What's Behind Behavior Matters: The Effects of Disabilities, Trauma and Immaturity on Juvenile Intent and Ability to Assist Counsel

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The delinquent act itself is often the primary basis for determining intention and competency of children under 18 in adult or juvenile court. But behaviors result from one or more of a diverse range of factors, each of which has different effects on decision-making. The capacity of juveniles to plan or to stop an action may be limited by a variety of disabilities, as well as trauma and developmental delay. Working with their lawyers and understanding what is happening in court is also affected by immaturity and how juveniles process information. For every behavior—leading up to and including the delinquent act, waiving rights, and cooperating with counsel—we have to ask, "What is the effect, if any, of disabilities, trauma and immaturity on this behavior by this juvenile?" Age, IQ, and diagnosis tell us little about the young person's capacity to plan and carry out an offense or to participate meaningfully in decisions about their case. Whether the offense is car theft, armed robbery, incest, or homicide and whether he or she is 12 or 17, without a thorough assessment of the unique interweaving of disabilities, trauma and immaturity a young person's intent or competency cannot be determined.

A. DISABILITIES[1]

1. *Problems Processing Information*

About 17-53% of delinquents have learning disabilities, in comparison to 2-10% in the overall child population.[2] Learning disabilities are defined as academic skill problems not due to mental retardation or a vision or hearing defect. Learning disabilities include a variety of problems in listening, thinking, reading, writing, spelling and doing calculations. Learning disabilities include dyslexia and perceptual processing problems, especially phonics, visual discrimination and memory. Children with learning disabilities are typically challenged by digesting information—difficulty in organizing, prioritizing, strategizing, or

presenting material. Children with visual processing problems may not be able to comprehend what is written and have to rely instead on cues from what others say. Children with auditory processing problems may not be able to process what they hear and learn primarily from what they read or observe.

Delinquents "have higher rates of neuropsychological deficits as reflected in language, verbal intelligence, working memory, and reading. Of special interest are deficiencies in 'executive' functions that are served primarily by the frontal lobes of the brain . . . [including] abstract reasoning, goal setting, anticipating and planning, self-monitoring and self-awareness, inhibiting of impulsive behavior, and interrupting and ongoing sequence of behavior in order to initiate a more adaptive behavior."[3]

Problems processing information are the result of faulty receptors, neurotransmitters, and signals between different parts of the brain, but neurological assessment is usually normal. Neuropsychological evaluations and tests for specific learning disabilities can identify the problems a child is having processing information and are usually initiated because the child has poorer achievement than would be expected with his/her intelligence. By the time the learning disability is identified, many children are lacking in basic skills necessary to comprehend schoolwork. Often the learning disabled child gets into a negative cycle with self-dislike and attention-seeking, from feeling stupid, interfering with school participation.[4] Truancy—from feeling picked on by a teacher and embarrassment for not being able to comprehend the material— can begins early in learning disabled children. Special teaching techniques enhance organizational skills, improve the child's processing of information using their strongest method of comprehension, and develop compensatory skills.

Example of a juvenile whose information processing problems affected assisting counsel

A is a 15-year old dyslexic African American who processes information slowly and reads at the second grade level. He is outgoing, so at first his lawyer mistook his cooperation as comprehension. A had digested virtually nothing of what his lawyer had explained during the initial hearings in adult court and was overwhelmed by the publicity surrounding the felony murder by his older brother in which A was the lookout. In trying to understand his thinking at the time of the offense, his lawyer repeatedly rephrased every question to help A provide what was being asked. A has great difficulty with hypotheticals because they require abstract thinking. When asked

what he would have decided himself in a dilemma he described facing his friend, he responded, “I can’t tell you. Not ‘til I’m in the situation myself do I know what I am going to do.” A got frustrated with how difficult it was to imagine something he did not do—he was incapacitated by his concrete thinking. When the expert suggested his lawyer break the alternatives into simple segments and write each one on a card taped to a colored plastic cube and let A move them around as they considered each one, he still was unable to think about more than one block at a time or imagine options in the future.

