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31.19 Child Psychiatry: Special Areas of Interest 31.19a Forensic Issues in Child Psychiatry Forensic evaluations of youth span a broad spectrum of situations and settings, including child custody during a parental divorce, trauma and abuse situations, and juvenile offender evaluations pertaining to juvenile and criminal court cases. Child and adolescent psychiatrists are increasingly being sought out by patients and attorneys for evaluations and expert opinions related to child sexual and physical abuse, to criminal behaviors perpetrated by minors, and to evaluate the relations between traumatic life events and the emergence of psychiatric symptoms in children and adolescents. As more youth enter the juvenile justice system, an increasing need exists for forensic psychiatrists with expertise in evaluation and treatment for detainees and committed youths. The specific tasks and role of a child and adolescent psychiatric forensic evaluator are distinctly different from a child and adolescent psychiatrist doing a clinical evaluation and clinical treatment intervention. In clinical settings, child mental health professionals provide psychotherapy, medication evaluations, and advocacy for youth with psychiatric diagnoses. As a forensic child psychiatric evaluator, however, the main task is to be an expert, to report objective psychiatric findings related to the questions asked. Two essential characteristics of a forensic evaluator, in contrast to a clinician are (1) the relationship between the evaluator and the patient is not therapeutic, rather, it is information seeking, and (2) there are clear limits of confidentiality in this situation, that is, the information disclosed during a forensic evaluation may be brought to court, or to an attorney, or to whomever initiated the evaluation. Society's view of children and their rights has evolved dramatically. In 1980, the American Academy of Child and Adolescent Psychiatry (AACAP) published a code of ethics that was developed to publicly endorse the ethical standards of this discipline. The code is based on the assumption that children are vulnerable and unable to take adequate care of themselves; as they mature, however, their capacity to make judgments of, and choices about, their well-being develops as well. The code has several caveats: From the standpoint of child and adolescent psychiatrists, issues of consent, confidentiality, and professional responsibility must be seen in the context of overlapping and potentially conflicting rights of children, parents, and society. Confidentiality, or intensive trust, refers to the relationship between two persons with respect to the "entrustment of secrets." Until the 1970s, little attention

was paid to issues of confidentiality pertaining to minors. In 1980, among the items in the AACAP Code of Ethics, six principles were related to confidentiality. Breaches and limits of confidentiality can be obtained in cases of child abuse or maltreatment or for purposes of appropriate education. Although unnecessary with a child or adolescent, consent for disclosure should be obtained when possible. In 1979, the American Psychiatric Association (APA) stated that a child 12 years of age could give consent for disclosure of confidential information and, with the exception of safety issues, a minor's consent is required for disclosure of information to others, including the child's

parents. According to the AACAP Code of Ethics, the consent of a minor is not required for disclosure of confidential information. Specific ages for consent are not addressed in the code. Child and adolescent psychiatrists often face the dilemma of weighing the potential benefits and possible harm in sharing information obtained confidentially from a child with the child's parents. Although the smoothest transition occurs when the child and the physician agree that certain information can be shared, in many situations that border on "dangerousness to the child or others," the child or adolescent does not agree to share the information with a parent or another responsible adult. Among adolescents, these secrets that are sometimes shared with a psychiatrist may involve drug or alcohol use, unsafe sex practices, or a thrillseeking act that places the adolescent in danger. A psychiatrist may choose to work with the child or adolescent toward agreeing to share confidential information when it is determined by the treating psychiatrist that the probable outcome would be beneficial. The initial treatment contract, however, limits confidentiality to situations of "danger" to the child or others. CHILD CUSTODY Child custody evaluations by child and adolescent psychiatrists may be initiated by divorcing parents who cannot come to an agreement regarding custody of their children, or can be requested by an attorney. Attorneys are most likely to seek child custody evaluations when allegations are made of parental incompetence, or issues of alleged physical or sexual abuse arise. Comprehensive custody evaluations by mental health professionals may play a significant role in successful negotiations of custody by parents without the necessity of proceeding to a trial. The evolution of child custody decision-making has been influenced by increasing awareness and recognition of the rights of children and women, as well as by a broadening perspective on the developmental and psychological needs of the children involved. Historically, children were considered to be their fathers' property. At the beginning of the 20th century, the "tender years" doctrine became the standard for determining child custody. According to this doctrine, the relationship between mother and infant, later generalized to mother and child, is responsible for the optimal emotional development of the child; the doctrine thus supported custody decisions in the mother's favor in most cases. With this doctrine as its guide, psychological issues in developing children became an acceptable dimension to consider in the determination of custody. In controversial and unclear cases, psychological expert testimony began to be accepted as a valuable part of child custody decision-making. The "best interest of the child" standard replaced the "tender years" doctrine and expanded considerations of the optimal parent to include assessing issues of emotional climate, safety, and educational and social opportunities for the children. The "best interest of the child" grew from the movement to support legislation about the rights of children in the areas of compulsory education, child labor laws, and child abuse and neglect protection laws. Therefore, although "best interest" standards have broadened the dimensions considered in evaluating which parent is best able to serve the best interest of the child, how to measure these qualities in a parent remains vague. In view of the lack of clarity regarding what specific parameters in a parent best correspond to the interest of the child, child and adolescent psychiatrists have increasingly

