by Kathryn Seifert, Ph.D., DABPS

Rates of Juvenile Violence in our Society

Juvenile violent crime rates increased 49 percent from 1988 to 1993 and declined six percent during 1993 through 1997 according to the Office of Juvenile Justice and Delinquency Prevention (OJJDP). However, the rates for juvenile drug and curfew violations, sex offenses and simple assault have continued to increase. For example, juvenile arrests for violent crimes accounted for 12 percent of all violent crimes in 1997. However, only five to eighteen percent of all juvenile delinquents commit a whopping 75 percent of violent juvenile crimes. The fastest growing delinquent population is boys under age 12 (OJJDP).

A Profile of Violent Youths

Violence among children and teens is a complex phenomenon that can be best understood from the perspective of type and origin. Dr. Dorothy Otnow Lewis (1998) speaks from her experience of having examined and written about numerous violent children. She discusses the interplay of brain damage and/or psychiatric disorder, horrific abuse, violent family background, paranoia and external circumstances that lead to childhood violence.

The Violent Child

Profiles, Assessment and Treatment

Psychological, Environmental and Developmental Risk Factors

OJJDP has identified categories of risk and protective factors for youth violence. The six categories of risk factors include community, economic, family, individual, school and peers. According to OJJDP, 80 percent of children with more than five risk factors and fewer than six protective factors are at risk for committing future violent acts.

Community/Society

If the community is one where norms favor drug use and firearms and there is easy availability of these items, the children of that neighborhood are more likely to use violent means to accomplish their goals. Additionally, according to Dr. Prothrow-Stith (1993), by the time most children are grown, they have seen 100,000 acts of violence on TV, video games and in the movies. Many experts agree that the present level of media violence negatively affects children. When extreme economic deprivation and other factors, such as failure in school, block or deny the path of prosocial success, teens may seek out other, often antisocial means to have money, "things" and power.

Family History

The families of violent children often have histories of violence, aggression, problem behavior, weak family bonding, little warmth and nurturing, family conflict, family attitudes favorable to drug usage and crime, child abuse and neglect (Crespi & Rigazio-DiGilio, 1996). If parents do not monitor what the child does or reinforce positive behavior, and if the child is not part of a prosocial peer group, the youth will often follow a deviant peer group that reinforces the use of aggression as a means to an end.

Individual Characteristics

Poor Reality Testing. Conduct-disordered violent youths have poor reality testing, which is similar in many ways to those who have thought disorders. They do not perceive or interpret their environment accurately, so they tend to oversimplify information.

According to Dr. Dorothy Otnow Lewis (1998), paranoia is probably the most common symptom fueling repeated violence. Paranoia can be described as the misperception that someone has threatened, endangered, or disrespected the youth when, in fact, no one has.

Unmodulated Emotion. Violent children experience little emotion, but when they do, it is often explosive and poorly modulated. They are also preoccupied with the need for immediate gratification, which is a developmental issue. They have poor anger management, problem solving and social skills. Violent offenders are unable to self-soothe or self-calm. Violent children work themselves up until there is no turning back. It is a sure formula for disaster.

Neurological Impairment and Psychiatric Disorders. Many violent offenders examined by Dr. Lewis have frontal lobe damage and a history of seizures. The areas damaged in violent children are those that modulate aggressive behavior. She found children incarcerated for murder who had severe brain damage as a result of accidents and deliberate abuse. However, she points out, while this damage is a factor, it is not sufficient to explain extreme violence and murder. Usually there are other contributing or correlating factors.

Lack of Empathy. Caregivers can facilitate the learning of empathy and interpersonal skills by explaining divergent points of view to children and providing a safe environment to explore. Additionally, the caregiver must have provided initial bonding by understanding the child's point of view. Violent children have not bonded, nor have they learned the necessary social skills to cope with a society that fosters widely varying opinions and levels of safety (Levy, 1998). Children who use violence as a coping mechanism lack empathy for others, and they do not expect others to cooperate with them.

