit violence in the future. A number of large-scale longitudinal studies of children and adolescents support this finding, each showing a similar and clear age-related trend. Table 1.1 shows three examples.

Among those who will engage in (though not necessarily be arrested for) acts of serious violence, boys are most likely to commit their first violent act around the age of 16, while girls are most likely to commit their first violent act around the age of 14. Around 20–25% of males and 4–10% of females report ever participating in serious violence, generally defined as an act of physical battery that caused sufficient victim injury to it require medical attention or a threat of battery with a weapon in hand. After the age of 17, participation rates drop dramatically, and, as noted above, about 80% of those who were violent during adolescence will cease aggressive behavior by the age of 21. After the age of 20, if an individual has not yet engaged in an act of serious violence, the statistical likelihood that he or she will ever initiate such an act is very low (U.S. Department of Health and Human Services, 2001).

IDENTIFIABLE TYPES OF DELINQUENTS

Researchers have identified a relatively small subgroup of chronically violent adolescents who are termed *life-course-persistent* delinquents, while others are referred to as *adolescence-limited* delinquents. These two types are different with regard to the timing and duration of their antisocial and violent behavior (Moffitt, 1993, 1997)

Life-Course-Persistent

There is a small group comprising between 5 and 10% of all delinquents who engage in antisocial and violent behavior at every developmental

TABLE 1.1. Earlier Onset of Violence Increases Risk for Future Violence

National Youth Survey (Elliott, Huizinga, & Loeber, 1986)

- About 50% of youths continued violent behavior into adulthood if their first violent acts occurred prior to age 11.
- About 30% of youths continued violent behavior into adulthood if their first violent acts occurred during preadolescence (ages 11–13).
- About 10% of youths continued violent behavior into adulthood if their first violent acts occurred during adolescence.

Rochester Youth Development Study (Thornberry, Huizinga, & Loeber, 1995).

- About 40% of youth became chronic (i.e., high-frequency) violent offenders by age 16 if they began committing violent offenses before age 9 (11% of sample).
- About 30% of youth became chronic violent offenders by age 16 if they began committing violent offenses between ages 10 and 12.
- About 23% of youth became chronic violent offenders by age 16 if they began committing violent offenses between ages 10 and 12.

Denver Youth Study (Thornberry, Huizinga, & Loeber, 1995)

- About 62% of youth became chronic violent offenders during adolescence if they began committing violent offenses at or before age 9.
- About 48% of youth eventually became chronic violent offenders if they began committing violent offenses between ages 10 and 12.

stage. They appear at both ends of the age–crime curve, and usually have some co-occurring behavior disorder. Many of the *preschool onset type* have attention-deficit/hyperactivity disorder (ADHD), while the *childhood-onset type* have persisting oppositional behavior.

A typical progression for these children involves defiant and aggressive behavior by the age of 3, giving way to a diagnosis of conduct disorder (CD) in elementary school, then to arrest in the teen years (Elliott et al., 1986). A first arrest between the ages of 7 and 11 is strongly associated with long-term offending (Loeber, 1982).

For these children, the nature of the specific behavior may change, but the predisposition to antisocial conduct remains stable. They may hit and bite in preschool, bully and threaten in middle school, and steal and assault in high school.

In preadolesence, these children show significant behavior problems; they are the "difficult children" in school. They often have ADHD, oppositional defiant disorder (ODD), or other mood or neurological disorders. Their first police contact is typically before the age of 13, and their attachments to others are generally poor and lacking in depth.

In adolescence, they engage consistently in maladaptive antisocial behavior. Their childhood disorders, such as ADHD, ODD, and CD, likely persist and continue to cause them significant impairment in their overall functioning. These teenagers often engage in a pattern of predatory violence, hurting others for fun or minor gain. Their attachments to others are superficial with markedly deficient capacities for guilt or empathy.

