A review and discussion of three articles concerning young offenders.

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Introduction.

A review of three articles regarding was undertaken. The main areas that were looked at was the role of empathy in young sex offenders, the psychological health and bullying behaviour of young offenders and the psychological needs of young offenders from an inner city area. The various type and definitions of empathy are discussed along with the causes and consequences of any empathic deficiencies. A study into the role of bullying in prisons amongst young offenders and the effect it has on young offenders

There is an inconsistency in the definition of empathy with the majority of the research in the area of general empathy. While there have been a number of theories put forward to define general empathy there has been suggestion that the sub categories of victim and victim-specific empathy (or lack thereof) also exist. The role of empathy has been hypothesized as being to prevent ongoing harmful behaviour towards a person in distress, therefore failure to recognize this distress would facilitate harmful behaviour (Marshall et al 1995). Victim empathy deficits in sexual behaviour and considered to be empathy deficits for specific classes of potential victims. This empathy deficit would relate to a general type of victim e.g. women, children, race etc but not to the general population as a whole. Victim-specific empathy deficits are considered to be empathy deficits for the offenders own specific victim. In this case the offender might have empathy for children as a whole but totally lacks empathy for there own victim as a person. There has been suggestion that this may be brought about by a cognitive distortion in the offenders thinking that allows them to commit the offence in the belief that their victim did not come to any harm and may in fact have "enjoyed" the experience. Another factor in this cognitive distortion may be in the influence of the media in sexualising children however, more research would have to be carried out in his area (Fisher, Beech, Browne 1999)

It is generally believed that sexual offenders are deficient in empathy (Freeman-Longo, Bird, Stevenson & Fiske, 1995). Some of the key background factors of these offenders are a dysfunctional family life characterised by poor communication and role modelling. Factors such as physical and domestic violence (especially where weapons are involved), substance abuse and poor academic performance can lead to aggressive sexual behaviour being seen as acceptable. This environment may contribute to offending as a learned behaviour or to a lowering of self esteem due to parental rejection that the offender seeks to address through offending. Rationalisation and minimising coping strategies are used to counter victim suffering. Offenders tend to be more assaultive, more isolated and more resentful than non

sexual offenders. They have greater anxiety levels and find it harder to develop bonds within their peer groups.

A major problem when assessing the literature is that many studies utilized a small sample, and very few studies replicate the measures used by others (Vizard, Monck & Misch, 1995).Varker et al (2008) felt that there was a gap in the research in this area and proposed that further research into adolescent offenders would be fruitful . The authors found for instance that the only study that specifically tackled the area of victim-specific empathy in adolescent sex offenders was a study by Curwen in 2003. A further problem identified is the disparity between methods, subjects and cultures where these studies were carried out. A significant amount of these studies come from the US as opposed to the UK and Australia. The different treatment programs and criminal procedures between countries may make a study in one country less relevant to another.

Varker, Devilly, Ward & Beech 2008 conclude by noting that adolescent offenders are a distinct group from juvenile offenders. They propose that more research in the area should be carried out with measures that are more specifically designed to be adolescent orientated. As most therapeutical programs define empathy development as a core treatment goal, this is an important issue.

When offenders are incarcerated they find themselves in an environment that depends on power and dominance as part of the social structure and this can lead to bullying as a form of exercising this power (Palmer and Farmer 2002). This bullying may come in direct form such as physical assault, intimidation and verbal abuse (Ireland 1997). More covert forms of bullying would include rumour spreading, ostracizing and gossiping (Ireland and Archer, 1996). Research into the effects of this behaviour has showed a correlation between increased bullying and poor psychological health. As a result there was an increased symptom's of depression, anxiety, insomnia and suicidal ideation. There was also a marked increase of self harm and in comparison to non incarcerated offenders. Females showed higher scores on psychosomatic scales measuiring symptoms of headaches, stomach aches and dizziness (Forero et al 1999).