2. *Fetal Substance Exposure*

Because the brain of the fetus develops throughout pregnancy, many brain changes can result from prenatal drug, alcohol and tobacco use. Typically the delinquent looks normal, but his/her thinking and self-regulation are different. From infancy the prenatally substance exposed child may have difficulty with arousal and attention regulation, getting easily overstimulated, having limited self-calming skills, being disorganized in play and on tasks, and getting quickly frustrated. The child may not learn from experience, repeating the same mistake over and over. He/she may be repeatedly surprised by obvious consequences of actions, sometimes developing what appears to be a habit of Iying to avoid responsibility. The child may be oblivious to simple rules that other children routinely obey, and an inability to comprehend and follow instructions may be significantly delayed. Frustrated families and teachers understandably get increasingly controlling, particularly when behavior modification does not produce improvement. “Time outs” may result in the escalation of the prenatally substance exposed child’s behavior rather than helping him/her calm down. The prenatally substance exposed youngster cannot help being unable to regulate his/her behavior, so the emphasis should be on what the child can do, to use his/her competencies more effectively to reduce brain limitations, with the environment providing effective support for desired behavior. All the adults involved with the prenatally substance exposed delinquent must respond as if he/she were younger than his/her chronological age.

Example of a juvenile whose delay due to fetal substance exposure affected intent

B is a prenatally substance-exposed Hispanic 14-year old with delayed development from his mother’s social drinking during early pregnancy, treated for ADHD and oppositional defiant disorder with no effect because he had an unrecognized disability requiring different interventions. The message B has gotten since age 5 is “You

are bad because you refuse to behave within the rules like other children." The concept behind intervention should instead have been recognizing that his brain had not developed the capacity to comprehend consequences so he was unable to choose to do the right thing that was obvious to other children. B needed, but did not receive, repetitive practice on sequencing (explaining the steps of how things happen), training in stopping to think before acting, and instruction in interpreting social situations. B and a friend were getting high, impulsively took a bike from a youth from another neighborhood, and were charged with assault after the victim was hospitalized. Afterwards B showed no planning of the offense and his comprehension of consequences was so impaired he was still surprised that the victim did not "just walk away with a bloody nose, like on TV."

3. ADD& ADHD

Attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) are the most frequently diagnosed behavior disorders of childhood.[5] About 19-46% of delinquents are diagnosed with attention deficit disorders, in comparison to 2-10% in the overall child population.[6] Attention and concentration difficulties and activity level and high injury rates that do not fit the child's age and that interfere with adjustment at home, school and with friends are typical of children with ADD and ADHD. Distractibility and impulsiveness are prominent characteristics of attention deficit disorders, making these young people less able to stop behaviors, which may contribute to delinquency (especially when they have immature cognitive processes and are unable to see alternative choices at the time of an offense). Both the diagnosis of ADD and ADHD and treatment with stimulants, diet and behavior interventions (contingency management such as point systems and time outs; parent training, and problem-solving strategies and self-talk instruction) remain controversial, in part because of the variety of approaches used by pediatricians, psychiatrists, and teachers. Studies consistently find that medication can reduce distractibility, with little improvement in academic achievement or social skills among children with ADD and ADHD. There is little documentation of effective treatment of the inattentive type of ADD (without hyperactivity, typically with excessive daydreaming), which appears to include a high proportion of girls.

Example of a juvenile whose ADD/ADHD affected assisting counsel

A Caucasian charged with severely injuring a pedestrian by throwing things out a bus window, C just turned 15 and is the most immature youngster his lawyer has ever encountered. In many ways he is functioning like a 12-year old. He restlessly walked around the

> room, chewed on a pen top, drummed on the desk, made special effects noises, went to the bathroom, and was distracted by every noise and passerby outside the interview room. In two hour-long interviews, only about ten minutes of quality interaction occurred. C cannot sit still long enough for his lawyer to finish a sentence, and he is unable to hold his attention even on a discussion of the crime scene which they attempted to draw on a piece of paper together.