Negative Self-image. The self-image of the violent child is overwhelmingly negative, and he or she does not expect to succeed in society by prosocial means. Children of violence are not successful in school, but they think they can become successful through anti-social means, exacerbated by the fact that the only reinforcement they get is usually from anti-social peers.

Substance Abuse. Violent children are often substance abusers, many times coming from substance-abusing families.

Chronic Behavior Problems. Violent youths often have exhibited early and persistent antisocial behavior beginning with minor behavior problems around age seven. This aberrant behavior progresses to moderate problems at about age nine, turning to serious behavior problems around age 11 to 12 if the pattern is allowed to continue. These youths are often alienated, impulsive and rebellious. However, many people are surprised to learn that aggressive behavior can sometimes be seen as early as three or four years of age.

Not Learning From Their Mistakes. Troubled children such as these do not learn from their mistakes. Furthermore, they have lower social anxiety than what is considered normal for

... by the time most children are grown, they have seen 100,000 acts of violence on TV, video games and in the movies. Many experts agree that the present level of media violence negatively affects children.

Continued on page 8

The Violent Child

Continued from page 5

children. For most people, social anxiety keeps their behavior within social norms, but chronically aggressive and conduct-disordered children do not respond to punishment as predictably as ordinary people.

Deficits in Information Processing. By age 11, children are learning to process abstract material and use logic to solve problems. If their environment has not included adults who answer "why" questions and explain the world to them, children make mistakes in interpretation, creating youths who are less efficient in the problem-solving process. In many children who perform violent acts, logic is not fully developed.

Moral Development. Just as there are stages of physical and emotional development, there is a progression of moral development throughout one's lifetime. Kohlberg, in 1969 studied the moral development of boys while Carol Gilligan has studied the moral development of girls. Aggressive and violent children are often in the early stages of moral development at the same time that others may have progressed beyond beginning levels.

Comorbidity of Psychiatric Disorders. Children with behavioral disorders, including those with aggressive and violent acting out often have a variety of other psychiatric disorders, including mood disorders, obsessive-compulsive disorder, anxiety disorders and attention-deficit/hyperactivity disorder (ADHD).

Success and positive self-worth is a universal need. When children fail to find affirmation, they look for other youths with similar problems and views.

Attachment Disorders. "Attachment is the deep and enduring connection established between a child and caregiver in the first several years of life. It profoundly influences every component of the human condition" (Levy & Orlans, 1998). Severe abuse and neglect at critical stages in development can result in lack of strong attachment. Problems in the development of primary attachment bonds can produce children who are violent, lack empathy and are out of control. Statistics indicate that 800,000 children with severe attachment disorders are coming to the attention of the child welfare system every year. Boys who experience attachment problems early in life are three times more likely than others to be violent (Levy & Orlans, 1998).

School Problems

Violent teens often experience academic failure as early as the elementary grades; consequently, they lack a commitment to school. In their eyes, the system of education holds neither success nor positive reward for them. Many of these children are either learning-disabled or have low IQ.

Peers

Success and positive self-worth is a universal need. When children fail to find affirmation, they look for other youths with similar problems and views. In this deviant culture, they can become successful in the eyes of their peers. The counter culture becomes self-perpetuating because the children who have identified with this group find it increasingly difficult to relate to "straight" kids. As they become more entrenched in their own subculture, these outcasts progressively think, feel and act differently from the peers that previously rejected them. Bridging the expanding gap becomes a considerable task that becomes more daunting as time passes.

Protective Factors & Resiliency

Looking at the reverse of the above risk factors shows the conditions having the potential to protect youths from a violent lifestyle. It gives us hints as to where to proceed with prevention and treatment. Each child needs constant, positive and nurturing caregivers that set rules, respect the child's individuality and provide secure attachment to ensure the emotional health of the child. School success and having prosocial peers can be a protective factor. Having a positive social orientation is also helpful. Higher IQ and resilient temperament can help a child heal from environmental insults and learn to cope more effectively. When there are bonds to supportive, prosocial family, teachers, counselors or other adults, kids have a chance to make choices other than violence. Clearly stated family and community rules, expectations and monitoring of child behavior can be effective in helping children learn to follow social norms. A child who has good social and problem-solving skills, moral maturity and an ability to manage emotions, particularly anger effectively will have fewer problems with violence. Children who are curious, enthusiastic and alert, setting goals for themselves, have high self-esteem, causing internal locus of control to be more resilient (Levy & Orlans, 1998).

