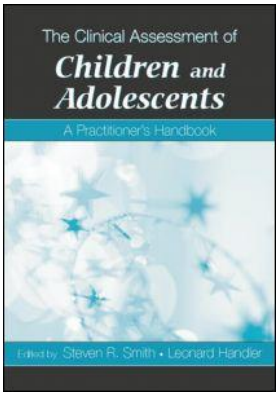

The Clinical Assessment of Children and Adolescents: A Practitioner's Handbook

Steven R. Smith, Leonard Handler

Delinquet and Antisocial Behavior

Publication details
https://www.routledgehandbooks.com/doi/10.4324/9781315827308.ch22
James L. Loving
Published online on: 11 Aug 2006

CHAPTER

22

DELINQUENT AND ANTISOCIAL BEHAVIOR

James L. Loving
Private Practice, Philadelphia, Pennsylvania

All mental health professionals who work with children and adolescents encounter delinquency in one form or another. Even professionals who do not assess or treat acting-out youth often come into contact with the havoc they wreak on the lives of loved ones and other victims. In fact, acting-out behavior, broadly defined, is routinely cited as being among the most common reasons youths are referred to mental health professionals in any setting. In one recent sample of 1.3 million children participating in mental health services (Pottick et al., 2002), the disruptive behavior disorders collectively represented the most frequent category of diagnoses (30.8% of the overall sample). Aggression was among the most common presenting problems overall and, not surprisingly, was the single most prevalent presenting problem in both inpatient and residential settings (accounting for 48.7% and 66.2% of referrals, respectively).

Conversely, delinquent youth as a group are rife with diagnosable behavioral and emotional problems. Although precise data are difficult to collect, it has been estimated that youths in the juvenile justice system are at least twice as likely to qualify for a psychiatric diagnosis as are their counterparts within the general population (Otto, Greenstein, Johnson, & Friedman, 1992). This is especially true in detention settings, where the presence of one or more psychiatric disorders is the rule rather than the exception. In one of the largest and most systematic studies available (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002), nearly three quarters of detained juveniles met criteria for at least one disorder, and comorbidity was commonplace. Even after eliminating Conduct Disorder from consideration, roughly 60% of males and roughly 70% of females met criteria for other mental health disorders.

Unfortunately, these youths are often misunderstood and consequently mismanaged. This is not only due to the complexity of some cases, but also to the emotional reactions that many of them can stir in us as clinicians. At one extreme, there is a risk of prematurely dismissing patients as untreatable, especially when certain reprehensible actions impede our capacity to remain objective. At the other extreme, there is a risk of naively underestimating risk while overinferring traits and experiences that certain patients do not possess. We may misunderstand the patient's underlying personality structure and then presume or project our own empathy, capacity for guilt, need to attach, and other qualities, when in reality

these features are absent or impaired. For all of these reasons, working with delinquent youth requires the most comprehensive and systematic assessment that circumstances will permit.

This chapter presents overarching concepts and specific methods for conducting psychological assessment in cases of delinquent or antisocial behavior. First, I present a conceptual overview of Conduct Disorder and related conditions that are most relevant to youthful antisociality. Next I discuss general assessment guidelines intended to help overcome obstacles typically encountered with this population. The primary focus of the chapter then consists of an outline of traditional assessment methods as they relate to these cases, as well as an introduction to several specialized instruments that have been developed for specific use with delinquent populations. I conclude with an illustrative case example, before touching on some areas in need of further research.

CONDUCT DISORDER AND RELATED CONDITIONS

Before delving into a discussion of assessment strategies, it is necessary to narrow and define our terms. The focus of this chapter is on delinquent and antisocial conduct. Here these terms are used in an essentially interchangeable fashion, as both are associated with behavior that disregards societal norms and/or the rights of other people. However, it might be more precise to restrict the term "delinquency" to arrestable behavior, or actions that directly violate existing laws. In slight contrast, antisociality refers to behavior that is fueled by a lack of consideration of, or indifference to, the rights and needs of others. Antisocial behavior may or may not be delinquent, depending on whether it violates the local laws that apply to the juvenile in question. This broad collection of behaviors may or may not include violence, which could be simply defined as physical aggression carried out against other people. What follows is not a specific discussion of juvenile violence, although many of the concepts included here obviously apply to and overlap greatly with that specific form of behavior.

Delinquency is a multidetermined behavior carried out by a tremendously diverse array of individuals. The professional literature contains many efforts to disentangle this population into meaningful subgroups, for the sake of understanding, predicting, and managing behavior. A lengthy discussion is not necessary for the purposes of this chapter. However, it would be helpful to discuss the most relevant categories that are outlined in the latest *Diagnostic and Statistical Manual* (*DSM-IV-TR*; American Psychiatric Association, 2000), given its pervasive use and its centrality to our practice.

Conduct Disorder (CD) is defined by a repetitive, persistent pattern of behavior that violates the rights of others or major age-appropriate societal norms. The *DSM-IV-TR* offers 15 wide-ranging behavioral criteria that are divided into four categories: aggression toward people and animals, destruction or property, deceitfulness or theft, and serious violation of rules. The conceptual essence of CD is budding psychopathic personality, whose phenomenology has been described extensively in the literature (e.g., Cleckley, 1976; Hare, 1993; Meloy, 1988). For the prototypical psychopath, interpersonal relations are superficial and dismissive, usually characterized by parasitic and/or blatantly aggressive interactions. Affect is shallow and primitive. Behavior tends to be erratic, short-sighted, and independent of societally defined rules. Conceptually, the antisocial behavior of psychopaths is perpetuated by the interpersonal and affective traits that underlie the disorder, although these are more difficult to assess directly and sometimes must be inferred to some degree from the behavior itself. In criminal adult populations, psychopathy (as measured with the Revised Psychopathy Checklist or PCL-R; Hare, 1991, 2003) has been identified as one of the most robust pre-

dictors of both general and violent re-offending, and its presence is strongly correlated with many other negative outcomes (see, e.g., Hart & Hare, 1997, for a review). As discussed extensively elsewhere (e.g., Hare, 1996), psychopathy is closely related to, but importantly distinct from, adult Antisocial Personality Disorder (APD; American Psychiatric Association, 2000). Psychopathy is a more homogenous and higher-risk construct, which is present in perhaps only one third of APD individuals. This is critically important, because although many professionals use the terms *antisocial* and *psychopathic* interchangeably, many APD patients are not truly psychopathic; they carry out persistent antisocial behavior because of factors that are minimally related to underlying personality (e.g., substance dependence; subcultural pressures).

CD is a necessary childhood precursor to APD and adult psychopathy. Both of these adult conditions are conceptualized as having early developmental origins, and both require retrospective evidence of CD as a defining criterion. In fact, many features inherent in APD and psychopathy are listed in the *DSM-IV-TR* as associated features of CD, such as lack of empathy, lack of guilt, callousness, and overly inflated self-image (American Psychiatric Association, 2000). However, these are not required diagnostic criteria for CD, and CD is not synonymous with juvenile psychopathy. Because of the tremendously wide range of diagnostic criteria, most of which are exclusively behavioral in nature, it is common for a juvenile to qualify for the CD diagnosis in cases where the characterological features of psychopathy are only partially formed or even essentially absent. Some distinctions between psychopathy and CD and limitations of the latter have been discussed elsewhere (e.g., Loving & Gacono, 2002). There is an asymmetrical relationship between CD and psychopathy, in that most psychopathic youth meet the criteria for CD, whereas only a subset of conduct-disordered individuals are truly psychopathic. In many cases, the psychopathic personality is still crystallizing, and numerous individual and environmental factors may still prevent the further development of the condition before adulthood. This view is supported by the fact that CD has high rates of comorbidity not only with other externalizing disorders but also with various internalizing disorders (Zoccolillo, 1992). In cases where conduct disorder is accompanied by symptoms of depression and anxiety, for example, the antisocial personality structure is very likely in a nascent stage, with at least vestiges of emotional vulnerability and attachment capacity still present.