4. Low Intelligence

An IQ below 70 and accompanying deficits in adaptive functioning affect the young person's ability to conform to standards of social behavior, daily living skills, and independence expected for his/her age. Individuals with IQs under 70 are a heterogeneous group; mildly mentally retarded children are more similar to peers with normal IQs than to severely retarded children. For example, some young people with IQs in the 60s may have basic reading, writing and money management skills and may live independently and be able to have a job. The measurement of intelligence has been found to have culture bias and is affected by quality of early education. Nonetheless, it is widely assumed that IQ scores predict academic performance and relate to problem-solving skills. Juveniles with low intelligence may not be aware of social expectations that are obvious to children with higher IQs. They often naively do things at others' request to please them, with no idea when and how not to do so. About 7-15% of delinquents are considered mentally retarded, in comparison to 3% or fewer in the overall child population.[7]

Example of a juvenile whose low intelligence affected intent

> D is a 17 year old African American charged as an adult in a drug-related shooting. He has been in a self-contained class and labeled educable mentally retarded, although his current tested IQ is 71 (at age 13 he was reading and doing arithmetic at a third grade level). The baby of the family, he spent all his time with his siblings and cousins and felt taken care of by them. Because of his dependency on others, it is believable when D says he had nothing better to do than ride in the car with his cousins and had no idea the offense was going to occur. He went to the police and still does not understand why they arrested him for being there.

B. TRAUMA

A Trauma typically slows down development in children and, depending on the individual, can interfere with all aspects of the child's functioning. Children who were physically or sexually abused or lost an important person in their lives may be functioning emotionally close to

the age when the trauma occurred. Children who have been exposed to violence repeatedly often have trouble concentrating in school, are fearful, have nightmares an may seem emotionally detached and pessimistic about the future.[8] Children who have been abused or felt their parents did not protect them often blame themselves and have trouble trusting others. Reactions to trauma may significantly interfere with the child's life and put him/her at risk of delinquency, even in children whose symptoms do not meet the criteria for Post Traumatic Stress Disorder.[9] One study found that 32% of delinquents had Post Traumatic Stress Disorder, in comparison to 3% or fewer in the overall child population.[10]

Depression is a common reaction to trauma, but often is not diagnosed in delinquents: usually what is focused on in school and home is their problem behavior rather than their underlying sadness. Depression is associated with self-dislike and distorted thinking.[11] Depressed children appear to have a greater dependence on peers, but being depressed is correlated with teacher and peer ratings of unpopularity.[12] Traumatized children often abuse substances to numb painful feelings and memories.

Aggression can be a defense against the helplessness common among traumatized children. Young people who have been abused often respond self-protectively like younger children when they feel threatened. They may have learned to rely on aggression for resolving disagreements.

Trauma can affect the development of the brain, with a reactive alarm response remaining the child's coping method for every small stress. Because the experience of traumatized children is one of fear, unpredictability and frustration, they may not grow out of primitive reactions such as dissociation or aggression. Traumatized children may not learn to soothe themselves and instead manage their fears with combative self-preservation.

Example of a juvenile whose depression due to trauma affected intent

> E was an immature 16-year old African American who was shocked when her older boyfriend hijacked a car. She is significantly impaired by depression from sexual abuse by her stepfather, her mother's chronic involvement in domestic violence, and her older brother's near-murder and subsequent imprisonment. Although she has a normal IQ, E thinks slowly and takes little initiative. Shy and unpopular, E was grateful for male attention and lacked the self-confidence to stand up to her boyfriend, especially when everything happened so quickly.

Example of a juvenile whose fear response due to trauma affected intent

F was the focus of severe abuse by his father which continued over his early years. F was repeatedly traumatized by loss: he had a strong attachment to his mother, but because of her substance abuse parental rights were terminated, and F, a childish 12-year old African American, has had 18 placements. After years of maltreatment, a reflexive aggressive response remains F's primary method of coping with anxieties and fears. Even with minor provocations in the present, F's hurt and anger from cruelty and loss in the past overwhelm him. He is oversensitive, perceives many people as hostile, lacks the ability to self-soothe, and does not think before he reacts to protects himself. F is being prosecuted for kicking a group home staff member who was physically restraining him. F has not been in a program with well-trained staff who understand traumatized children and make sure they feels fairly treated and not threatened and where de-escalation and avoiding power struggles prevent behavior problems.