been asked to help make decisions by defining relevant psychological conditions in parents and in the relationships between parents and children. Psychiatric evaluators may be asked to give an opinion about child custody at various points during the separation and divorce process. Sometimes, a psychiatric evaluation is requested by the parents before any legal action occurs. When the parents and an evaluator can agree on custody decisions before the legal process, a court is likely to go along with these decisions rather than launch an additional investigation. A psychiatric evaluation may be ordered by the court or by the attorneys representing the feuding parents. In such cases, an evaluator is faced with two disgruntled parents, who often are consumed by their mutual conflict to the point that neither is willing to compromise, even in the child's interest. The advantage in such cases, however, is that evaluators represent the court and can act as advocate for the child without the same pressures that an evaluator hired by only one parent faces. A psychiatric evaluation also may be initiated by a guardian ad litem, an attorney who is appointed by the court to represent the child. Psychiatric evaluators also may be requested to give an opinion about custody during a mediation process. Mediation is a legal process that usually involves one attorney and one evaluator. Because mediation can occur outside the judicial system, some families may prefer it to going through a trial. In addition to custody, psychiatric evaluators often are asked to give opinions about visitation. In undertaking a custody evaluation, an evaluator is expected to determine the best interests of the child while keeping in mind the standard elements that the court considers. These considerations include the wishes of the parents and the child; relationships with significant others in the child's life; the child's adjustment to the current home, school, and community; the psychiatric and physical health of all parties; and the level of conflict and potential danger to the child under the care of either parent. A psychiatric evaluator must maintain his or her role as an advocate for the best interest of the child and does not consider the fairest outcome for parents. The psychiatric evaluator conducts a series of interviews, often including at least one separate interview with each parent and the child alone and one interview with the child and both parents. The evaluator may obtain a written waiver of confidentiality from all parties because he or she may have made disclosures to opposing attorneys and in court before the judge. The evaluator uses direct questioning as well as observations of the relationships between the child and each parent. The age and developmental needs of the child are considered in making a judgment regarding which parent may better serve the child's interests. As part of the psychiatric assessment of the child custody evaluation, the evaluator determines the need for psychiatric treatment of any of the parties involved. The child custody evaluation generally is provided in a written report. This document is not confidential and can be used in court. The report contains a description of the relationship between the child and parents, the capabilities of the parents, and finally, the custody recommendations. In view of data supporting the importance of continuing a relationship with both parents in most cases, it is recommended that joint custody be considered before other options. When sufficient cooperation exists to negotiate for joint custody, the best interests of the child often are served. Joint custody may not be the best option for a child when the relationship of the child with either parent is jeopardized and undermined by the other. The next most frequent choice when joint custody is not advisable is full custody by one parent with visitation rights for the other parent. The parent awarded full custody should be able to support the visitations and relationship with the noncustodial parent. In custody disputes involving a biological parent and a nonbiological parent, the biological parent generally has the right to custody unless he or she is shown to be unable to provide for the child. After the custody evaluation has been submitted in writing, the results must be communicated to the