In community samples, prevalence estimates for CD cover a fairly wide range, from less than 1% to more than 10% (American Psychiatric Association, 2000). In these general populations, CD implies a relatively severe and high-risk condition. However, in any setting where base rates for delinquency and violence are higher, the prevalence of CD reaches such high levels (upwards of 95% or higher in some samples; e.g., Forth, 1995; Loving & Russell, 2000) that the presence of the condition is arguably rendered useless for differentiating subtypes of offenders. Especially within these extreme populations, despite the tendency of many clinicians to view this diagnosis as an end-point to assessment, the CD diagnosis should be viewed as a starting point for understanding a youth's personality and behavior (Grisso, 1998).

CD has at least short-term implications for risk of re-offending, risk for violence, and other negative outcomes. However, clinicians often mistakenly inflate the disorder's associations with adult criminality, APD, and psychopathy. It has been estimated that only 40% of CD youth progress to diagnosable adult APD (Zoccolillo, Pickles, Quinton, & Rutter, 1992), and that proportion is almost certainly even lower when adult psychopathy is predicted from CD. This is in line with the often-cited literature on adolescence-limited versus life-course-persistent delinquency (Moffitt, 1993), which points out that most delinquent youths can be

expected to desist once they pass through early adulthood. Some of the most effective predictors can be obtained simply through a thorough behavioral history, as outlined later in this chapter.

Closely related to, but importantly distinct from, CD is Oppositional Defiant Disorder (ODD; American Psychiatric Association, 2000). ODD is defined by a lasting pattern of negativistic, hostile, and defiant behaviors, meeting at least four of eight criteria (e.g., active defiance of rules; frequent loss of temper; deliberate annoyance of others). The features of ODD are typically noticeable in cases where CD is present, so when both are diagnosable, only CD is assigned.

At the most simplistic level, ODD might be seen as a nonaggressive or less severe variant of CD. However, these two conditions could arguably be viewed as qualitatively distinct constructs that are strikingly different in terms of interpersonal relatedness. That is, the truly conduct-disordered, or psychopathic, individual is interpersonally indifferent and dismissive, unable to attach in any deep or meaningful manner. In contrast, the ODD child often acts out in ways that actually initiate and perpetuate human contact, albeit in dysfunctional and conflict-ridden ways. When the ODD child defies rules, he is typically acting out *against* or *in spite of* some personally meaningful authority (especially a caregiver), whereas the CD child acts out because of a blatant *disregard for* the people who surround him. When aggression is present with ODD, it is often seen as provocation toward, or a reaction to, significant others, whereas aggression in true CD is more often indiscriminant, including opportunistic violence against unknown victims. Although both groups are heterogeneous, this conceptual distinction may be helpful in differentiating between ODD and CD and would have meaningful implications for managing behavior in specific cases.

Developmentally, onset of ODD is typically earlier than that of CD, and although nearly all youth diagnosed with CD (at least those in the early-onset subtype) have behavioral histories consistent with ODD, most ODD children "outgrow" these behaviors, rather than progressing toward eventual CD (Lahey, Loeber, Quay, Frick, & Grimm, 1992; Loeber, Keenan, Lahey, Green, & Thomas, 1993). There appears to be a great deal of variability in the long-term course of ODD, with numerous factors, such as certain parenting styles and peer alienation, influencing the ultimate outcome. Although ODD could be distinguished from CD as an inherently relational disorder, one can understand how a prolonged period of social conflict and repeated rejection could lay the groundwork for interpersonal disconnection that allows CD to evolve.

Other conditions that can play a role in establishing and perpetuating delinquent behavior include Attention-Deficit/Hyperactivity Disorder (ADHD; American Psychiatric Association, 2000). Strong evidence shows that children with comorbid CD and ADHD are at substantially higher risk for violence, delinquency, and general long-term maladjustment than are children with either condition alone (Lynam, 1996). This mix of conduct-disordered features, coupled with the impulse control deficits and/or hyperactivity of ADHD, is a particularly volatile recipe for long-term antisociality. Even in the absence of a specific ADHD diagnosis, youth who display problems with impulsivity are at heightened risk for delinquency and other long-term negative outcomes.

Although not a focus of this chapter, numerous other conditions must be considered as part of an assessment of delinquent behavior. These include the presence of underlying (and possibly undiagnosed) mood disorders or other internalizing disorders, which are being expressed behaviorally in the form of irritable, reactive, or disorganized conduct. As already noted, internalizing disorders are comorbid in a substantial proportion of CD and ODD cases;

however, conceptually, one would not expect to find substantial depression or anxiety in cases where a psychopathic personality is already fairly well crystallized.

Also worth considering are patterns of conduct that are primarily fueled by social or subcultural influences. Especially in cases where antisocial behavior has an adolescent-onset or is fairly circumscribed in nature, even a cursory social history may reveal obvious social factors (e.g., poverty, substance use, pervasive peer influences). In these cases, a thorough assessment will probably rule out the presence of psychiatric or characterological factors. These statements may seem obvious to the reader, but in actual practice, many clinicians are quick to overlook contextual factors while quickly turning attention to presumed pathology inherent in the child. Testing can provide idiographic findings with respect to personality structure, interpersonal dynamics, and emotional functioning, but traditional models of assessment run the risk of overfocusing on individual factors, while underappreciating the significance of environmental variables that play a tremendous role in the understanding and prediction of antisocial behavior.

GUIDEPOSTS FOR ASSESSMENT IN DELINQUENCY CASES

Many of the core features that characterize antisocial youth directly interfere with information-gathering, thus undermining effective evaluation. As examples, delinquent youth commonly approach the assessment process with a posture that is at best defensive and at worst overtly hostile and aggressive. Adversarial dynamics are magnified by the court-involved contexts where many of these youth are encountered. Furthermore, information-gathering can be sabotaged by overt deception and more subtle distortion of information, not to mention pervasive defensive maneuvers (e.g., externalization, rationalization) that function to ward off self-blaming experiences that would otherwise threaten the youth's sense of comfort with the self.

In court-involved settings, clinicians adopt a forensic assessment framework to guide method selection and case conceptualization. Even outside of court contexts, professionals would benefit from adopting such a framework to help combat the obstacles that many delinquent youth pose. Evaluators who adhere to a traditional clinical model are at risk of gathering incomplete and unreliable findings, because some fundamental clinical assumptions and practices do not translate effectively to our work with antisocial populations. As one example, the clinician may intellectually understand the need to be on the alert for deception and noncooperation, but because of deeply engrained expectations about an inherent, mutually felt assessment alliance, he may naively overlook evidence of distortion or manipulation.

One guideline that is inherent in forensic assessment and applicable to working with delinquent populations is to view multimethod assessment as critically important (American Academy of Child and Adolescent Psychiatry, 1997, 2005; Heilbrun, 2001). Of course, a battery approach is typically desirable in any clinical context, but within a forensic model, reliance on multiple relevant tests, as well as background-gathering from multiple parties, is absolutely essential. Ideally, background and impressions are collected not only from the youth and his caregiver(s), but also from involved professionals. Advance review of records is critical, so that the evaluator can be as informed as possible before facing a potentially vague, inarticulate, or obfuscating interviewee. The testing battery ideally includes multiple routes for data-gathering, including self-report measures, parent/caregiver rating scales, and

performance-based instruments. At the same time, tests must be limited to those that are both relevant to the referral question and empirically supported for the application at hand (Heilbrun, 1992).