Example of a juvenile whose mistrust due to trauma affected assisting counsel

G, a 13-year old African American, is diagnosed with Post-Traumatic Stress Disorder due to her nightmares about abuse and how much her sexualized behavior and oversensitivity to criticism interfere with her daily life. G's aggression generally surfaces when she is told 'No' and when she becomes frustrated with her school work. G has suffered significant losses in her life beginning with her absent father, Jailed and substance addicted mother, her brothers' placement in group care, and G's removal from her grandmother's home and having multiple foster home placements. G operates at the "I want what I want" level of a much younger child, but she does not like to need nurturing from others—consequently, she is irritable and moody. If she does not want to continue talking about a topic, she simply does not respond. She remains angry at her mother and untrusting of others, expecting and sometimes contributing to repeated abandonment. Her lack of trust and swings from dependency to apparent maturity make her a challenging client to represent for sexually molesting another child in her residential program.

C. IMMATURITY[13]

A. *Cognitive Development*

Adolescents think differently from adults. Even late in their teens young people can have immature thought processes, including:

1. Not anticipating

Adolescents often do not plan or do not follow their plan and get caught up in unanticipated event. They usually view as "accidental" the unintended consequences of actions that adults would predict could have a bad outcome. Learning to have a long-term perspective develops slowly. Carrying, and even using, a weapon does not mean that the child pictured an injured victim and intended harm.

2. Fear interferes with the adolescent's ability to make choices.

Decision-making can be very immature when they are scared, particularly if they have been mistreated in the past. A common form of immature cognitive processes in adolescents is reacting to threat that adults might consider exaggerated. Their fear has to be evaluated from the teenager's perspective at the time.

3. Minimizing danger

Risk-taking typical of adolescents reduces their use of mature cognitive strategies—they seldom consider the worst possible outcomes of their actions. Difficulty in managing impulses is a normal characteristic of teenagers. Drugs and alcohol lower inhibitions and reduce the young person's ability to use mature judgment and are a frequent contributor to delinquency.

4. Having only one choice

In situations where adults see several choices, adolescents may believe they have only one option, especially those with disabilities. It is not unusual, even for intelligent adolescents, to imagine only one scenario. When things do not unfold as they imagined, because of their immaturity, they behave as if they are incapable of adapting with another reasonable choice. Adolescents only gradually develop the advanced cognitive ability to weigh alternative choices simultaneously.

Example of a juvenile whose
immature thinking affected intent

At age 15, H, who is Native American, was self-conscious about being 4'9" and 90 pounds. He was the perfect crime partner for adults since storekeepers never suspected he would rob them. Homeless after domestic violence drove his mother and younger

siblings to a shelter, he has the expression of abused children when he recalls the maltreatment of the criminals who took him in: they were always armed, they hit him repeatedly, they shot him with nails from a BB gun, and they picked him up and threw him in the car. He was convinced they would track him down if he escaped. They knew where his mother was and threatened to kill her. He believed their threats because they talked about having shot other people. Terrified, H was coerced into committing offenses they arranged and was unable to see any way out.

Example of a juvenile whose immature thinking affected assisting counsel

J is a 13-year old Asian immigrant who has been picked on for his differentness since he arrived in middle school. He believes in standing up for himself, although he insists he would never start anything, because "You can't let someone bust your nose." When a classmate called his mother a name, J was overheard to threaten him and another child reported it to the principal. J did not intend to harm anyone when he reacted to insults by making a threat. There are no guns in his home, and he did not have a gun or access to one. He reacted reflexively without any thought, plan or intention, which is not surprising given his simplistic thought processes at his age. Like many survivors, J stridently proclaims through his behavior that he can handle everything himself, and he thinks that reliance on others is weak and does not believe adults can help when others persecute him. In adolescents, not taking responsibility for causing an unanticipated consequence does not demonstrate lack of remorse or weak moral values. J does not think the students who heard his threat thought he was serious or were hurt or fearful because of it. If someone was harmed by being scared, he is sorry. He feels considerable shame for what he did, which makes it even harder for him to face that what was unintended could be harmful. His immature thinking makes working with his lawyer difficult because he does not think he should be charged for making a threat that was not threatening and he does not want to accept help.