parents, the child, and possibly their respective attorneys. The evaluator may be called on to testify in court, and the parties can use the custody evaluation to mediate other areas of their dispute. Many complications can occur in an ongoing bitter dispute between divorcing or divorced parents. Both true and false allegations of psychiatric illness, drug or alcohol abuse, or sexual or physical abuse are not uncommon during custody battles. The evaluator must be prepared to verify any allegations and to carefully discuss their effects on custody and visitation. Evidence suggests that markedly elevated numbers of unfounded allegations of child sexual abuse occur during the course of custody disputes. Tremain, age 9 years, has been in a therapeutic foster home for 2 years, having been removed from his home along with his younger sister, due to profound neglect, as well as physical abuse. Although he is receiving cognitive-behavioral therapy, medication, and a social skills group, he remains volatile, and typically becomes more aggressive and regressed after weekly supervised visits with his mother. Tremain's sister has been reunited with their mother, and his guardian ad litem requests that a child psychiatrist perform a forensic evaluation to determine whether visits should continue. She reviews extensive records, evaluates each parent, obtains history from them and the foster parent, and then observes a visit. Tremain's little sister totally dominates the visit, and her mother is at a loss to control her aggressive and hyperactive behavior. Tremain is passive and clingy with his mother. According to the social work supervisor, this is a fairly typical visit. When the child and adolescent psychiatrist meets individually with Tremain, he expresses concern that his sister is probably being abused at home, and he likes to check on her during these visits. Tremain wants to go home, but he says that his mother has too many problems to take care of him. Tremain has developed a positive relationship with his foster father and, in contrast, has little to say about his biological mother. The child and adolescent psychiatrist recommends a psychiatric evaluation of the sister, but Tremain's mother does not follow through. The child and adolescent psychiatrist recommends cutting visits back to monthly, but Tremain's anxiety and aggressive behavior persist around these limited visits. It also becomes apparent that Tremain's mother is not up to the demands of caring for two special-needs children, as she is having difficulty containing her little daughter. The child and adolescent psychiatrist recommends delaying efforts at parental reunification however, maintaining contact between Tremain, his mother, and his sister. (Adapted from case material from Diane H. Schetky, M.D.)

JUVENILE OFFENDERS

According to the AACAP Practice Parameter for Child and Adolescent Forensic Evaluations, at least 2.7 million youth younger than 18 years are arrested each year in the U.S., and more than 1 million youth will have a formal interaction with the juvenile

justice system. Historically, a separate juvenile court system in the United States occurred by statute in the state of Illinois in the late 1800s. Its mandate was to rehabilitate rather than to punish. Despite the protective intentions of the legal system, children and adolescents involved in the juvenile justice system are at high risk for multiple psychiatric disorders and suicidal thoughts and behavior. The omission of various constitutional safeguards, such as the rights to counsel, confrontation, and cross-examination of an accuser, eventually led to criticism and disillusionment with this system. Juvenile offenders of small and significant crimes often were sent to state-run residential programs that were criticized for being overcrowded, neglectful, and frankly abusive. Despite the strong sentiment to increase due process protection for juveniles rather than pretrial, trial, and sentencing, the juvenile court system includes intake, adjudication, and disposition. The intake is a determination of whether probable cause exists that the youth committed a crime. A youth who confesses may be diverted from the court system altogether at this time, and appropriate plans for rehabilitation can be made in a community setting. For more serious crimes

or when juveniles deny perpetrating a crime, the process continues. Juveniles must be represented by counsel, and an attorney is provided if the family cannot afford to provide its own. Unlike adult court, in juvenile court, guilt or innocence is determined by a judge, not a jury. The case is argued by a prosecuting attorney and a defense attorney, and the judge is bound by the same standards as in adult court; that is, a judgment of delinquency requires proof beyond a reasonable doubt. When the charge is substantiated and the judgment is for delinquency, the juvenile is an "adjudicated delinquent." Disposition must next be determined. Dispositions include a wide range of options, from placement in youth correctional facilities, to residential treatment settings, to psychiatric hospitalizations for further evaluation. Delinquent acts refer to ordinary crimes committed by juveniles; status offenses refer to behaviors that would not be criminal if perpetrated by adults, such as truancy, running away, or drinking alcohol. Sometimes, youths who are believed to have committed a serious crime are turned over (receive a waiver) to adult criminal court.