In studying young and juvenile offenders Ireland used the *Direct and Indirect Prisoner behaviour Checklist-Revised* (DIPC-R) (Ireland, 2002). The DIPC-R is used to measure behaviours that are indicative of bullying. It is left to the researcher to interpret the results as the term ”bullying” is not actually used in the interview. The reason for this is that the term “bully” is an emotive label that could lead to a biased result. People do not want to be seen as a bully or to be labelled as a victim. This is especially true in a prison setting where perception that you are a victim is a sign of a weakness and can lead to further victimization. Another aspect is that aggressive behaviours are perceived as being a normal part of prison life and so may not be seen

as bullying unless those behaviours become extreme in their nature (Palmer and Farmer 2002). The *General health Questionnaire* (Goldberg and Hillier, 1979) was also used to measure somatic symptoms such as anxiety and insomnia, social dysfunction and severe depression.

The results of this research showed that victims of bullying showed increased psychological problems with anxiety, depression and insomnia being the most significant. While these symptoms were common to all victims, those who were pure victims alone and who did not engage in bullying behaviour themselves suffered additional social dysfunction. Subjects who were pure bullies and those not involved were found to be in much better psychological health.

One of the problems with the study was the fact that it does not determine whether poor psychological health was present before or after bullying behaviour was reported. The DIPC-R measures the tendency to bully or be bullied and it is up to the researcher to categorize subjects into the various categories. The author notes that only through longitudinal research can the full impact of bullying be assessed.

Young offenders in an inner city environment are at increased risk of health and psychological problems. Substance abuse, mental health, poor academic performance and riskier sex practises are all common traits within this group. Mental health problems have included depression, anxiety, Post Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder.

A sample of 52 young offenders and 86 non offenders were surveyed. All were from the same geographical area and gave a broad representation of the general population. The *Psychosocial Assessment for Young People and Children* (PAYC) (Attride-Stirling et al, 2000) was used to assess the psychosocial and health problems of the subjects. The PAYC is a semi structured interview that looks at 53 psychosocial and 44 risk factors. For this study the PAYC was shortened so as to keep young offenders interested without losing coverage of the areas being studied. In the community sample the questions were altered to remove areas that would have been more relevant to younger children and expanded in areas the areas of sexual behaviour. Questions from the *Salford Needs Assessment Schedule for Adolescents* (Kroll et al 1999) were also included.

The methods used in the survey allowed for a direct comparison between young offenders and non-offenders growing up in the same inner city areas. A greater proportion of young offenders reported clinically significant, impairing levels of depression/misery, worry, and problematic substance use than adolescents in the community sample in the three months prior to the interview, and markedly higher life-time rates of head injury (Carswell et al 2004). This would appear to show that young offenders were at increased risk of behavioural problems in comparison to non-offenders. The author does note however, that because of the small sample size a

larger study would need to be carried out so as to ascertain how imprisonment affects these elevated problem rates.

Another result of the study was the increased amount of problems correlating with increased amount of convictions. This was especially true of offenders that were involved with violent offences (Carswell at al 2004). While this study looked at inner city areas, further research was proposed to look at rural settings as problem rates of psychosocial difficulties tend to be lower in these areas (Rutter et al, 1998). The study highlighted the need for ongoing mental screening for young offenders both before and after being placed in custody. In acknowledging the fact that mental health services are already overstretched (Audit Commission 1999); it was proposed that Youth Offending Team's would include mental health specialists. Their role would be envisaged as providing direct contact with young offenders as well as a training, consulting and supervisory role with other members of the YOT. This would allow for a much wider provision of mental health care within the existing resources available.

When looking at young offenders the mental health and social/familial backgrounds are prime factors in both the etiology of the offence and the treatment of it. A dysfunctional family background can lead to a distorted set of social skills and an inability to interact with peers and society in a normative way. A Meta analysis of young sex offenders has shown that coming from a single parent background as a result of divorce, separation or death was prevalent in just under half the cases dealt with (Graves et al, 1996). Children from family systems that show disparency's in cohesiveness and adaptability may also use the offence as a misplaced means to unite the family unit or seek help for other familial problems e.g. substance abuse (Bischof, Stith, Wilson 1992)
Where family units break down, the adolescent may seek support through their peers which can often lead to gang membership either formally or informally. Either way these gangs will normally be lead by a delinquent teen which increases the danger of offending. Once an offence is committed and detected, the teen tends to be labelled, first by society, then by them and without proper intervention this will only lead to a cycle of offending and retribution.