Adolescence-Limited

The adolescence-limited pattern is more common. A substantial number of adolescents will engage in antisocial behavior that begins and ends during their teen years. Approximately one-third of males will commit an act of serious violence or crime and many more will have police contact for some minor infringement, mostly during the adolescent years. (Farrington, Ohlin, & Wilson, 1986). At least 75% of these desist by early adulthood (Farrington, 1986; Moffitt, 1991). The preponderance of empirical evidence shows that the influence of delinquent peers is central to understanding the adolescence-limited pattern of offending (Moffitt, 1993).

In preadolesence, these children typically do not show significant behavior problems. Most do not have their first police contact until after the age of 13, if at all. Typically, they have no major childhood mental health or behavioral disorders, and their attachments to others are generally adequate.

In adolescence, they may show antisocial, even violent behavior, but it tends to be less consistent across situations than that with the life-course persistent Adolescent. They may engage in episodes of proactive aggression, though it tends not to be a pattern. These teenagers usually maintain primary attachments, but they may be rebellious and their relationships with parents may be strained for a while. In general, they develop an appropriately healthy sense of guilt about misbehavior and have the capacity for empathy.

PATHWAYS TO DELINQUENCY

Loeber and Hay (1997) took a different approach to analyzing pathways and patterns of delinquent offending. Their approach also has a developmental orientation but focuses more on the nature and progression of behavior over time. The idea is that the type of problem behaviors observed in early childhood give some indication of the kinds of problems the youth is likely to experience in pre-/early adolescence, which then portend the nature of antisocial behaviors in later adolescence. They identified three pathways, which are shown in Figure 1.3.

The *authority conflict pathway* begins with stubborn and resistant behavior before the age of 12. This gives way to defiance and disobedient behavior, then finally to authority avoidance, such as truancy, running away, and staying out late.

The *covert pathway* begins with minor sneaky and hidden behaviors like shoplifting and habitual lying. Later, it moves to property damage, such as vandalism and firesetting. Eventually, it leads to moderate or even serious delinquency, including burglary, serious theft, and fraud.

In the *overt pathway*, the juvenile begins with minor aggression like bullying and intentionally annoying others. From there, it moves to physical fighting, which could include gang violence. Finally, it leads to a pattern

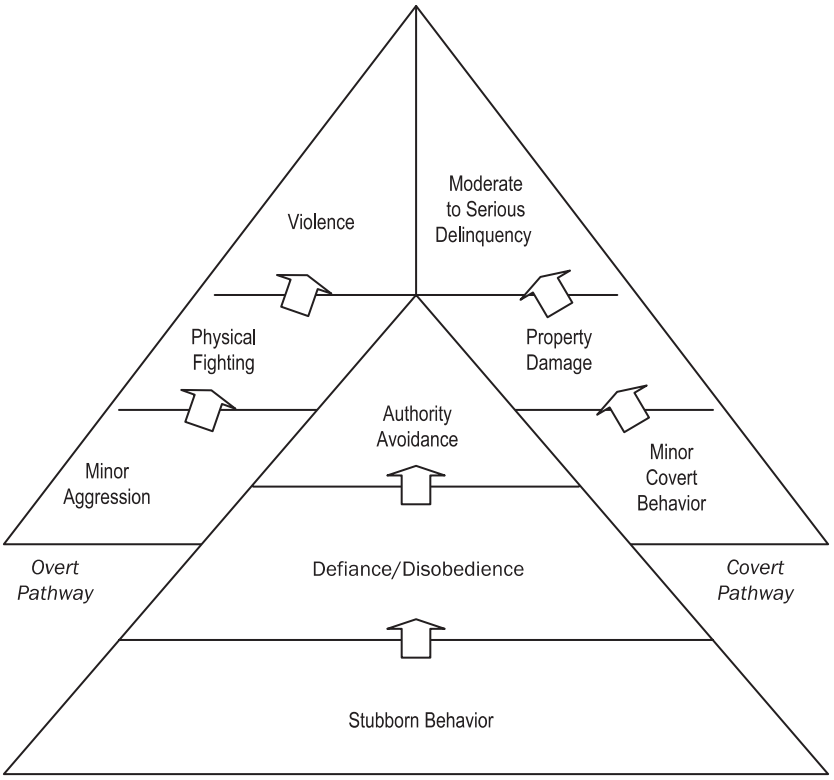

FIGURE 1.3. Loeber and Hay's (1997) pathways to delinquency authority conflict pathway (before age 12).

of serious violence with behaviors like rape, strong-arm attack, and other serious physical assaults.