DEVELOPMENTAL IMMATURITY VERSUS JUVENILE COMPETENCE TO STAND TRIAL A growing body of research is elucidating the significance of "developmental immaturity" on the capacity of children and young adolescents' competency to stand trial. Starting in the 1960s, the Supreme Court mandated a series of due process rights in juvenile court proceedings including the rights to notice of charges, an adversarial hearing with representation by counsel, the ability to cross-examine witnesses, and a trial transcript. Furthermore, juveniles have the right to a hearing prior to being transferred to adult court, and use of the standard of proof beyond a reasonable doubt to sustain a delinquency petition; however, there is no mention of the right to be competent to stand trial in delinquency proceedings. In the 1960 landmark case *Dusky v. United States*, the Supreme Court established a minimum national standard for

competency in criminal proceedings for adults. This standard mandates that in order for a defendant to be competent to stand trial, he or she must possess "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against him." Thus, there is no legal requirement for juveniles to be competent to participate in delinquency proceedings; however, many states have adopted their own competency standards for their juvenile courts. This is critical insofar as research suggests that developmental level has a definite impact on a child or early adolescent's understanding of legal concepts, and long-term implications of legal decisions, and thereby influences their competency to stand trial. The following two U.S. Supreme Court rulings have provided legal stipulations pertaining to the limitations of developmental immaturity and legal culpability. (1) In the case, *Roper v. Simmons* (2005), a successful argument was made that, among other reasons, but including a juvenile's normative immaturity, including impulsive decision making, susceptibility to peer pressure, and transitory behavior patterns, youth younger than 18 years of age should be excluded from the death penalty. (2) In 2010, in the case *Graham v. Florida*, using the developmental information that fueled the exclusion of minors from the death penalty, the Court ruled that a life sentence without parole for a juvenile offender, (with the exclusion of homicide cases), constituted cruel and unusual punishment. In one study using vignettes to elicit responses from children and adolescents pertaining to competent participation in legal proceedings, findings included that children 11 years to 13 years were less able to recognize risks and long-term consequences associated with their decisions and were more likely than adults to accept plea agreements; whereas youths up to 15 years also demonstrated greater compliance with authority figures in their decision making, compared to adults. Researchers in this field have concluded that due to developmental status alone, young juveniles are at greater risk to make poor

decisions on their own behalf in the context of working with their own attorneys. There are many factors that may influence a juvenile's competency, and several are essential in a competency evaluation of a juvenile, including: (1) age, with special consideration in any child of 12 years or younger; (2) developmental stage with respect to judgment, reasoning, responsibility, risk perception, suggestibility, temperance (seeking advice rather than acting without the facts), and future orientation; (3) assessment of mental disorder and intellectual level.

MENTAL HEALTH NEEDS OF YOUTH IN THE JUVENILE JUSTICE SYSTEM

Youth in the juvenile justice system are at extremely high risk for psychiatric disturbance, and unmet mental health needs have reached such high proportions that they are of public health concern. Adolescents in juvenile justice residential facilities not only have higher rates of psychiatric disorders, including depression, substance use, and suicidal behavior, but they are also significantly more likely to have been victims of physical and sexual abuse, educational failure, and family conflict. A survey of 991