A second suggested guideline is to anticipate and assess unusual response styles. In voluntary clinical settings, self-descriptions are colored by various motives, but in the broadest sense, the clinician presumes that the patient's self-descriptions are reasonably balanced and accurate. In forensic situations, and in delinquent evaluations, the presumption is quite different. Because of engrained interpersonal tendencies and obvious secondary gains, a distorted response set can drastically affect data that are collected throughout interviews and testing. This presumption has two specific corollaries. First, interview data should be corroborated by outside accounts, behavioral observations, and testing results. Second, whenever possible, the test battery should be composed of instruments that include validity scales to help objectively assess the patient's degree of dissimulation. In the absence of validity scales, tests must be interpreted conservatively, especially when there is behavioral evidence of response distortion or when test results appear highly implausible in relation to outside data.

For adults, several instruments have been developed for the specific purpose of assessing forms of deception, particularly malingering. Unfortunately, no such instruments have yet been developed specifically for younger populations, and little validation research has been conducted to show that adult instruments can be applied to adolescent populations. Some authors (e.g., McCann, 1998b) suggest that well-validated adult malingering tools (e.g., the Structured Interview of Reported Symptoms; Rogers, Bagby, & Dickens, 1992) can be cautiously applied to adolescents. In reality, clinicians more often rely on traditional instruments that have been validated with younger populations, using those tests' validity scales to assess response styles.

A third guideline for these cases is to employ rigorous empirical standards for method selection. Although true for all clinical settings, this concern is magnified in forensic cases and in work with delinquent youth. Among other reasons, evaluations in these cases are likely to have greater ramifications than in other settings. Also, evaluators are more likely to face close scrutiny in the courtroom. As discussed elsewhere (see, e.g., Heilbrun, Marczyk, & DeMatteo, 2002, for an overview of key issues), clinicians must select only those assessment methods that are empirically supported, both in general and for the specific application at hand. In court-involved cases, the assessor must possess an updated working knowledge of her tests' psychometric properties and important current literature. She must also be aware of applicable legal standards for admissibility, in order to help ensure that she is not using tests or other methods that could be excluded from the court's consideration.

In this regard, the test that has by far been subjected to the most detailed and heated debate has been the Rorschach (Rorschach, 1921; Exner, 2002), so a few brief points about this instrument deserve mention here. First, several separate authors have offered cogent arguments to show that the Rorschach should be deemed admissible, using the *Daubert* standard and other tests of admissibility (Gacono, Evans, & Viglione, 2002; Hilsenroth & Stricker, 2004; McCann, 1998a; Ritzler, Erard, & Pettigrew, 2000a, 2000b), whereas others have reached the opposite conclusion (Grove & Barden, 1999; Grove, Barden, Garb, & Lilienfeld, 2002). Second, traditionally, Rorschach evidence has rarely been subject to serious legal challenges or excluded from testimony (Meloy, Hansen, & Weiner, 1997; Weiner, Exner, & Sciara, 1996). More recently, this finding has found at least preliminary post-*Daubert* replication (Owens, Patrick, Packman, & Greene, 2004). At present, professionals who use the Rorschach appropriately should be able to draw on its findings in court-involved cases, although they should also expect more frequent and sophisticated challenges than they faced a decade ago.

As one final guideline, when these cases are in fact court-involved, the reader should keep in mind the many practical considerations that impinge upon preferred practice. As one example, clinicians should be cognizant of the tremendous caseloads and burdens that weigh on juvenile courts. As a concrete illustration, to expedite huge numbers of cases, it is not unusual for juvenile court judges to demand that evaluation be completed and reports submitted within one week of referral (National Council of Juvenile & Family Court Judges, 2005). Anecdotally, it seems that one of the greatest adjustment difficulties experienced by many clinical psychologists who venture into court work is related to this demand for rapid turnaround time, after having grown accustomed to the more liberal time constraints that are afforded in most other settings.

Along the same lines, Grisso and Underwood (2004) offered several guidelines to help address the practical needs of delinquent populations. These include anticipating low reading levels for the typical examinee and selecting tests with appropriately low reading levels; choosing tests that are empirically supported for application to clients with diverse ethnic, cultural, or linguistic backgrounds; and, when possible, using tests that have been specifically validated within juvenile justice populations.

SPECIFIC ASSESSMENT METHODS

Collecting the Behavioral History: Interviews and Collateral Input

In delinquency cases, the cornerstone of assessment is the collection of a detailed, informative behavioral history. In cases where referral questions are elementary, this sort of data collection may be sufficient, without the addition of psychological testing. Even in cases where issues are more complex and numerous methods are employed, the behavioral history remains key. This is true for several reasons, including the fact that much of the available longitudinal research identifies certain behavioral variables as being most strongly predictive of negative short- and long-term outcomes. Specific historical data crucial in these cases include, to name a few:

- Early/preadolescent onset (of CD symptoms, of delinquent activity, of violence)
- Callous, malicious, or purposefully destructive behavior (e.g., cruelty to animals and/or people, intentionally destructive fire setting)
- Recurrent pattern of delinquency, which is especially telling if the youth has been subjected to serious deterrents but then has persisted in the same behaviors
- Wide variety or versatility of delinquent behavior (versus a more circumscribed behavior problem)
- Instances of instrumental delinquency or violence (e.g., assault in the context of armed robbery), versus only reactive incidents (e.g., provoked assault)
- Substance abuse and/or dependence

These data points are most relevant to risk assessment but also help more generally in the understanding of the nature and progression of the youth's conduct problems. Every effort must be made to collect behavioral data from multiple credible sources, including not only the examinee and caregivers, but also involved professionals or professional records.

Although not as numerous as in adult clinical work, structured and semistructured interviews are available for use with delinquent populations. One example is the semistructured interview guide that is available as an adjunct to the Psychopathy Checklist: Youth Version (PCL:YV; Forth, Kosson, & Hare, 2003; discussed later here). Despite the advantages of these systems of inquiry, most evaluators employ an individualized semistructured interview format that takes into account the wide-ranging needs of various evaluations with this population.

Traditional Personality Testing

Psychological testing data can play an important role in elucidating findings that are available through more direct means; corroborating or refuting statements made by the examinee or others; and generating important hypotheses that might otherwise be overlooked based on interviews alone. Already mentioned but worth reiterating, a comprehensive evaluation takes into consideration a wide variety of factors, including not only features of the individual but also aspects of his family, community, and broader environment. In some cases, the behavioral history and environmental factors are of critical importance, but testing can shed light on individual factors that speak to risk, guide case conceptualization, and inform treatment decisions. Testing in these cases involves a search for individual variables that bear on risk for delinquency, such as various traits associated with psychopathic personality, impulsivity, presence of comorbid internalizing symptoms and other psychiatric conditions, aspects of the self image and object relations that feed into confrontational interactions, and so on.

Self-report measures, especially the Minnesota Multiphasic Personality Inventory–Adolescent (MMPI–A; Butcher et al., 1992), are the most widely used to assess adolescents (Archer & Newsome, 2000). Broad-band instruments such as the MMPI–A and the Millon Adolescent Clinical Inventory (MACI; Millon, 1993) hold an important place in the delinquent test battery, for at least two reasons. First, they provide in-depth descriptions of personality and overall functioning that contribute to assessment of those features that are tied to risk and planning. Second, most of these multiscale instruments include validity scales that are invaluable for reasons already noted. Even in cases where clinical findings appear to be unremarkable, validity scale profiles can shed light on the examinee's test-taking approach, in turn supporting or refuting impressions of his overall veracity during the evaluation.

Of all broad-band self-report instruments, the MMPI–A has been subjected to the most empirical attention by far, followed by the MACI. Although neither test was originally normed on delinquent populations, both have garnered a large amount of research to identify common elevations and their correlates within this population. The descriptive findings yielded by these tests can aid diagnosis and can identify specific traits that are strengths or areas of concern.