Adolescents who have moved along the overt pathway are more likely to engage in serious violence against others than those who have progressed along the other two pathways. Rhose along the other pathways may, however, engage in serious violence more readily than nondelinquent youth because they are more likely to find themselves in situations, such as drug deals, burglaries, or associating with violent peers, where they are more inclined to use violence.

GENDER DIFFERENCES

Males commit the majority of criminal offenses, particularly violent ones. In official crime records for 1992, four out of five offenses against persons were committed by males. The overrepresentation of males in juvenile and adult violent crime statistics is one of the most robust and stable findings in American criminology (Freeman, 1996; Odgers & Moretti, 2002; Quinsey, Skilling, Lalumière, & Craig, 2004).

During the surge of juvenile violence in the mid-1980s and early 1990s, the proportional increase in violence among girls was even greater than it was for boys. Between 1989 and 1993, the arrest rate increase for juvenile females was more than twice that of males. Even more troubling, as seen in Figure 1.4, is the fact that since the peak around 1993, the rates of the most common violent offenses committed by girls, such as simple and aggravated assault, have not dropped nearly as much as they have for boys. In 2002, females were responsible for nearly 30% of juvenile arrests for violent crime. Moreover, there is also strong evidence that girls are entering gangs with increasing frequency.

From late childhood on, boys tend to show higher rates of conduct problems than girls (Farrington, 1987), and the association between early and later aggression is somewhat stronger than it is for girls (Cummings, Ianotti, & Zahn-Waxler, 1989; Kellam, Ensminger, & Simon, 1980; Stattin & Magnusson, 1989). Some studies, however, have shown that measures of the stability of aggressive behavior in girls over time are often as high as they are for boys (Cairns, Cairns, Neckerman, Ferguson, & Gariepy, 1989; Piquero, Brame, & Moffitt, 2005; Verhulst, Koot, & Berden, 1990).

Girls may engage in as much aggressive behavior as boys, but boys commit more acts of serious violence, such as aggravated assault, robbery, and murder (Rutter & Giller, 1983; Quinsey et al., 2004). Girls tend to display more indirect verbal and relational aggression, such as exclusion of peers and malicious gossip (Bjorkvist, Lagerspetz, & Kaukiainen, 1992;

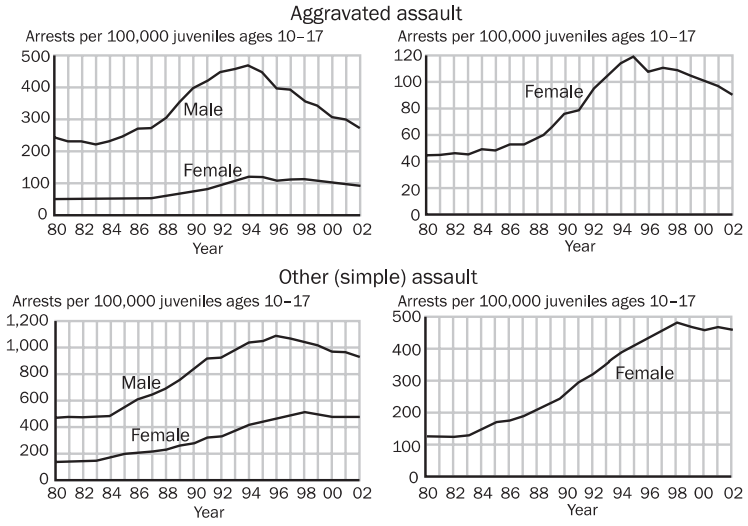

FIGURE 1.4. Male juvenile arrest rates for aggravated assault and simple assault fell from the mid-1900s through 2002, while female rates remained near their highest levels. Data source: Analysis of arrest data from the FBI and population data from the U.S. Bureau of the Census from the U.S. Bureau of the Census and the National Center for Health Statistics. From Snyder (2004).