B. Identity Development

Adolescents gradually refine a stable definition of themselves. Becoming good at something is an essential aspect of identity development. Doing well in school, arts, sports, or a hobby is how adolescents define themselves and feel appreciated by others. Many delinquents have not experienced success, particularly in school.

Belonging to family is the framework for identity and remains powerful for teenagers. Identifying with peers is another important aspect of self- membership is necessary for a young person to feel valued. Lacking stable identities, young people need considerable approval from family and peers. Conflicting identifications—between two groups of peers or between family versus peer expectations may cause unpredictable behavior in a teenager, especially under stress.

Example of a juvenile whose immature identity affected intent

Now 16 and in adult jail for her first arrest, a robbery, K has been on an identity roller coaster that has caused significant delay in her development. She is Caucasian, was raised in an old-fashioned foster home, but remained desperate for acceptance from her biological mother and ran away to her. Her mother disappointed her, they used drugs together, and her mother physically abused her again. K fled and lived under a bridge with a group of runaways who routinely "rolled" (robbed) new arrivals to the street life. She needed to feel she belonged, but afterwards felt remorseful she had gotten intoxicate an followed along. She hoped it was not to late to return to her foster family's values.

Example of a juvenile whose immature identity affected assisting counsel

Although it is not unusual at 16 to rely on parents, L's close relationship to his father who raised him, his unacknowledged sadness from his mother's abandonment, and his uncertain identity because he is biracial combine to make him unable to make important decisions independently. He wants his father or his lawyer to tell him what to do. His depression has increased his desire to please others. He is too immature to face the possible outcomes of a plea or trial—it would be overwhelming emotionally for him to understand that he may spend years in adult prison for a fight, so he blocks out such thoughts. He will do whatever he believes his father wants, and until he matures he will be unable to fully appreciate what he would be giving up in choosing a plea over trial. He cannot assist in his own defense as an adult would— even though his lawyer reviews his choices repeatedly to help him consider options and evaluate issues for himself, L is unable to make well-informed decisions that reflect his own independent choices.[14]

C. Moral Development

Adolescents are moralistic, insisting on what should be and intoler-

ant of anything that seems unfair. They may become involved in offenses naively in order to right wrongs, often out of loyalty. Their insistence on fairness may significantly interfere with working with their lawyers. They may know right from wrong and be frustrated that they cannot explain why they used poor moral reasoning during the offense.

Example of a juvenile whose immature moral reasoning affected assisting counsel

M is a 16-year old Caucasian who spent an evening with his best friend drinking, smoking marijuana and playing like little boys with unloaded guns as if they were toys. Neither he nor their girlfriends, one of whom had passed out, know how one of the guns got loaded. Believing it was unloaded, M pulled the trigger in play and had no idea it would kill his best friend. M cannot concentrate on legal strategy because he gets stuck due to his preoccupation with the unfairness of facing a long adult sentence for what he considers a tragic accident.

These 12 cases illustrate how behavior can be affected by disabilities, trauma and immaturity, demonstrating the importance of careful assessment of the uniqueness of how each delinquent thinks before determining his/her intent and competency to assist counsel

D. ASSESSMENT OF JUVENILE INTENT AND ABILITY TO ASSIST COUNSEL

Traditional competency and mental health evaluations are unlikely to provide a complete assessment of disabilities, trauma and immaturity that contributed to a juvenile's behavior at the time of the offense or his/her ability to participate in decisionmaking about his/her case. Evaluators can be specifically requested to assess disabilities, trauma and immaturity by tailoring the following questions to each juvenile:

1. Does this young person have problems processing information?
    - Listening
    - Organizing, prioritizing, strategizing
    - Reading, writing, spelling or doing calculations
    - Self-dislike and attention-seeking connected to poor performance

2. Does this young person have the symptoms and history of fetal substance exposure?
    - From early childhood difficulty with:

- Attention regulation
- Getting easily overstimulated
- Limited self-calming skills
- Comprehending and following instructions
- Being disorganized in play and on tasks
- Getting quickly frustrated

- Does not learn from experience, repeating the same mistakes
- Surprised by obvious consequences of actions
- Oblivious to simple rules that other children routinely obey
- Stimulant medication does not produce improvement
- Behavior modification does not produce improvement
- Seems younger than his/her chronological age
- What was child's biological parents' alcohol, drug and cigarette use prior to conception and during pregnancy?

