

Juvenile Justice Fact Sheet

Effects of Adolescent Psychopathology on Juvenile Competence to Make Medical and Legal Decisions

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The uncertainty regarding the ability of adolescents and young adults to make adequate decisions has generated accommodations to the "bright line" distinction of 18 years as the age of majority. Two areas affected by adolescent psychopathology are adjudicative competence, where capacities required by various legal proceedings are relevant, and medical competence, where competence to consent to treatment for mental illness may be in question.

There is a dearth of empirical studies on the direct effects of adolescent psychopathology on competence. One study by Mulvey and Peeples (1996) suggested that the teenagers most likely to come in contact with mental health professionals, social services or the juvenile justice system are least likely to be able to make competent decisions for themselves. In a study of 30 psychiatric adolescent inpatients, Casimir and Billick (1994) found competence to understand general clinical and legal issues of hospitalization was comparable to that of voluntary and involuntary psychiatric adult inpatients; however, adolescents scored more poorly on appreciation of their psychiatric disorders and need for hospitalization. Finally, a longitudinal study conducted at a general medical care clinic found that 54% of girls diagnosed a priori with conduct disorder later became pregnant, compared to 12% of girls without any type of psychopathology (Kovacs, Krol, & Voti, 1993), suggesting poor judgment with regard to medical decision-making.

Depending on the context, competence may require a variety of capabilities: understanding, rational thinking, appreciation, and communication. In considering adolescent competence, there are two important comparison groups: adults with similar psychopathology and adolescents without psychopathology. In adults with psychopathology, delusional disorders and irrational thought processes pose a significant

threat to abilities that comprise competence. Although there is a small body of research comparing symptom presentation of adults and adolescents with similar disorders, results are mixed. In some disorders, symptoms are similar, regardless of developmental age; in some, symptom presentation is less obvious in adolescents, resulting in misdiagnosis (e.g., bipolar disorder being misdiagnosed as ADHD). For one diagnosis, ADHD, symptoms appear to persist into adulthood, but have only recently been identified beyond the early years of childhood, resulting in a lack of evidence about the later effects of this disorder on competence.

The following is a brief summary of the disorders with symptoms known to potentially compromise competence, and related research on these disorders in adolescents.

- Schizophrenia. Adolescents with schizophrenia are similar to adults with schizophrenia, but different from adolescents with psychotic depression and adolescents with medical conditions only. Schizophrenic adolescents and adults exhibit fallacious reasoning, loosely related conceptual formulations, and confusion about what is being perceived. First episode patients were found to perform as poorly as older, chronic patients on neuropsychological functioning. There is increasing biological evidence that schizophrenia as a disease process is consistent in presentation when compared across age of onset groups from children to adults. Furthermore, brain imaging studies offer evidence that, in the rare cases of childhood onset, deviations of brain development occur early in the disease process and accelerate during adolescence.
- Bipolar Disorder. Bipolar disorder is difficult to assess in childhood and adolescence, and, at present, is the focus of research into the similar presentation of manic symptoms and attention deficit hyperactivity disorder (ADHD). Symptoms of early onset bipolar disorder can vary significantly from adult onset symptoms, and are easily confused with early onset schizophrenia. Early onset of bipolar symptoms often precedes dramatic and abrupt academic decline, and is associated with later occupational dysfunction. Symptom phenomenology in adolescents can be complicated, including psychotic symptoms, which can increase the likelihood of impaired insight and limited appreciation of one's circumstances. Additional symptoms of mood lability and abrupt and severe deterioration present the possibility of impaired communications between patients and health care or legal professionals. Youths with bipolar disorder are faced with several treatment dilemmas, but current treatments for adolescent- or childhood-onset symptoms are based on outcome studies conducted with adult subjects. An adolescent with a diagnosis of bipolar disorder faces a less favorable prognosis than an adult with a similar diagnosis, and accepted treatments pose even greater risks because of the unknown effects of medications on developmental course.
- Depression. Compared to adults with depression, adolescents present with

similar negative cognitive distortions, neurovegetative decline, and mood disorder. In rare cases of unipolar depression in adolescence, psychotic symptoms also occur. Compared to children with a similar diagnosis, depressed adolescents endorse more symptoms of anhedonia, hopelessness, hypersomnia, weight change, and substance abuse, and report greater lethality in their suicide attempts. The cumulative effect of any combination of these symptoms may lead to impaired problem-solving abilities and a lack of motivation to self-preservation. Treatments for depression in adolescents have been based on models developed for adult patients, but adolescent response to medication has been less consistent than adult outcomes. Medications are not as likely to be effective with adolescents, and the validation of cognitive-behavioral interventions for adolescent depression is still in the early stages of research.

- Attention Deficit Hyperactivity Disorder (ADHD or ADD). Longitudinal studies of ADHD have shown that symptoms observed in children continue in adolescence and adulthood. Studies of older children and young adults up to 22 years with ADHD show that subjects perform significantly worse than controls on tests of problem-solving abilities and attentional capacities, even when controlling for the effects of co-morbid (i.e., co-occurring) diagnoses.
- Conduct Disorder. Conduct disorder is characterized by age inappropriate aggressive behavior and disregard for the rights of others, often resulting in delinquent behavior. Frontal lobe dysfunction and neuropsychological deficits associated with frontal cortex impairment, and inability to shift set as a problem-solving strategy, are hallmarks of conduct disorder. Mulvey and Peebles (1996) found that adolescents with behavior problems understand factual content and make inferences similarly, compared to control subjects, but were less successful at logical manipulation of information.
- Substance Abuse. Substance abuse in adolescents is often co-morbid with several other diagnoses. There is a group of adolescents characterized by behavioral difficulties beginning as early as pre-school years that is especially vulnerable to substance abuse, often diagnosed with oppositional defiant disorder, conduct disorder, or ADHD. Although adolescents usually do not exhibit the cognitive deterioration seen in long-term adult substance abusers, perhaps because of the time-limited duration of their abuse, they may exhibit academic delay, aggressive behavior, impulsivity, verbal or auditory processing disabilities, or an inability to learn complex social behavior. Many of the symptoms of substance abuse or dependence can also masquerade as other disorders, including major affective disorders. Accurate diagnosis may require detoxification and a period of abstinence in order to assess which symptoms persist beyond intoxication. These associated, persisting syndromes may pose sustained threats to decision-making capacities.

SUGGESTED READING

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