Cairns et al., 1989; Tremblay et al., 1996). Boys also engage in relational aggression, but their repertoire of aggressive behavior is more likely to include hitting and other harmful acts of physical battery (Archer, 2004; Quinsey et al., 2004).

The rise and subsequent persistence of violent behavior in girls has garnered increased attention from researchers and policy makers (Mullis, Cornille, Mullis, & Huber, 2004; Pepler & Craig, 2005). Over the past half century, most studies of the causes, correlates, and trends in violent offending have included only males. This has raised questions about whether the findings from developmental criminology on risk factors and offending patterns will apply equally to both sexes (Moretti, Catchpole, & Odgers, 2005; Odgers & Moretti, 2002). Marlene Moretti and her colleagues from the Gender Aggression Project (GAP) in Canada have done some of the most significant work to advance the scientific understanding of gender differences in aggression, particularly the implications of those differences for clinical applications such as risk assessment (Odgers, Moretti, & Repucci, 2005).

Gender and Risk Factors

The research comparing boys and girls is probably too preliminary and too limited to draw any firm and sweeping conclusions. Different empirical studies have arrived at different conclusions (Blitstein et al., 2005). In general, studies of large community samples in the United States, Canada, and New Zealand tend to find few differences between boys and girls in risk factors for violence or developmental trajectories for offending. Select studies of incarcerated samples, however, suggest that the sex differences may be more pronounced (Moretti, Catchpole, & Odgers, 2005; Odgers & Moretti, 2002). Interestingly, in adult women, marked differences also are seen between community samples and psychiatric samples (Krakowski & Czobor, 2004).

It is probably fair to say that the preponderance of empirical research suggests that most risk factors for violence apply similarly to males and females (Blum, Ireland, & Blum, 2003; Connor, Steingard, Anderson, & Melloni, 2003; Fergusson & Horwood, 2002; Huizinga, Esbensen, & Weither, 1991; Moffitt, Caspi, Ritter, & Silva, 2001; Pepler & Sedighdeilami, 1998; Rowe, Vazsonyi, & Flannery, 1995; Simourd & Andrews, 1994). One of the most striking examples is seen in reports from the International Self-Report Delinquency Study (ISRD), which sampled thousands of youth from 10 European countries and one site in the United States. Regarding risk factors for general offending and delinquency, the study "data indicate that globally these correlates are similar for males and females and that no greatly significant gender differences appear in the correlations of delinquency with important background variables . . . [and concluding that] there seems to be no need for radically different explanations of offending in girls and boys (Junger-Tas, Ribeaud, & Cruyff, 2004, p. 367).

A couple of possible exceptions may be emerging from this new body of research. The first is that trauma—particularly from sexual abuse—may bear a stronger causal relationship to violent behavior in girls than in boys (Breslau, Davis, Andreski, & Peterson, 1991; Levene et al., 2001; Moretti, Catchpole, & Odgers, 2005; Odgers & Moretti, 2002; Wall & Barth, 2005). In samples of incarcerated or clinic-referred youth, both boys and girls consistently report high levels of physical abuse and neglect, although cumulative rates of abusive experiences among girls are typically the highest. Some, but not all, studies show that girls are more likely than boys to have been victims of violence (Huizinga & Jakob-Chen, 1998; Odgers & Moretti, 2002), and we know that violent victimization, regardless of sex, substantially increases risk for engaging in juvenile violence (Blum, Ireland, & Blum, 2003). Moreover, girls also appear to be more vulnerable than boys to trauma-related morbidity (Giaconia et al., 1995).