Despite their strengths, these instruments also pose challenges for this population. Reading levels can be prohibitive, and even if options are available to bypass reading deficits (e.g., audiotaped administration), test length still taxes many delinquent youths' attentional capabilities. There are other problems—for example, the undesirably high rate of within-normal-limits MMPI–A profiles within delinquent and other clinical adolescent samples (Archer, Handel, & Lynch, 2001). Moreover, when elevations are present, descriptions may be unhelpfully overinclusive, unless other scales are available to help refine the findings, as in the case of Adam:

> When Adam, age 14, completed the MMPI–A, his most pronounced elevation was on Scale 4, or Pd. The most common basic scale elevation among delinquent samples (and most other adolescent

groups), high Scale 4 yields a wide variety of potential inferences. Some reflect observable behaviors (e.g., high probability of delinquent, externalizing, and/or aggressive behaviors), while some are tied to associated personality traits (e.g., relative absence of guilt and remorse). A cursory scanning of Scale 4 correlates does not help us to decide which of these features apply to Adam. In this case, inspection of the Harris-Lingoes subscales for Scale 4 revealed that much of the basic scale elevation was accounted for by two of its five subscales: Family Problems and Self-Alienation. Collectively, these elevations suggested a great deal of interpersonal conflict and dissatisfaction at home, as well as more generalized unhappiness and negatively-tinged affect. A potential error in this case would be to infer core antisocial attitudes and traits based on an elevated Scale 4, when in fact Adam's actual pattern of responses suggested acting-out primarily in the context of emotional distress and familial conflict.

Brief, symptom-focused self-report measures can play a complementary role in the delinquent battery, especially when specific problem areas are of interest. In the case of the adolescent who describes severe adjustment problems and apparent depressive symptoms in reaction to being arrested and held in detention, tools such as the Beck Depression Inventory (BDI–II; Beck, Steer, & Brown, 1996) can not only help pinpoint specific symptoms but also provide a nomothetic frame of reference for assessing the overall level of symptom severity. Unfortunately, because of most of these measures' transparency and lack of validity scales, they must be interpreted conservatively. These results must be viewed as reflecting the examinee's *self-reported* experiences, which may be distorted by secondary gains. Even when we appreciate this point and interpret cautiously, there is the risk of failing to convey the same cautions to nonpsychologists who receive our results. Counselors, judges, and others run the risk of inferring that these test scores are direct reflections of psychological functioning, so the evaluator must be explicit in describing findings as being reflections of the examinee's self-presentation.

A second broad category of applicable tests is caregiver rating scales. Varying in length and specificity, these instruments are typically multiscale, broad-band tools but may be focused on one or more specific domains of functioning. These instruments allow many of the benefits of self-report measures, but also allow for much-needed input from outside sources. Arguably the most useful feature of these instruments, when available, is the opportunity for cross-informant comparisons. Administering the same instrument to both parents and discovering striking discrepancies can be informative as to the parents' differing perceptions of their child. In fact, in the context of feedback in these cases, comparing profiles can be a concrete, eye-opening experience for parents, who may not have realized how widely divergent their views are. In many cases, parallel forms are also available for the youth himself and for other involved parties (e.g., teachers). Again, cross-informant comparison is potentially useful in these cases, especially when the child's self-report can be compared directly with those of an outside party.

Probably the most widely recognized instrument in this category is the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001) and its parallel forms, the Youth Self-Report (YSR) and Teacher's Report Form (TRF). This family of instruments illustrates many of the key strengths and drawbacks that are seen with other caregiver rating systems. The CBCL is conceptually useful and immediately understandable, as it taps into general categories of internalizing and externalizing behavior problems, while also assessing numerous specific subcategories. CBCL items were selected with an effort to correspond closely to items on the YSR and TRF, which facilitates cross-informant comparisons. On the negative side, this instrument (and many others like it) lacks validity scales or any systemic means for detecting unusual response sets. Because these scales are typically fairly face valid, they

are susceptible to intentional distortion of results, similar to concerns noted above for brief self-report measures (see the chapter by Achenbach in this volume).

A third broad category of tests for consideration in delinquent cases is performance-based techniques, such as the Rorschach, storytelling tasks, and projective figure drawings. These tools provide for indirect means of data collection that can complement more direct measures described above. Because these methods do not rely on a pencil-and-paper format, reading delays and other deficits are not direct threats to validity. Moreover, given delinquent youths' proclivity for defensiveness and distortion, it is ideal to include varying testing formats. In cases where children are verbally limited or simply resistant to traditional methods, performance-based tasks sometimes afford freedoms that allow for more open expression of their internal experiences. Having said this, psychologists sometimes need to disabuse referral sources of the erroneous notion that these tests have unique powers to elicit "the truth" from otherwise reticent clients. Just as he is able to sabotage the interview and invalidate self-report measures, the resistant client is able to approach projective methods in such an underproductive manner that he essentially prevents detailed, accurate interpretation.

Of these instruments, the Rorschach stands out as the method with the most widely used systematic approach to administration, scoring, and interpretation (Exner, 2005). The Rorschach's nomothetic approach and its extensive research base make it a suitable option when test selection standards are rigorous, including in court-involved contexts (see above). The Rorschach has been applied extensively to various antisocial populations (see Gacono & Meloy, 1994, for the best source). However, efforts to identify variables associated with CD or juvenile psychopathy have been promising but not consistently replicated. Rorschach findings can potentially yield rich individualized descriptions of the youth's personality characteristics, but they must be interpreted conservatively and in conjunction with data from other sources.

> Ben, a 9-year-old with early-onset conduct problems, completed the Rorschach as part of an evaluation to guide treatment. The Rorschach provided detailed hypotheses about Ben's internal experiences, including his sense of self and his perception of social interactions. As an example, his Mediation cluster scores (e.g., very low X+ and Pop, high Xu and X−) suggested that he misperceives incoming information much of the time. Considered alongside Ben's pervasive aggressive imagery (elevated AG, plus striking aggressive content in several responses), his proneness to distorting input from the world around him could be understood in terms of a hostile attribution bias, where neutral actions are perceived as implying malicious intent. With this idea in mind, his therapist was able to help Ben's parents to build empathy for his perception that the world is filled with hostility and potential threats, making them better able to understand why he was so quick to respond to the slightest gestures with self-protective aggression. They were also helped to appreciate the need for concrete, unambiguous communication as one strategy for reducing Ben's aggression at home.

Along the same lines, traditional projective methods can offer supportable hypotheses with regard to self-perception, perception of social interactions, and other areas of functioning. Empirically driven scoring and interpretation systems are available for some of these instruments, and case examples are available to illustrate the effective blending of formalized scoring systems with rich, idiographic interpretation (see, e.g., Porcerelli, Abramsky, Hibbard, & Kamoo, 2001, for applications of the TAT). However, in routine practice, most evaluators find formalized scoring systems to be overly cumbersome and instead rely on less systematic procedures. Given their potential for misapplication, it has been argued convincingly that

projectives on the whole should not be deemed admissible under commonly used legal standards (e.g., Lally, 2001, in relation to the human figure drawings). It is reasonable to conclude that, with the exception of the Rorschach, projectives would be most useful in purely clinical contexts, where detailed descriptions can be offered to further the treatment and integrated with convergent sources of data without running the risk of misuse in high-stakes psycho-legal contexts. In the case of Ben, above, for instance, TAT stories included a jarring amount of extreme and arbitrary violence, which dovetailed with findings from the Rorschach to help understand his perceptions of the world as a hostile, unpredictably threatening place.