Treatment of High-Risk Youths: What Works

For many years the common wisdom was that "nothing works" in treating violent and chronically delinquent youths. However, although there are now effective methods for helping troubled youth, recent research indicates that not everything works for every child. Treatment is not "one size fits all." Goldstein and Glick (1987) discuss the concept of prescriptive programming that takes into account child versus provider temperament along with type of program.

The importance of reserving the full range of intensive services for the highest risk youths is well established (Seifert, 1992). Low risk kids do not need the same intensity of services, and there are many risk assessment tools available (OJJDP) for this.

Multimodal treatment which meets the community, family, social, cognitive, emotional, personal and educational needs of the child is essential for high risk youths (Seifert, 1992). The various risk factors need to be assessed and addressed. Behavioral treatments show larger effect sizes than humanistic treatments, which have better results than individual psychodynamic interventions (1996, Roth & Fonagy). It is also important to target criminogenic factors such as deviant peers and lack of empathy in addition to the importance of rules and the social order.

Parent Management Training (PMT) is a program in which the therapist works with the parents to develop effective interventions. This training has been found effective during and after treatment for as much as 14 years following mediation to reduce delinquent and disruptive behaviors. Additionally, Problem Solving Skills Training (PSST) has been found to be effective, especially when in combination with PMT.

Cloe Madanes at the Family Therapy Institute of Washington, DC has developed a successful program for sex offenders. Moral Reconation Therapy (MRT) from CBTR in Memphis, Tenessee deals with moral development issues and has had good outcomes. There are many anger-management, problem-solving and social-skill programs on the market, as well.

Good prevention programs are Head Start with family involvement and programs that prevent addicted mothers from using drugs and alcohol while pregnant and help them bond with their children post-delivery. Home visiting nurses that help at-risk mothers care for and bond with their infants appear to be effective as well.

Necessary Program Components

Several important components of effective treatment include continuous case management and emphasis on re-integration into the community. There must be clear and consistent consequences for misbehavior, but reinforcers should outnumber punishers by a ratio of four to one. By combining a variety of individual, group and family therapies matched to the youth's needs, professionals can target maladaptive behaviors. Opportunities for success and the development of a positive self-image and youth bonding to prosocial adults can increase the chances for success. However, treatment needs to be started early, and it must be long term.

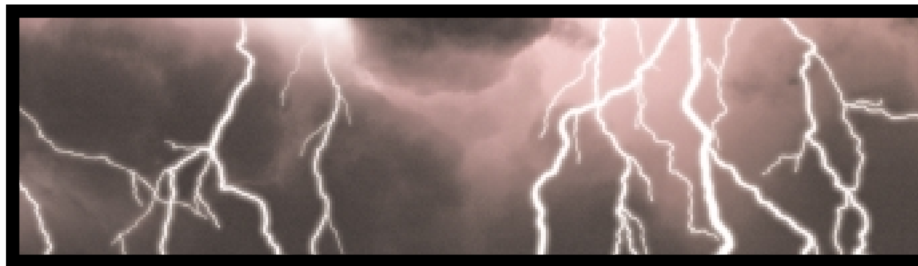
Promising Therapy

The Holding-Nurturing Therapy for Reactive Attachment Disorder developed by Dr. Terry Levy and Michael Orlans at Evergreen Consultants in Evergreen, Colorado has had very good success for aggressive, out of control children. It is an intervention that needs further research.

Barriers to Treatment

Children and adolescents are very under-served populations in terms of mental health care. In fact, there are estimates that approximately 22 percent of children and adolescents have emotional or behavioral problems. Three to five percent have serious emotional problems, yet only two percent receive treatment through the present mental health system (Briscoe, October 1996). So, we must increase the number of quality treatment programs in the schools, communities and juvenile institutions (Bilchik, OJJDP Fact Sheet, July, 1998).

