Dicle Tıp Dergisi / Dicle Med J (2024) 51 (1) : 36-45

www.diclemedj.org

Original Article / Özgün Araştırma

Sociodemographic and Clinical Characteristics of Delinquent Children and Factors Associated with Recidivism

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Received: *24.11.2023;* ***Revised:*** *15.02.2024;* ***Accepted:*** *16.02.2024*

Abstract

Introduction: Many studies have shown that the prevalence and rate of delinquency in adolescents tends to increase during adolescence and decreases rapidly from the 20s to the early 30s. Juvenile delinquency is considered as a serious social problem because it is often occurs at a young age, is repeated and is often committed as a group. In this study, we aimed to investigate the demographic and clinical characteristics of children between the ages of 12 and 18 who engage in delinquent behavior and the factors that contribute to recidivism.

Methods: Children between the ages of 12 and 18 who were referred by the judicial authorities for alleged crimes were included in the study. The files of the children were reviewed retrospectively. Age, gender, psychiatric diagnoses, types of crimes, intelligence levels, family history of crime, number of crimes were evaluated and the factors associated with recidivism behaviors were investigated.

Results: A total of 91 children referred by the judicial authorities to the outpatient clinic for child and adolescent psychiatry were included in the study. The average age of the children at the time of the offense was 14.10±1.25 years and 87 (95.6%) were boys and 4 (4.4%) were girls. At least one active psychopathology was found in 38 (41.8%) of the cases. The most frequent psychiatric disorders among the psychopathologies during the study were attention deficit hyperactivity disorder in 19 (50.0%) children and conduct disorder in 17 (44.7%) children. The presence of a family criminal history ($p=0.024$), school attendance ($p<0.001$), parental employment status ($p=0.024$), lifetime use of tobacco, alcohol and drugs ($p=0.005$), the presence of peers involved in criminal offenses ($p=0.011$) and the presence of a psychiatric disorder ($p<0.001$) in the child were found to be associated with recidivism.

Conclusion: Risk factors associated with delinquent behavior in childhood are also among the important risk factors for recidivism. Although the male gender has a higher risk for delinquent behavior, there are many individual, environmental, and familial factors that contribute to such behavior, such as psychiatric disorders, a family history of crime, peer environment, and dropping out of school.

Keywords: adolescent, juvenile delinquency, recidivism, risk factors

DOI: 10.5798/dicletip.1451488

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Suça Sürüklenen Çocukların Sosyodemografik, Klinik Özellikleri ve Tekrarlayıcı Suç İşleme Davranışı ile ilişkili Faktörler

Öz

Giriş: Yapılan birçok araştırma gençlik döneminde suç işleme prevalansının ve oranının ergenlik dönemine geçiş ile birlikte artış eğiliminde olduğunu ve 20'li yaşlardan 30'lu yaşların başına kadar hızla azaldığını ortaya koymuştur. Çocuk suçluluğu; eylemlerinin sıklıkla genç yaşta ortaya çıkması, tekrarlanması ve sıklıkla bir grup olarak işlenmesi nedeniyle ciddi bir sosyal sorun olarak kabul edilmektedir. Bu çalışmada suç işleme davranışları sergileyen 12-18 yaş arasındaki çocukların demografik ve klinik özellikleri ile suçun tekrarlanmasına neden olan etkenlerin araştırılması amaçlanmıştır.

Yöntemler: Çalışmaya adli makamlar tarafından işlediği iddia edilen suçlarla ilgili yönlendirilen 12-18 yaş arasındaki çocuklar alınmıştır. Çocukların dosyaları retrospektif olarak taranmıştır. Çalışmada yer alan olguların yaş, cinsiyet, psikiyatrik tanıları, suç tipleri, zeka düzeyleri, ailede suç işleme öyküleri, suç sayıları değerlendirilmiş ve tekrarlayıcı suç işleme davranışları ile ilişkili etkenler analiz edilmiştir.