Specialized Test Instruments

Traditional assessment methods may be supplemented by more contemporary, specialized instruments that have been developed for specific application to delinquent populations. A handful of such tests are currently available, with varying degrees of empirical support to date. These tests could be broadly categorized into three types: Broad-band or multiscale inventories developed specifically for delinquent populations, risk assessment guides, and tests of psychopathy or antisocial personality. A selection of the most widely available and most promising instruments is outlined next.

The Massachusetts Youth Screening Instrument (MAYSI–2; Grisso & Barnum, 2001) is a 52-item self-report measure intended to screen for a variety of psychiatric difficulties commonly encountered in juvenile justice populations. Not surprising, given its brief format, is the fact that the MAYSI–2 does not include validity scales. It is not intended as a substitute for comprehensive assessment, but it is suitable for use by mental health professionals and allied staff, for example, to assist with screening youths at the time of intake to juvenile facilities. Seven scales tap into the following domains: alcohol/drug use, anger/irritability, depression/anxiety, somatic complaints, suicidal ideation, thought disturbance, and traumatic experiences. Despite being developed fairly recently, the MAYSI–2 has amassed empirical support for its factor structure, reliability, and validity (see, e.g., Archer, Stredny, Mason, & Arnau, 2004). It is currently available for use by mental health professionals and juvenile justice professionals.

Another multiscale test for use specifically with delinquent samples is the Jesness Inventory (JI–R; Jesness, 2003). Initially developed in 1965 but updated more recently, the JI–R is a 160-item self-report test intended to provide broad-band personality descriptions that can be applied to classifying and managing juvenile offenders. It has been normed on both the general adolescent population and delinquents (half male and half female). It includes rudimentary validity scales designed to detect underreporting and random responding. The JI–R is composed of numerous clinical scales, covering areas such as immaturity, social anxiety, manifest aggression, and several others. The instrument has been criticized on certain grounds, most notably some limitations of the standardization samples, which probably limit generalizability of findings (e.g., delinquent sample predominantly African American but nondelinquent sample overwhelmingly Caucasian; delinquent sample collected mostly from one site). On the other hand, strengths include the recent inclusion of scales designed to aid in the diagnosis of CD and ODD (Rhoades, 2005; Yetter, 2005).

Juvenile risk assessment is a topic that remains in its empirical infancy. To date, a small number of instruments have been developed for the purposes of drawing from that small but growing literature, in order to guide risk assessment in juvenile justice cases. One such instrument is the Youth Level of Service/Case Management Inventory (YLS/CMI; Hoge & Andrews,

1999). This is a guided risk assessment protocol that is clinician-rated, based on the juvenile's known history and characteristics. It consists of 42 items, falling into eight categories, such as offense characteristics, family circumstances, peer relations, and substance abuse. Drawing from the major risk factors identified in the literature, the YLS/CMI assists the rater in reaching global conclusions about the examinee's level of re-offense risk. It is a straightforward, conceptually useful instrument that essentially serves as an *aide-mémoire* for systematically considering major risk factors. However, it does not possess (or claim to possess) adequate empirical support for use as a precise predictor or measure of re-offense risk. Its authors clearly describe the YLS/CMI as a tool to be used to guide risk assessment decisions.

Not unlike the YLS/CMI, the Structured Assessment of Violence Risk in Youth (SAVRY; Borum, Bartel, & Forth, 2002) is a guided risk assessment protocol, completed by the clinician after the collection of relevant information from interview and collateral sources. Its format is borrowed from comparable adult tools, such as the HCR–20 (Webster, Douglas, Eaves, & Hart, 1997). Unlike the YLS/CMI, the SAVRY draws from the literature specific to violence risk, rather than re-arrest risk. It is composed of 24 items, each representing an empirically supported risk factor associated with youth violence, and these items are grouped under the general rubric of historical, social/contextual, and individual factors. Six protective factors are also scored.

SAVRY research is under way but still relatively limited. At present, it is most prudent to use the SAVRY to identify specific risk factors to be targeted and protective factors to be capitalized upon, but not to draw firm or precise conclusions as to level of risk. It appears to be a useful aide to case conceptualization but is likely to undergo adjustments to items before it becomes more widely available and used.

Finally, a great deal of attention has been directed toward assessing psychopathy in youth, as an extension of the voluminous literature base that has accumulated with adult psychopathy and the PCL–R (Hare, 1991, 2003). A small number of instruments have been developed to assess antisocial and/or psychopathic features in youth (see, e.g., Frick & Hare, 2001). The tool that has been subject to the most attention by far has been an adolescent adaptation of the PCL–R: The Psychopathy Checklist: Youth Version (PCL:YV; Forth, Kosson, & Hare, 2003). This clinician rating scale consists of 20 items, each associated with behavioral, affective, and interpersonal features that are conceptually and empirically associated with the prototypical psychopathic personality. PCL:YV scoring is predicated upon a lengthy semi-structured interview and collateral record review. The "checklist" itself appears deceptively simple to use, but its authors urge caution about participating in formal training and practice in order to appreciate the specific scoring criteria for each item. This issue raises the potential for abuse of the PCL:YV, which mirrors concerns that have been discussed extensively with the adult version of the instrument (e.g., Gacono & Hutton, 1994).

Though only recently published for clinical and forensic purposes, the PCL:YV has undergone extensive empirical study and has been shown to demonstrate excellent psychometric properties. As with its adult counterpart, high PCL:YV scores have been associated with violence, recidivism, and other negative outcomes. However, longer-term predictive studies are not yet completed, so a major point of contention centers on the question of whether high scores on the PCL:YV predict adult psychopathy, criminality, and violence. At present, the most prudent approach is to use the instrument to assist with shorter-term decision-making, but to withhold conclusions that have a long-term impact on juveniles' sentences and other matters.

In fact, the central issues of identifying and labeling psychopathy in youth have been the focus of vigorous debate, before and since the release of the PCL:YV. For an excellent

treatment from various points of view, see the journal series that includes Frick (2002); Hart, Watt, & Vincent (2002); Lynam (2002); and Seagrave & Grisso (2002); see also Edens, Skeem, Cruise, & Cauffman (2001). Despite its potential benefits, the PCL:YV carries with it a great potential for misapplication and misunderstanding. Even more so than with any of the other newly developed instruments, users of the PCL:YV will need to be familiar with conceptual and practical issues surrounding its use.

CASE ILLUSTRATION: MICHAEL

Michael Jones (name and all identifying data disguised) is a 16-year-old African American male who was referred for a psychological evaluation by his juvenile probation officer. Michael had recently been arrested in connection with an armed robbery. He and three male acquaintances were accused of ordering a pizza to be delivered to an unoccupied address and, upon his arrival, taking the deliveryman's cash (and the pizza) at gunpoint. All four teens were arrested a short time later, and Michael was soon released to his mother on bail. As of this evaluation, his case was still open in juvenile court. He admitted his involvement in the robbery, but by all accounts his role was merely to serve as lookout. The evaluation was requested to help gain a better understanding of Michael's treatment needs, including whether he was appropriate for placement in a residential facility.

This was Michael's third arrest. He incurred his first two arrests at ages 14 and 15, both times for assault in connection to fights with peers. It is worth noting that both fights took place in large social contexts. The first arrest occurred after Michael recruited a group of peers to retaliate against several boys after they "jumped" his younger cousin. Charges were ultimately dismissed. The second involved a large melee that broke out on school grounds. Several peers were involved, but only Michael was arrested, as he had severely injured another student. He was remanded to probation, but within three months he was arrested for the robbery incident.

Michael is the only child of long-separated parents. He has always been in the care of his mother, and they have always remained in the same high-risk urban neighborhood (marked by high rates of crime, drug use and sales, poverty, and other risk factors). His father has been uninvolved, and there have been no other male figures in his home. Michael and his mother both report a strong, positive relationship but acknowledge that it has been increasingly strained over the past two years, mainly because of his worsening behavior.