3. Does this young person have the symptoms of ADD/ADHD?
   - Attention/concentration difficulties/distractibility for child's age
   - High activity level for child's age
   - Impulsiveness (less able to stop behaviors) for child's age
   - High injury rate for child's age
   - Without hyperactivity, excessive daydreaming for child's age
   - Poor social skills/problems with peers for child's age
   - Has he/she had a diagnosis of ADD and ADHD?
     - When? By whom? Results of treatment?

4. Does this young person have low intelligence?
   - Dates and results of IQ testing, with subtest scores
   - Deficits in adaptive functioning (social behavior, daily living skills, independence, comprehension of others' expectations, indiscriminate compliance to please others)
   - Reading and math grade level

5. Was this young person traumatized?
   - Chronology of physical abuse, sexual abuse, exposure to violence, loss of important individuals, significant failure
     - What are the symptoms remaining from this trauma?
     - Slowed development (specifically what areas?)

    — Trouble concentrating
    — Fearfulness (being on constant alert)
    — Nightmares
    — Emotionally detached/numbing feelings (with substances)
    — Self-dislike
    — Controlling
    — Mistrust of others
    — Irritability
    — Depression/suicidal thinking and behavior
    — Unusual dependence on peers/adults
    — Unpopularity
    — Aggressiveness/belligerent outspokenness ("big mouth")
    — Self-protective when threatened (reactive alarm response)
    — Difficulty self-soothing/self-calming
    — Oversensitive/perceives others as hostile, mean, and unfair
    — When feelings are hurt, flooded with anger from the past out of proportion to the present provocation

6. Does this young person have immature thinking?
   - Difficulty anticipating consequences/planning
   - Childish decision-making when scared
   - Minimizes danger /not recognizing worst possible outcomes
     — Sees only one option
     — Substance abuse?
     — Envisioned having a weapon would cause injury?

7. Does this young person have an immature identity?
   - What is he/she good at?
   - Does he/she have a positive, realistic view of self in the future?
   - Does he/she have a strong sense of belonging to family?
   - Does he/she have strong relationships with positive peers?

8. Does this young person have immature moral reasoning?
   - Moral values, including loyalty as a moral principle
   - Intolerant of unfairness—acts to right wrongs
   - For whom does he/she show empathy?

Evaluators can be asked to give opinions of how disabilities, trauma and immaturity each and in combination may have affected the young person's intent and his/her capacity to assist counsel.[15]

E. CONCLUSION

For young people under 18, determining intent or competency requires a thorough assessment of the possible contribution of disabilities, trauma and immaturity. Behavior by itself tells us so little about capacity that it is likely that two co-defendants of the same age involved in the same offense would have different intent and/or competency, based on their own unique combination of disabilities, trauma and immaturity. Further complicating this complex picture is that many delinquents have more than one of these factors contributing to their intent and/or competency. For example, at the time of the offense the young person may have been unable to comprehend what was happening because of a reaming disability or low intelligence <u>and</u> he/she may have had an immature identity with a history of ridicule and followed peers out of desperation to be accepted.[16]

The court, familiar with mental retardation and mental illness as reasons for incompetency, may be persuaded of impairment only if there is a diagnosis of a severe psychiatric illness, when in fact for children and adolescents it is usually a combination of disabilities, trauma and immaturity that explains his/her capacity to intend an action or to assist counsel. Often factors such as fetal substance exposure and prior abuse or suicidal feelings and immature cognitive processes, especially in combination, are the indicators of the adolescent's poor decision-making, but are either not diagnosed prior to the offense and/or are considered not as severe as impairments generally recognized by the court.