Bulgular: Çalışmaya çocuk ve ergen psikiyatri polikliniğine adli makamlar tarafından yönlendirilen toplam 91 çocuk dahil edilmiştir. Çocukların suç işleme tarihinde yaş ortalaması 14.10±1.25'ti ve 87'si (%95,6) erkek, 4'ü (%4,4) kız olgulardan oluşmuştur. Olguların 38'inde (%41,8) en az bir aktif psikopatoloji saptanmıştır. Değerlendirme sırasında psikopatolojiler içerisinde en sık saptanan psikiyatrik bozukluklar sırasıyla; 19 (%50,0) çocukta dikkat eksikliği hiperaktivite bozukluğu ve 17 (%44,7) çocukta davranım bozukluğu olmuştur. Ailede suç öyküsünün varlığı (p=0.024), eğitime devam durumu (p<0.001), ebeveynlerin iş durumu (p=0.024), yaşam boyunca sigara, alkol, madde kullanım öyküsü (p=0.005), suça ortak akranlarının olması (p=0.011) ve çocukta psikiyatrik bozukluğun varlığı (p<0.001) suçun tekrarlayıcılığı ile ilişkili bulunmuştur.

Sonuç: Çocukluk çağı suç işleme davranışları ile bağlantılı risk etkenleri aynı zamanda tekrarlayıcı suç işleme davranışları için de önemli risk etkenleridir. Suç işleme davranışları açısından erkek cinsiyette olmak riski yükseltmekle birlikte bu tür davranışların riskini arttıran etkenler arasında psikiyatrik bozukluklar, ailede suç öyküsü, akran çevresi, okulu bırakmış olma gibi birçok bireysel, çevresel ve ailesel etkenler de bulunmaktadır.

Anahtar kelimeler: ergen, çocuk suçluluğu, tekrarlayıcı suç, risk faktörleri.

INTRODUCTION

Adolescence is a transitional period in which young people try to adapt to many changes and are prone to risky behavior due to their social, hormonal, cognitive and neurobiological immaturity. For this reason, a high rate of criminal behavior is observed during adolescence. For this reason, criminal behavior is particularly common in adolescence[1]. Juvenile delinquency is a term often used in academic literature to refer to a young person who has committed a criminal offense, although the exact definition may vary depending on local laws[2]. Juvenile delinquency is recognized as a serious social problem, as crimes are often committed at a young age, are repetitive and are often committed as a group. A number of reasons have been identified that contribute to juvenile delinquency, including economic reasons, revenge, curiosity, impulsivity, random events, dissatisfaction with reality and inattention[3]. While minor delinquent behavior in adolescence may appear to be normative and transient, a subset of later offenders exhibits a serious and persistent pattern of delinquency that begins in childhood[4].

It is harmful to society and to the person's own life when a child exhibits delinquent or antisocial behavior. Delinquency is the result of a variety of factors that interact in complex ways to produce the resulting aggressive actions. There are two widely accepted views on the cause of juvenile delinquency. Primary causes include biological and psychological factors and secondary causes include social and environmental factors[5]. Recent research has shown that severe antisocial behavior occurs primarily in young males and that early onset of such behavior increases the risk of lifelong persistence. While many young people are occasionally involved in antisocial or illegal

activities, only a small minority commit serious crimes on a sustained basis. However, this small minority accounts for a significant proportion of the crimes committed[6]. Adolescents involved in crime are more likely to suffer from substance abuse and occupational difficulties as adults, due to the increased risk of delinquency[4]. Population-based surveys conducted in many countries and at different times show that the prevalence and rate of delinquency among young people tends to increase during their teenage years and then declines rapidly from the 20s to the early 30s[5,7]. It is reported that the number of children driven to delinquency has increased in recent years in our country and the number of children driven to delinquency referred to hospitals for forensic evaluation has increased[8]. Mental disorders such as attention deficit hyperactivity disorder (ADHD), conduct disorder (CD), parents' educational attitudes, the child's school attendance, the child's harmony with peers, the child's compliance with rules at home and at school, and the presence of peers with antisocial behavior in the environment are among the factors that influence delinquent behavior in children[1,9]. Studies of youth who are driven to delinquency consistently report a higher prevalence of psychiatric disorders than in the general youth population and that youth who are driven to delinquency have more severe psychiatric disorders[2]. In addition, family factors such as parental substance abuse, maternal mental health problems, failure of parental control or supervision, parental conflict, domestic violence and antisocial peers are among the risk variables that have a cumulative effect on the onset and continuation of juvenile delinquency[10].

This study examined sociodemographic characteristics, type of delinquency, comorbid psychiatric diagnoses and factors associated with recidivism. It was conducted on children referred from forensic departments to the child and adolescent psychiatric outpatient clinic of a university hospital.