Ms. Jones reports that her son was always an active, energetic, exhausting child. She feels he has always been sweet and kind, but he has also been overly sensitive to any perceived slights or threats. As early as preschool, he sporadically fought with other boys, and in his mother's view, this was always after he felt provoked by some comment or gesture. In elementary school, his conduct and performance varied widely. Ms. Jones has always worked very long hours, and when Michael was young, he was usually watched by various relatives. By age 12, he was alone for much of his free time, and it was at this age that he began to gravitate toward delinquent peers. Ms. Jones reported being concerned about his friends and activities since then, but she has felt very little control, because of both her work schedule and her sense of guilt over being so often absent. Also of concern to her is her son's marijuana use. He reports smoking almost daily with friends, although there is no evidence of use of any other substances.

Michael's mental health treatment history has been limited, consisting of one failed attempt at conjoint individual and family therapy. Treatment was prompted by probation

and was intended to help Michael manage his anger more effectively and to make better social decisions, as well as to help his mother manage his behavior. Mother and son attended a small number of sessions but then failed to comply, citing scheduling problems.

Assessment in this case included input from four main sources: interviews with Michael and his mother; review of probation records (which were fairly detailed in this case); and psychological testing. As is often the case, Michael had been involved with multiple professionals through probation and mental health, but because of his noncompliance and staff turnover, none of those individuals knew him well enough to provide any detailed impressions.

The behavioral history, arguably the most important source of data in cases like this, was notable in many ways. As one example, Michael displayed lifelong temperamental factors that predisposed him to active behavior and sensation-seeking. He did not meet specific criteria for ADHD, but he did experience chronic, subdiagnosis levels of impulsivity that made it difficult for him or his mother to manage his behavior consistently. These problems were magnified by his mother's inability to provide much consistent adult oversight or household structure. In many ways, Michael was undersocialized and was left to learn the basics of self-discipline and emotional regulation on his own. Second, descriptions from all sources provided strong evidence for attachment capacity, even though Michael's most important relationships were strained. As a preadolescent, he would have met criteria for ODD, although most hallmark symptoms of CD were absent. Third, Michael's behavior began deteriorating at age 12, in relation with his new peer contacts and escalating marijuana use. The history portrays Michael as an adolescent-onset conduct-disordered youth, with some positive prognostic indicators, even despite the seriousness of his behaviors and significant risk for re-arrest.

Test results are summarized in the Appendix. Some selected findings are discussed here, organized for our purposes in a test-by-test manner. The Achenbach scales were completed by Michael and his mother, not only to provide a screening of major behavioral and emotional problem areas, but also to allow for a comparison of their respective views of his presenting problems. Both mother and son acknowledged significant difficulties in terms of externalizing behaviors, although Michael endorsed more symptoms and higher levels of difficulty in nearly all areas. More striking is their pattern of discrepancies on the internalizing scales. A working hypothesis at this point is that he experiences internalizing symptoms that are discomforting for him, but that his mother fails to recognize. If borne out, this finding would be important not only to bring to Ms. Jones's attention but also to share with professionals, who would also be at risk of overlooking important emotional difficulties while they focus on his overt conduct problems.

MMPI–A results add further evidence for undetected emotional discomfort. Michael approached the testing in a fairly open and candid manner, and I was able to point to the MMPI–A's validity scale findings (as well as elevations on scales that acknowledge problems with family, school, and substance use) to support this same impression from the interview. MMPI–A results included pronounced elevations on scales 4 and 9, as is very commonly seen with this population. However, as with the case of Adam above, a closer inspection of subscales helped to individualize these findings. For instance, Michael acknowledged a significant amount of family conflict and problems with authority, but there was little evidence for the emotional toughness or insensitivity that characterize some of his more antisocial peers. Also notable are his scale elevations tied to depression and emotional discomfort. We might expect Michael to vacillate between instances of acting out and periods of regret and self-deprecation. Coupled with the behavioral history, a portrait begins to emerge of a youth who recognizes his actions have painful consequences, but who is too impulsive and shortsighted to change his patterns without help.

The Rorschach in this case adds more support for hypotheses related to underlying depression-like symptoms and emotional control problems. Although content (not included here) was simplistic, bland, and unremarkable, structural scores suggest a great deal of emotional discomfort and confusion. Also suggested are long-standing, serious social coping difficulties. Michael appears to lack basic socialization skills and is prone to become passive in situations when he would be better served by asserting himself. Rorschach findings point to the need for basic social skills and assertiveness training, in addition to therapeutic interventions to address emotional difficulties that may be unseen. This echoes findings from the YSR and MMPI–A.

In this case, ample records and interview time made use of the PCL:YV possible. At its most global level, this instrument revealed an overall severity of psychopathy features that is normative for other juveniles on probation. Inspecting Michael's scores on the PCL:YV's subscales was more informative. Although he does have a notable history of irresponsible, even parasitic life-style features, as well as a concerning history of aggression and antisocial conduct, what is relatively absent is evidence for strong interpersonal and affective traits that underlie the psychopathic character. Like many conduct-disordered youth, Michael is certainly at risk for progressing to more pervasive patterns of antisociality, but at this point, he still displays attachment capacity and affective accessibility that can be capitalized upon in treatment efforts.

The YLS/CMI points out several features unique to Michael and his environment that place him at a roughly moderate overall risk for re-arrest at the time of evaluation. This instrument, as a way of formalizing and organizing the behavioral history and interview data, helps to identify several domains in need of intervention in order to mitigate Michael's risk.

Recommendations for Michael were guided in large part by a knowledge of what had been attempted (successfully or not) in the past, and what is currently available within his jurisdiction. In this case, a reputable and fairly effective treatment program was available to provide multisystemic treatment for Michael and his mother, offering intensive home-based and community-based professional supports. Individual therapy was also recommended to help Michael recognize his emotional difficulties, to see how they might feed into his problematic conduct, and to get his needs met without resorting to acting out. Without this assessment, and in a jurisdiction with different resources, Michael might have been viewed as a poor candidate for treatment. In reality, the evaluation identified numerous strengths that could be capitalized upon, while also making clear that Michael continued to pose a significant risk for re-offense if certain factors were not addressed with professional interventions.

CONCLUSIONS AND FUTURE DIRECTIONS

Although there is an extensive literature on delinquency, antisociality, and their assessment, several areas remain in need of development. As one pressing example, female delinquency is currently receiving increasing attention but continues to be understudied. It is unclear to what degree our male models of violence and delinquency actually generalize to females and in what ways we should conceptualize girls differently. Furthermore, the subfield of juvenile risk assessment (with respect to violence, recidivism, and other specific outcomes) is still emerging. This will evolve into a fuller appreciation for the multitude of risk factors and protective factors that interplay at various levels.

As for testing instruments, attention is likely to be focused on developing and refining specialized tools, including those outlined in this chapter. As the field's model for risk assess-

ment grows more precise, so will related assessment methods. Today, these tools are essentially loose frameworks for guiding interviewing and case conceptualization, but in the coming years, these will undoubtedly be supplanted by more precise efforts to quantify and classify levels of risk.

In the meantime, evaluators have access to a large arsenal or assessment methods, each with particular strengths and shortcomings, which should complement each other as part of a well-integrated, multimethod approach to assessing these challenging youth.

