Juvenile delinquency continues to impact society in a number of problematic ways. Stouthamer-Loeber, Loeber, & Thomas (1992) report that as much as half of all juvenile referrals to community mental health agencies and one quarter of all special services in schools are a result of disruptive and delinquent child behavior. In addition, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) report that in 1999 law enforcement agencies across the United States made an estimated 2.5 million arrests of persons under the age of 18.

Theorists and researchers alike contend that youth are influenced at all ecological levels (i.e., community, school, neighborhood, peers, family, and individual characteristics, however recent studies have focused on the impact of family environment and individual characteristics. These studies have demonstrated that maladaptive family environments are significant factors in the development and maintenance of delinquent behavior and that individual characteristics such as self-esteem play an important role in the way that delinquent activity is expressed (McMahon & Estes, 1997).

The large volume of literature on juvenile delinquency has concentrated on individual experiences and characteristics in relation to offending patterns (i.e., violent vs. non-violent; adolescent vs. life-course persistent), rather than investigating individual differences in clinical functioning among youth labeled as delinquent. The
The present study examines the psychological functioning of these young people and identifies differences in clinical profiles that are likely to improve assessment techniques and intervention efforts. In addition to identifying clinical profiles, the study investigates differences in self-reports of child abuse, family discord and measures of self-esteem among the profiles.

Participants in the study are 916 youth (55% male and 45% female), between the ages of 12 and 18, who were referred for evaluation by the juvenile court. These youth completed the Millon Adolescent Clinical Inventory (MACI) as part of their evaluation. Cluster analysis conducted on MACI Clinical Scales (i.e., Delinquent Predisposition, Impulsive Propensity, Substance Abuse Proneness, Anxious Feelings, Depressive Affect, Eating Dysfunction, and Suicidal Tendency) identified three distinct profiles. Group 1 (n = 265) can be characterized as high in Impulsive Propensity, Delinquent Predisposition, and Substance Abuse Proneness. Group 2 (n = 243) scored higher on internalizing behaviors such as Depressive Affect, Suicidal Tendency, and Eating Dysfunctions and Group 3 (n = 408) can be characterized by high scores on Anxious Feelings measures and low scores on Impulsive Propensity and Substance Abuse Proneness. Group 3 also tended to be older than the other two groups.

ANOVA analyses found significant differences among the groups on MACI Clinical Scales and measures of poor self-esteem (i.e., MACI subscales Self-Demeaning, Self-Devaluation, Introverted, Inhibited, and Debasement) and MACI subscales Childhood Abuse and Family Discord. The group scoring significantly higher on internalizing
behaviors (Group 2) scored significantly higher on child abuse, family discord and poor self-esteem subscales than the other two groups.

These findings carry with them implications for assessment and intervention strategies as they make clear the need to include measures of psychological functioning and child maltreatment when evaluating youth involved in delinquent activity and to base treatment goals on individual clinical profiles.
References