An unfortunate trend is the idea that family violence is a social rather than mental health or public health issue. If mental health treatment is scarce, treatment for violent families is even scarcer. When the legal, mental health and social service communities combine to solve this problem collaboratively, we will make more progress in eliminating family violence, including child abuse and



neglect. Effectively dealing with the problem will prevent future violent acting out by the children living in these aggressive families.

Typically, children who have the potential to become violent are not identified by the juvenile justice system until they are 12 or 13 years of age. Yet, research indicates that their problems begin around six or before. Intervention is needed between infancy to age six when maternal attachment and brain growth is critical. Elimination of family violence must become a national priority.▼

Kathryn Seifert *received her Ph.D. from the University of Maryland, Baltimore Campus in 1995. She is a Diplomate in forensic psychology and a Fellow in the American College of Advanced Practice Psychologists. Dr. Seifert has worked for 30 years in the areas of mental health, addictions and corrections. In addition to authoring a book chapter to be released this fall, she is writing and editing a book on juvenile violence. Dr. Seifert has also written CARV, a screening and referral tool to identify youth at risk for violence. CARV is presently being standardized in 18 sites around the world. She founded Violence Intervention and Prevention, Eastern Shore Psychological Services and Forensic Solutions. These organizations provide services for youths and their families as well as training for other treatment providers. Dr. Seifert lectures nationally on the topic of childhood violence. She may be contacted by e-mail at Kseifert@compuserve.com or call 410/546-8111.*

Multimodal treatment which meets the community, family, social, cognitive, emotional, personal and educational needs of the child is essential for high risk youths.

References

Abidin, R.R., "Parenting Stress Index, Professional Manual." *Psychological Assessment Resources,* Odessa, FL, (1995).

Bilchik, S., "Mental Health disorders and substance abuse problems among juveniles." *OJJDP Fact Sheet,* #82, (July, 1998).

Briscoe, J., "A collaborative effort: Examining juvenile offenders with mental impairments." *Corrections Today,* pgs. 106-109 & 136, (October 1996).

Crespi, T.D. and Rigazio-DiGilio, S.A., "Adolescent homicide and family pathology: Implication for research and treatment with adolescents." *Adolescence,* vol. 31, 122, pg. 353(15), (Summer,1996).

Goldstein, A.P. and Glick, B., *Aggression Replacement Training: A Comprehensive Intervention for Aggressive Youth.* Research Press: Champaign, IL, (1987).

Hare, R. D., "Psychopaths: New trends in Research." *The Harvard Mental Health Letter,* Harvard University: Boston, MA, (1995).

Lewis, Dorothy Otnow, *Guilty by Reason of Insanity: A Psychiatrist Explores the Minds of Killers.* Fawcett Columbine: New York, (1998).

Levy, T.M. and Orlans, M., *Attachment, Trauma, and Healing.* Child Welfare League of America Press: Washington, DC, (1998).

Madanes, C., *The Violence of Men.* Jossey-Bass: San Francisco, (1995).

National Institute of Justice. "The cycle of violence revisited." *Research Preview,* U.S. Department of Justice: Washington, DC, (Feb., 1996).

Perry, B.D. and Pollard, R., " Altered brain development following global neglect in early childhood." *Society for Neuroscience: Proceedings from Annual Meeting: New Orleans,* (1997).

Pollack, S., "Differences in brain electrical activity among maltreated children." Society for Psychophysiological Research Conference. Paper Presentation (Fall, 1998).

Prothrow-Stith, D., "Deadly Consequences." *Harper Perennial.* New York, (1993).

Roth, A. and Fonagy, P., *What Works for Whom.* Guilford Press: New York, (1996).

Seifert, M.K., "An Ecological Approach to Delinquency Intervention: Evaluation of CHOICE." Unpublished Research Competency Paper. UMBC: Baltimore, MD, (1992).