APPENDIX

Selected Test Data for Michael

Achenbach Scales (T scores and percentiles)

	CBCL	*YSR*
Anxious/depressed	50 (≤50%)	65 (93%)
Withdrawn/depressed	50 (≤50%)	54 (65%)
Somatic complaints	50 (≤50%)	51 (54%)
Social problems	50 (≤50%)	50 (≤50%)
Thought problems	66 (95%)	62 (89%)
Attention problems	52 (58%)	57 (76%)
Rule-breaking behavior	64 (92%)	68 (97%)
Aggressive behavior	54 (65%)	75 (>97%)
Internalizing problems	34 (6%)	59 (81%)
Externalizing problems	59 (81%)	73 (>98%)
Total problems	52 (58%)	66 (95%)

MMPI–A (T scores)

Selected validity scales		*Basic scales*				*Selected supplementary scales*	
VRIN	51	1/Hs	54	6/Pa	60	MAC-R	61
TRIN	57F	2/D	69	7/Pt	58	ACK	67
F	49	3/Hy	56	8/Sc	64	PRO	66
L	62	4/Pd	75	9/Ma	68		
K	59	5/Mf	37	0/Si	42		

Harris-Lingoes subscales for elevated basic scales

D1/Subjective depression	65	Pd1/Familial discord	68	Ma1/Amorality	58
D2/Psychomotor retardation	35	Pd2/Authority problems	73	Ma2/Psychomotor acceleration	66
D3/Physical malfunctioning	41	Pd3/Social imperturbability	42	Ma3/Imperturbability	49
D4/Mental dullness	72	Pd4/Social alienation	46	Ma4/Ego inflation	53
D5/Brooding	51	Pd5/Self-alienation	53		

Selected content scales

A-dep	57	A-fam	64
A-ang	54	A-sch	65
A-cyn	59	A-trt	57
A-con	58		

Rorschach (selected raw scores)

Validity		*Constellations*			
R	17	PTI	0	S-CON	7
Lambda	1.13	DEPI	5(+)	HVI	No
		CDI	4(+)	OBS	No
Controls				*Affect*	
EB	1 : 4	FM	4	FC : CF + C3	0:3
EA	5.0	m	0	Pure C	2
eb	4 : 2	SumC′	2	Afr	0.42
es and Adj es	6	SumV	0	S	1
D and Adj D	0	SumT	0	Blends : R	3 : 17
		SumY	0		
Interpersonal perceptions				*Self perception*	
COP	0	SumT	0	Egocentricity Index	0.24
AG	0	Pure H	0	Fr + rF	0
GHR : PHR	2 : 0	PER	0	SumV	0
a : p	2 : 3	Isolate Index	0.12	FD	1
Food	0			An + Xy	0
				MOR	0
Processing		*Mediation*		*Ideation*	
Zf	10	XA%	0.82	a : p	2 : 3
W : D : Dd	10:6:1	WDA%	0.81	Ma : Mp	0 : 1
W : M	10:1	X−%	0.00	Intell. Index	4
Zd	−4.0	P	6	MOR	0
PSV	1	X+%	0.53	WSum6	6
		Xu%	0.29	M- and Mnone	0

PCL:YV: (T scores and percentiles, vs. male probationers)

Total Score = 20	*46 (49%)*
Factor 1/Interpersonal	14 (36%)
Factor 2/Affective	36 (44%)
Factor 3/Lifestyle	84 (58%)
Factor 4/Antisocial	78 (56%)

YLS/CMI (risk levels)

Overall total risk level	Moderate
Prior and current offenses/dispositions	Moderate
Family circumstances/parenting	Moderate
Education/employment	Moderate
Peer relations	High
Substance abuse	High
Leisure/recreation	High
Personality/behavior	Moderate
Attitudes/orientation	Moderate

REFERENCES

Achenbach, T., & Rescorla, L. (2001). *Manual for the ASEBA school-age forms and profiles.* Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families.

American Academy of Child and Adolescent Psychiatry. (1997). Practice parameters for the assessment and treatment of children and adolescents with conduct disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(10), 122S–139S.

American Academy of Child and Adolescent Psychiatry. (2005). Practice parameters for the assessment and treatment of youth in juvenile detention and correctional facilities. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(10), 1085–1098.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: American Psychiatric Association.

Archer, R., Handel, R., & Lynch, K. (2001). The effectiveness of MMPI-A items in discriminating between normative and clinical samples. *Journal of Personality Assessment, 77*(3), 420–435.

Archer, R., & Newsom, C. (2000). Psychological test usage with adolescent clients: Survey update. *Assessment, 7*, 227–235.

Archer, R., Stredny, R., Mason, J., & Arnau, R. (2004). An examination and replication of the psychometric properties of the Massachusetts Youth Screening Instrument–Second Edition (MAYSI–2) among adolescents in detention settings. *Assessment, 11*(4), 290–302.

Beck, A., Steer, R., & Brown, G. (1996). *Beck Depression Inventory manual: Second edition.* Boston: Harcourt-Brace.

Borum, R., Bartel, P., & Forth, A. (2002). *Manual for the Structured Assessment of Violence Risk in Youth (SAVRY).* Tampa, FL: University of South Florida.

Butcher, J., Williams, C., Graham, J., Archer, R., Tellegen, A., Ben-Porath, Y., & Kaemmer, B. (1992). *MMPI-A manual for administration, scoring, and interpretation.* Minneapolis, MN: University of Minnesota Press.

Cleckley, H. (1976). *The mask of sanity* (5th ed.). St. Louis, MO: Mosby.

Edens, J., Skeem, J., Cruise, K., & Cauffman, E. (2001). Assessment of "juvenile psychopathy" and its association with violence: A critical review. *Behavioral Sciences and the Law, 19*, 53–80.

Exner, J. (2003). *The Rorschach: A comprehensive system: Vol. 1. Basic foundations and principles of interpretation* (4th ed.). New York: Wiley.

Forth, A. (1995). *Psychopathy and young offenders: Prevalence, family background, and violence.* Ottawa: Ministry of the Solicitor General of Canada.

Forth, A., Kosson, D., & Hare, R. (2003). *Hare Psychopathy Checklist: Youth Version (PCL:YV). Technical manual.* Toronto: Multi-Health Systems.

Frick, P. (2002). Juvenile psychopathy from a developmental perspective: Implications for construct development and use in forensic assessments. *Law and Human Behavior, 26*(2), 247–254.

Frick, P., & Hare, R. (2001). *The Antisocial Process Screening Device.* Toronto: Multi-Health Systems.

Gacono, C., Evans, B., & Viglione, D. (2002). The Rorschach in forensic practice. *Journal of Forensic Psychology Practice, 2*(3), 33–53.

Gacono, C., & Hutton, H. (1994). Suggestions for the clinical and forensic use of the Hare Psychopathy Checklist-Revised (PCL-R). *International Journal of Law and Psychiatry, 17*(3), 303–317.

Gacono, C., & Meloy, J. R. (1994). *The Rorschach assessment of aggressive and psychopathic personalities.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Grisso, T. (1998). *Forensic evaluation of juveniles.* Sarasota, FL: Professional Resource Press.

Grisso, T., & Barnum, R. (2001). *The Massachusetts Youth Screening Instrument: Second Version (MAYSI–2).* Worcester, MA: University of Massachusetts Medical School.

Grisso, T., & Underwood, L. (2004). *Screening and assessing mental health and substance use disorders among youth in the juvenile justice system: A resource guide for practitioners.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs.

Grove, W., & Barden, R. (1999). Protecting the integrity of the legal system: The admissibility of testimony from mental health experts under *Daubert/Kumho* analyses. *Psychology, Public Policy, and Law, 5*(1), 224–242.

Grove, W., Barden, R., Garb, H., & Lilienfeld, S. (2002). Failure of Rorschach-Comprehensive-System-based testimony to be admissible under the *Daubert-Joiner-Kumho* standard. *Psychology, Public Policy, & Law, 8*(2), 216–234.

Hare, R. (1991). *Hare Psychopathy Checklist–Revised manual.* Toronto: Multi-Health Systems.