youth at an initial juvenile justice intake revealed high levels of suicidal ideation with recent attempts more common in females, and youth with major depression or substance use disorders, and those who were violent offenders. Few studies, however, have documented the needs of juveniles in residential facilities and the medical and psychiatric care available. A recent study collected data from the U.S. Department of Justice censuses of all public and private juvenile justice facilities in the United States: The Juvenile Residential Facilities Census (JRFC) and the Census of Juveniles in Residential Placement (CJRP) investigated data on death rates of youth under the age of 21 years who had been charged with, or adjudicated for, an offense and are housed in that facility because of the offense. In the 2-year period, a total of 62 deaths of youth occurred. The leading cause of death was from suicide (20 cases), followed by accidents (17 cases), illness (14 cases), and homicides by nonresidents (6 cases). No deaths resulted from acquired immunodeficiency syndrome (AIDS), homicide by another resident, or an injury that occurred before placement. The risk for death of youth in juvenile justice facilities was found to be 8 percent higher than the death rate for the general population of adolescents aged 15 to 19 years. Above all, the risk for suicide is clearly increased in the juvenile justice facility compared with the general population, indicating a significant need for increased mental health evaluation and treatment in this population.

FORENSIC ASPECTS OF SCHOOL BULLYING

The forensic aspects of school bullying have increased over the last two decades, particularly in the wake of the serious incidents of school violence that took place in the mid-1990s such as the Columbine school shootings. The responsibilities of schools to protect students and safeguard against injury have extended from a duty to care, to a duty to protect. Bullying is typically observed in four different realms: physical, relational, verbal, and cyberbullying. Forensic evaluations often begin with a referral from an attorney, the court, or a family. After obtaining a comprehensive history of the youths involved in a reported bullying incident, the evaluator is tasked with determining if the alleged bullying has had a negative impact on the mental health and well-being of the victim. In some cases, investigators have reported findings of increased suicidality in the bully as well as the victim. One study reported that victims of cyberbullying attempt suicide twice as often as other youth.

THE RELATIONSHIPS BETWEEN TRAUMA, ABUSE, AND VIOLENT DELINQUENCY

Child and adolescent psychiatrists are frequently sought out to evaluate children or adolescents who have been exposed to a traumatic or adverse life event and are exhibiting a variety of violent and delinquent behaviors. The child and adolescent psychiatrist may be asked to determine whether a child or adolescent is experiencing posttraumatic stress disorder or whether a given set of symptoms is likely to have been

caused by exposure to the adverse life event. It is clear from surveys of delinquent adolescents that there is a relationship between posttraumatic stress disorder, previous histories of trauma and abuse, and aggressive behavior. Some researchers argue that evidence supports a trauma-related psychopathology in youth that evolves into aggressive behavior, and often into delinquency. It appears that brain circuits that monitor “threat response,” that is, circuits that run from the medial nucleus of the amygdala to the medial hypothalamus and to the periaqueductal gray matter, are overly reactive in reactive/affective/defensive/impulsive aggression (RADI, also referred to as “hot” aggression), as well as in planned or predatory aggression (PIP, also referred to as “cold” aggression). Particularly in RADI, structures may have become dysregulated by traumatic emotional activation, resulting in a lack of subtle differentiation between emotions such as sadness, anger, and fear. The result is that any stress is perceived as a threat, and activates the “defense” system, leading to the flight or fight decisions. The final response seems to be “fight,” a response triggered during abusive or lifethreatening situations in which escape seems impossible. In another study, a cognitive mechanism for the link between abusive parenting and violent delinquency is offered. In this retrospective study of 112 adolescents (male 90; female 22), ages 12 to 19 years who were incarcerated in a juvenile detention facility pending criminal charges, participants completed questionnaires pertaining to exposure to abusive and nonabusive discipline, expressed and converted shame, and violent delinquency. The authors defined shame as a state in which negative attributions of the self and self-blame are made as a result of perceived failure in meeting their own expected standards. Higher levels of shame have been found among youth exposed to trauma. Converted shame is an expression of externalizing blame to others so that hostility is directed away from oneself, and decreases one’s own sense of responsibility for something negative, such as abuse. Converted shame can serve as a self-protective attribution. The findings of this study led to subjects’ responses, which fell into four groups: (1) Low shame, and low blaming of others; (2) Converters: low shame and high blaming of others, (3) Expressers: high shame, and low blaming of others, (4) High shame and high blaming of others. Subjects who were in group 2 (low shame and high blaming of others) had significantly more exposure to abusive parenting, and exhibited significantly more violent delinquent behaviors than those in group 3 (high shame, low blaming of others). Thus, although converting shame is “meant” to be self-protective, and a potentially adaptive response to consistent abusive parenting, those adolescents who strongly blamed others appeared to develop more violent delinquency. The authors considered the violent delinquency a pathological response to trauma. Dr. Sullivan is called by a defense attorney to review discovery material in a case that alleges permanent harm and suffering in 6-year-old Travis, who is alleged to have been sexually abused at age 3 in his day care center. Dr. Lane, the forensic expert for the plaintiff, has evaluated the child and performed psychological testing of him and concluded that the boy’s conduct problems are all related to the alleged