In one sample of female juvenile offenders, for example, nearly half (49%) met full diagnostic criteria for posttraumatic stress disorder (PTSD) and another 12% partially met criteria (Cauffman, Feldman, Waterman, & Steiner, 1998). Only one-third (32%) of the matched comparison group of boys qualified for a PTSD diagnosis.

Girls who are offenders also tend to report higher rates of sexual abuse than do boys. After examining numerous studies, Odgers and Moretti (2002) found that "rates of sexual abuse among incarcerated females ranged from 45% to 75%, versus a range of 2% to 11% for incarcerated males" (p. 108). This is particularly striking in light of fact that, unlike physical abuse and neglect, childhood sexual abuse tends not to increase substantially risk for violent offending in male offenders (Widom, 2000). For example, in a study of 301 incarcerated men, 13% of violent offenders reported being victims of childhood sexual abuse, compared to 18% for nonviolent offenders (Weeks & Widom, 1998).

Risk factors in two other areas may diverge somewhat for boys and girls, but the research is too preliminary to tell for sure. One of these areas is the effect of caregiver disruption and its subsequent impact on attachments. Some studies suggest that severely delinquent girls are more likely than their male counterparts to be placed outside the home (Moretti & Odgers, 2002). Relating this to aggression, the hypothesis is that, because girls' socialization more strongly emphasizes the importance of relationships and emotional connections, they may be disproportionately affected by this disruption, which impairs the development of normal, secure attachment patterns (Leve & Chamberlain, 2004; Moretti et al., 2005).

The other line of suggestive findings perhaps pertains to aggressive behavior more generally than to severe violence specifically. The emerging question here is whether there may be an interactive relationship between early sexual maturation (e.g., onset of menarche before 12.5 years) and peer relationships that predisposes girls to aggression. Studies have shown that early-maturing girls tend to affiliate with older peers, particularly older males. This could not only increase their exposure to more deviant/delinquent influences, but it could provide that exposure at a younger age than otherwise would occur. If they are exposed earlier to a potent risk factor, it may lead them to earlier engagement in antisocial behavior, which itself can negatively affect outcomes (Moretti et al., 2005).

Gender and Offending Pathways

A related question is whether the two-trajectory adolescence-limited and life-course-persistent patterns of offending apply equally to girls and boys. Moffitt and Caspi (2001), who originally developed the model, seemed to think that they did. Other researchers seem to have their doubts (Moretti

et al., 2005). One of the few empirical tests comes from a study of 72 incarcerated adolescents that found that early-onset or LCP-type patterns were so rare among girls as to be virtually nonexistent. Yet the girls who did ultimately become violent in adolescence had outcomes (including future violence) that were just as bad as those of the LCP/early starter boys. The authors concluded that girls' trajectories of offending might be better characterized by a single delayed-onset pathway, rather than the two-trajectory model (Silverthorn, Frick, & Reynolds, 2001). In a subsequent test of the delayed-onset model, White and Piquero (2004) drew data from a longitudinally followed cohort of 987 urban African American males and females. Defining early-onset offending as having police contact before age 13 they found boys and girls to be equally likely to experience early onset (see also Leve & Chamberlain, 2004). They also found the criminal outcomes for early-onset males and females to be similar and worse than those for the late-onset offenders. Late-onset female offenders did, however, share many risk factors and similarities with both early-onset and late-onset males. They suggest that conclusions from the study by Silverthorn et al. (2001) may have underestimated the prevalence of early-onset offending in females, and overestimated the similarity in outcomes between late-onset females and early-onset males (White & Piquero, 2004).

FINAL THOUGHTS

Understanding juvenile violence requires a working knowledge of child and adolescent development, an understanding of the types of aggression in youth, an awareness of the patterns of juvenile offending, and identifying types of delinquents and the various pathways to delinquency. An emerging body of research is examining whether and how offending pathways and risk factors may operate differently for boys and girls. That research base is still new but tends to show more similarities than differences. Clinicians should keep up with developments in this area. We turn to the risk factors for juvenile violence in the next chapter.

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