Hare, R. (1993). *Without conscience: The disturbing world of psychopaths among us.* New York: Pocket Books.

Hare, R. (1996). Psychopathy and Antisocial Personality Disorder: A case of diagnostic confusion. *Psychiatric Times, 13*, 39–40.

Hare, R. (2003). *Hare Psychopathy Checklist–Revised manual* (2nd ed.). Toronto: Multi-Health Systems.

Hart, S., & Hare, R. (1997). Psychopathy: Assessment and association with criminal conduct. In D. Stoff, J. Breiling, & J. Maser (Eds.), *Handbook of antisocial behavior* (pp. 22–35). New York: Wiley.

Hart, S., Watt, K., & Vincent, G. (2002). Commentary on Seagrave and Grisso: Impressions of the state of the art. *Law and Human Behavior, 26*(2), 241–246.

Heilbrun, K. (1992). The role of psychological testing in forensic assessment. *Law and Human Behavior, 16*, 257–272.

Heilbrun, K. (2001). *Principles of forensic mental health assessment.* New York: Kluwer.

Heilbrun, K., Marczyk, G., & DeMatteo, D. (2002). Juvenile competence to stand trial. In K. Heilbrun, G. Marczyk, & D. DeMatteo (Eds.), *Forensic mental health assessments: A casebook.* New York: Oxford University Press.

Hilsenroth, M., & Stricker, G. (2004). A consideration of challenges to psychological assessment instruments used in forensic settings: Rorschach as exemplar. *Journal of Personality Assessment, 83*, 141–152.

Hoge, R., & Andrews, D. (1999). *The Youth Level of Service/Case Management Inventory user's manual.* Toronto: Multi-Health Systems.

Jesness, C. (2003). *The Jesness Inventory manual.* Toronto: Multi-Health Systems.

Lahey, B., Loeber, R., Quay, H., Frick, P., & Grimm, J. (1992). Oppositional defiant and conduct disorder: Issues to be resolved for DSM-IV. *Journal of the American Academy of Child and Adolescent Psychiatry, 31*, 539–546.

Lally, S. (2001). Should human figure drawings be admitted into court? *Journal of Personality Assessment, 76*(1), 135–149.

Loeber, R., Keenan, K., Lahey, B., Green, S., & Thomas, C. (1993). Evidence for developmentally based diagnoses of oppositional defiant disorder and conduct disorder. *Journal of Abnormal Child Psychology, 21*, 377–410.

Loving, J., & Gacono, C. (2002). Psychopathy in juveniles: Clinical and forensic applications. In N. Ribner (Ed.), *Handbook of juvenile forensic psychology* (pp. 292–317). San Francisco: Jossey-Bass.

Loving, J., & Russell, W. (2000). Selected Rorschach variables of psychopathic juvenile offenders. *Journal of Personality Assessment, 75*(1), 126–142.

Lynam, D. (1996). Early identification of chronic offenders: Who is the fledgling psychopath? *Psychological Bulletin, 120*, 209–234.

Lynam, D. (2002). Fledgling psychopathy: A view from personality theory. *Law and Human Behavior, 26*(2), 255–259.

McCann, J. (1998a). Defending the Rorschach in court: An analysis of admissibility using legal and professional standards. *Journal of Personality Assessment, 70*(1), 125–144.

McCann, J. (1998b). *Malingering and deception in adolescents: Assessing credibility in clinical and forensic settings.* Washington, DC: American Psychological Association.

Meloy, J. R. (1988). *The psychopathic mind: Origins, dynamics, and treatment.* Northvale, NJ: Aronson.

Meloy, J. R., Hansen, T., & Weiner, I. (1997). Authority of the Rorschach: Legal citations during the past 50 years. *Journal of Personality Assessment, 69*(1), 53–62.

Millon, T. (1993). *Millon Adolescent Clinical Inventory (MACI) manual.* Minneapolis, MN: NCS Assessments.

Moffitt, T. (1993). Adolescence-limited and life-course persistent antisocial behavior: A developmental taxonomy. *Psychological Review, 100*(4), 674–701.

National Council of Juvenile & Family Court Judges. (2005). Juvenile delinquency guidelines: Improving court practice in juvenile delinquency cases. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs.

Otto, R., Greenstein, J., Johnson, M., & Friedman, R. (1992). Prevalence of mental health disorders among youth in the juvenile justice system. In J. Cocozza (Ed.), *Responding to the mental health needs of youth in the juvenile justice system* (pp. 7–48). Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System.

Owens, S., Patrick, K., Packman, W., & Greene, R. (2004). *Is the Rorschach still welcome in the courtroom?* Poster presented at the annual meeting of the Society for Personality Assessment, Miami, FL.

Porcerelli, J., Abramsky, M., Hibbard, S., & Kamoo, R. (2001). Object relations and defense mechanisms of a psychopathic serial sexual homicide perpetrator: A TAT analysis. *Journal of Personality Assessment, 77*(1), 87–104.

Pottick, K., Warner, L., Isaacs, M., Henderson, M., Milazzo-Sayre, L., & Manderscheid, R. (2002). Children and adolescents admitted to specialty mental health care programs in the United States, 1986 and 1997. In R. Mandersheid & M. Henderson (Eds.), *Mental health, United States.* Rockville, MD: U. S. Department of Health and Human Services.

Rhoades, E. (2005). Review of the Jesness Inventory-Revised. In Buros Institute of Mental Measurement: Test reviews online. Retrieved September 25, 2005, from http://buros.unl.edu/buros/jsp/lists.jsp

Ritzler, B., Erard, R., & Pettigrew, G. (2002a). A final reply to Grove and Barden: The relevance of the Rorschach Comprehensive System for expert testimony. *Psychology, Public Policy, and Law, 8*(2), 235–246.

Ritzler, B., Erard, R., & Pettigrew, G. (2002b). Protecting the integrity of the Rorschach expert witnesses: A reply to Grove and Barden (1999) regarding the admissibility of testimony under *Daubert/Kumho* analyses. *Psychology, Public Policy, and Law, 8*(2), 201–215.

Rogers, R. Bagby, R., & Dickens, S. (1992). *Structured Interview of Reported Symptoms (SIRS): Professional manual.* Odessa, FL: Psychological Assessment Resources.

Rorschach, H. (1921). *Psychodiagnostik.* Bern: Ernest Bircher.

Seagrave, D., & Grisso, T. (2002). Adolescent development and the measurement of juvenile psychopathy. *Law and Human Behavior, 26*(2), 219–240.

Teplin, L., Abram, K., McClelland, G., Dulcan, M., & Mericle, A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 59*, 1133–1143.

Webster, C., Douglas, K., Eaves, & Hart, S. (1997). *The HCR–20 scheme: Assessing risk for violence, version 2.* Burnaby: Mental Health, Law, and Policy Institute, Simon Fraser University.

Weiner, I., Exner, J., & Sciara, A. (1996). Is the Rorschach welcome in the courtroom? *Journal of Personality Assessment, 67*(2), 422–424.

Yetter, G. (2005). Review of the Jesness Inventory-Revised. In Buros Institute of Mental Measurement: Test reviews online. Retrieved September 25, 2005, from http://buros.unl.edu/buros/jsp/lists.jsp

Zoccolillo, M. (1992). The co-occurrence of conduct disorder and its adult outcomes with depressive and anxiety disorders: A review. *Journal of the American Academy of Child and Adolescent Psychiatry, 31*, 547–556.

Zoccolillo, M., Pickles, A., Quinton, D., & Rutter, M. (1992). The outcome of childhood conduct disorder: Implications for defining adult personality disorder and conduct disorder. *Psychological Medicine, 22*(4), 971–986.

This page intentionally left blank