abuse, which the child has difficulty recalling. His early history on the boy is cursory, however, and he has little information about the mother, who is a single parent, and he did not review medical records. In her thorough review of discovery material, Dr. Sullivan learns that Travis has witnessed extensive domestic violence and his mother’s rape, shown signs of hyperactivity since age 2, and has exhibited much anxiety related to his mother’s safety and several separations from her at times when she was unable to care for him owing to depression. Travis also has had delayed language development. Dr. Lane, at the time of his deposition, was asked why he had not asked about these matters. He said he considered the mother’s personal life a private matter and did not see its relevance to the litigation. Dr. Sullivan, when deposed, points out that many other factors beside the alleged abuse might account for Tony’s behavioral problems. (Adapted from case

material from Diane H. Schetky, M.D.) REFERENCES American Academy of Child and Adolescent Psychiatry: Practice Parameter for Child and Adolescent Forensic Evaluations. *J Am Acad Child Adolesc Psychiatry*. 2011;50:1299-1312. Bernet W, Corwin D. An evidence-based approach for estimating present and future damages from child sexual abuse. *J Am Acad Psychiatry Law*. 2006;34:224. Deitch M, Barstow A, Lukens L, Reyna R. From time out to hard time: Young children in the adult criminal justice system. Austin, TX: The University of Texas at Austin, LBJ School of Public Affairs, 2009. *Dusky v. United States*, 362 U.S. 402 (1960). Freeman BW, Thompson C, Jaques C. Forensic aspects and assessment of school bullying. *Psychiatr Clin N Am*. 2012;35:877-900. Gold J, Sullivan MW, Lewis M. The relation between abuse and violent delinquency: The conversion of shame to blame in juvenile offenders. *Child Abuse Neglect*. 2011;459-467. *Graham v. Florida*, 2010 U.S. LEXIS 3881. Hinduja S, Patchin JW. Bullying, cyberbullying, and suicide. *Arch Suicide Res*. 2010;14:206-221. Klomek A, Sourander A, Gould M. Bullying and suicide: Detection and intervention. *Psychiatric Times*. 2011;28:2. O'Donnell PC, Gross B. Developmental incompetence to stand trial in Juvenile Courts. *J Forensic Sci*. 2012;57:989-996. *Roper V. Simmons*, 543 U.S. 551 (2005). Schetky DH. Forensic child and adolescent psychiatry. In: Sadock BJ, Sadock VA, Ruiz P, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:3834. Soulier M. Juvenile offenders. *Psychiatr Clin N Am*. 2012;35:837-854. Steiner H, Silverman M, Karnik NS, Huemer J, Plattner B, Clark CE. Psychopathology, trauma and delinquency: Subtypes of aggression and their relevance for understanding young offenders. *Child Adolesc Psychiatry Ment Health*. 2011;5:21-32. Ttofi MM, Farrington DP, Losel F. The predictive efficiency of school bullying versus later offending: A systematic/metaanalytic review of longitudinal studies. *Crim Behav Ment Health*. 2011;21:80-89. Waller EM, Daniel AE. Purpose and utility of child custody evaluations: The attorney's perspective. *J Am Acad Psychiatry Law*. 2005;33:199. Wingrove TA. Is immaturity a legitimate source of incompetence to avoid standing trial in a juvenile court? *Neb Law Rev*. 2007;86:488-514. Zablotsky B, Bradshaw CP, Anderson C, Law PA. The association between bullying and the psychological functioning of

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