The mental health of the teen is also a major issue. Over 56% of remand young prisoners in the UK have a diagnosable mental illness and substance abuse was also common in this group (Stellar, Thomason, Churchyard, 2003). There is an acknowledged link between the onset and increase of mental health issues when combined with substances such as alcohol or cannabis for example. All three papers reviewed showed respondents with increased symptoms of depression, anxiety, insomnia as well as other mental health issues. Where the offender was incarcerated these issues continued due to bullying within the prison system.

When these areas are combined the lack of empathy, substance abuse, bullying and delinquent behaviour all point towards Conduct Disorder (Searight, Rotnek & Abby 2001). Approximately 16% of boys and 9% of girls show symptoms of this disorder in the general population. (Searight, Rotnek & Abby 2001). However the fact that 21% of the prison population and 50% of residential homes report bullying (C.P Monks et al 2009), along with figures mentioned for mental illness would suggest that there is a higher proportion of inmates incarcerated with this disorder. Figures for Antisocial Personality Disorder in prisons average at 47% (Fazel & Danesh 2002). As Conduct Disorder is closely related to APSD this must give cause for concern.

Conclusion.

As mentioned previously the small size or lack of research in these areas is of concern as the issue of young offenders and conduct disorder should be treated with more gravitas. While there is much research done in the area of the general prison population and their backgrounds there is a far lesser amount done into young offenders. This research is also s lot more relevant to some countries and does not take into account cultural, social and sexual mores that can be different in other countries. Conventional wisdom would surmise that tackling social and mental health issues at source would be a much wiser view than trying to treat an offender after the event. The lack of mental health services in the community for first time offenders as highlighted is something that should be urgently addressed. Preventative measures tackling the causes of young offending would be far cheaper in the long run than dealing with an offender through either the juvenile or adult judicial system. Core issues such as social housing, education and employment are often identified as contributory factors in minimising young offending. Indeed adults displaying symptoms of Antisocial Personality Disorder are more frequently found when there are deficits in these factors, Staunton (2011). Where these conditions exist they can act as stressors which can in turn lead to a dysfunctional life. The children brought up in these homes where one or more parents have ASPD may lack discipline or suffer random or harsh punishment. They lack emotional support for their parents, have less attachment or acceptance (Staunton 2011). These in turn lead to the very traits that can affect the child in such a way so as to precipitate conduct disorder and so the cycle begins all over.

As stated earlier adolescents who do not have a cohesive family unit to bond with may seek out other “families” such as gangs or substance abuse. In the case of gangs, the “love”, safety and feeling of attachment that that adolescent could not get at home is provided by the other gang members. While a gang in a rural area may be the local sports club or other worthwhile activity, youth’s in inner city areas generally lack these facilities and the gang takes on a more delinquent role. Where a youth may never before have gotten into trouble before, by joining a gang they immediately expose themselves to an environment that leaves them open conflict with the law. Just

by being in a gang the member automatically becomes labelled and it is very hard for them to break free of this labelling and indeed the gang it's self. Substance abusers tend to be drawn together as a result of their abusing. A bar or a house becomes a home or a place of safety; their fellow abusers become substitutes for the family unit. While the substance abuse may offer a short term escape from reality, the long term affects, especially where a mental health problem exists can be devastating.

The early identification and treatment of mental health and social issues should be seen as a priority in dealing with juvenile delinquency. There is a need for a streamlining of services so that juveniles do not fall between the cracks as so often happens when there are too many bodies working independently towards the same goal. By including mental health services in all aspects of dealing with juveniles such as social work, youth work and judicial services there will be a much better chance of preventing offending in the first place or combating recidivism after an offence has taken place.

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