Competency that never existed cannot be restored. If a juvenile has a disability and/or delayed development, until he/she is able to think differently—by compensating for brain problems in processing information, understanding consequences, reacting to threat, developing more maturity in thinking and identity—he/she is unlikely to make better decisions. For the immature juvenile to take responsibility for his/her actions requires learning to anticipate the worst outcome of actions, instruction about having choices and the steps of good decision-making, understanding and resisting peer pressure, having empathy for potential victims, and recognizing how righting wrongs can lead to doing something harmful. For the juvenile with disabilities to take responsibility for his/her actions requires specialized instruction the child can digest, especially on how actions affect others and seeing the sequence of events leading up to harmful acts and imagining how to prevent similar situa-

tions from occurring in the future. To help traumatized juveniles not react reflexively without thinking to threat requires teaching them to be less rejection-sensitive, giving them practice in self-regulation of anger and not using violence to solve problems, and support to make peace with their maltreatment so they are not flooded by anger from hurt in the past. Fortunately, adolescents have strengths to build on, so when services are designed specifically to meet the needs stemming from disabilities, trauma and immaturity, they are malleable enough to become non-criminal adults.

ENDNOTES

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Kazdin, op cit, p. 53. See also Pennington, B.F. and S. Ozonoff, "Executive Functions and Developmental Psychopathology," J CHILD PSYCHOL PSYCHIATRY, 37:51-87, 1996.

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For example, in a case where depression compromised a juvenile's capacity to make reasonable judgments and he frightened many children because he had a weapon which he intended to use to harm himself, the judge concluded, "The Court finds the statutory mitigating factor of reduced culpability based on substantial depression is present in this case . . . there was serious depression. There were serious stressors . . . [his] thought processes were quite irrational . . . There was no treatment in response to cries for help."

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Adolescent development is not a smooth linear progression—there are maturity differences between individuals of the same age and within the particular child. Immaturity that affects decision-making is typically not uncovered in traditional diagnostic assessment.

In a unique competency hearing in adult court, this 16-year's lawyer argued that although he is depressed, he "does not suffer from this condition to an extent that would be likely to render him incompetent to stand trial if he were an adult. The fact that he is an emotionally immature adolescent with a history of unresolved abandonment issues, however, compounds his condition in a manner that renders him unable to aid and assist counsel in a fair criminal trial process. In presenting this argument, the defense does not advance the position that all adolescents are incompetent to stand trial by virtue of immaturity, or that a simplistic additive calculation of one psychological diagnosis plus a certain developmental level equals incompetence. The calculation is complex and unique for each case. The court must decide whether this defendant is competent to participate meaningfully in the particular prosecution that he faces. Accordingly, the court must consider the unique confluence of factors that [his] level of emotional immaturity, history, and psychological profile create when inserted into the context of a high-stakes, complex [adult] trial process that demands significant and informed participation in order to avoid violations of due process . . . [His] desire to please his father and his lawyer, coupled with an inability to weigh alternatives that are before him in the process that determines whether he will negotiate a plea or proceed to trial, render him a reed that bends to the wind that is the will of his father and lawyer—this despite any and all attempts by either or both to remain neutral when such choices must be made. [He] has no independent will or opinion on these and other crucial decisions that he must make . . . While such overarching trust in authoritative adults may be not only normal but salutary in other contexts, it is not an acceptable substitute for the sort of knowing and intelligent choices that are required of [him] as a competent criminal defendant. Indeed, [his] obeisance to the will and/or opinions of his attorney render the agency that is the basis of the attorney/client relationship impossible."

Sometimes the young person has had a head injury or has a seizure disorder that has not been diagnosed. The evaluator may recommend neuropsychological testing, brain imaging, and/or other specialized assessment of the juvenile.

See Beyer, Marty, “Punishing Children for their Disabilities,” *Children’s Legal Rights Journal*, in press, for a discussion of capacity, giving the example of a child whose aggressive reaction to being restrained in her special education classroom was the result of a combination of Post- Trauma Stress Disorder and prenatal substance exposure.