METHODS

Participants

All cases aged 12-18 years referred to the ''Dicle University Faculty of Medicine, Child Psychiatry Outpatient Clinic'' between October 15, 2021 and October 15, 2022 for forensic psychiatric evaluation in connection with crimes allegedly committed by judicial authorities were included in the study. The files of 97 cases referred during this period were retrospectively scanned and 91 cases were included in the study as the data of six cases were incomplete. The psychiatric examination of all cases referred to our clinic for forensic psychiatric assessment is primarily carried out by a research assistant. During the psychiatric evaluation of the case, a socio-demographic questionnaire is filled out, which contains the socio-demographic and clinical characteristics of the case and is used in our clinic. In all cases referred to our clinic, an intelligence test (Kent E.G.Y.) is requested and a forensic psychiatric report is prepared after the case is re-evaluated with the faculty member in charge of the clinic. The patient's intelligence level is determined on the basis of the psychometric test, clinical assessment and medical history. The current psychiatric diagnoses of the cases were based on the DSM-5 diagnostic criteria[11]. Approval for the study was obtained from the local ethics committee (dated 14/10/2022 and numbered 257) and the study was conducted in accordance with the ethical standards of the Declaration of Helsinki.

Sociodemographic Data Form

Age at presentation to the clinic, gender, education level, presence of chronic medical conditions, age of parents, occupational status of parents, number of siblings, presence of psychiatric disorders in the family, family history of delinquency, age at time of delinquency, type of delinquency, and total

number of offenses is asked in this form. This is a researcher-generated form that is routinely completed for all referred cases. It includes demographic and clinical characteristics, such as a history leading to offending, smoking, alcohol/substance use or history, history of psychiatric diagnoses and treatment, current psychiatric diagnosis, and intelligence level.

Statistical Analysis

In the statistical analysis of the data obtained, the data obtained by measurement are expressed as arithmetic mean ± standard deviation; the data obtained by counting (categorical) are expressed as percentage (%) and number. The 2x2 chi-square test was used to compare categorically coded qualitative data (e.g., school attendance yes/no; history of delinquency yes/no; history of alcohol/substance/cigarette use yes/no) between two groups (e.g., between the single crime and recidivism groups). Cramér's V test was used to determine the strength of the relationship between the qualitative variables and the Phi coefficient was found. All data were analyzed using the program SPSS (The Statistical Package for Social Sciences) 23.0 and $p < 0.05$ was considered statistically significant.

RESULTS

Demographic Characteristics

The mean age of the children in the study at the time of referral was 15.6±1.5 years. 87 (95.6%) of the children were male and 4 (4.4%) were female. The average age of the children at the time of juvenile delinquency was 14.10±1.25 years. At the time of the study, only 42 (46.2%) of the children were attending school, while 49 (53.8%) children were not currently attending school. Of the children who were not attending school, 26 (53.1%) had dropped out the middle school, 10 (20.4%) the high school and 7 (14.3%) the elementary school. Six (12.2%) children had never started formal education. The average age of the children's mothers and fathers was 42.12±6.36 and 46.83±7.43 years respectively. When analyzing the educational level of the children's parents, it was found that 56 (61.5%) of the mothers had never attended school, 21 (23.1%) had completed primary school, 11 (12.1%) had completed middle school, 2 (2.2%) had completed high school and 1 (1.1%) had completed college. Of the fathers, 45 (49.5%) had completed primary school, 24 (26.4%) had never attended school, 9 (9.9%) had completed middle school, 8 (8.8%) had completed high school and 5 (5.5%) had completed college. When the occupational status of the parents was evaluated, 74 (81.3%) of the fathers were employed, while only 10 (11.0%) of the mothers were actively working. The mother of 2 (2.2%) and the father of 2 (2.2%) children were deceased. The mean number of siblings was 5.42±2.02 (min=1, max=13). It was found that 80 (87.9%) children had no chronic disease and 11 (12.1%) children had a chronic disease.

Characteristics of the Crime

The average age of the children at the time of the crime was 14.10±1.25 years. 69 (75.8%) of the children were referred for investigation for a single crime and 22 (24.2%) were referred for investigation for more than one crime. 62 (68.1%) children had not committed a similar crime, while 29 (31.9%) children had committed a similar crime (similar to the offense committed before). Forty-eight (52.7%) of the children were allegedly driven to commit the alleged crime together with others, while 43 (47.3%) children were alleged to have committed the crime alone. 15 (16.5%) of the children had a criminal history with their first-degree relatives (mother, father, siblings). The most common types of crimes requested for assessment were theft in 33 (36.3%) cases, assault in 16 (17.6%) cases, violation of the inviolability of the home and workplace in 16 (17.6%) cases, and sexual abuse in 15 (16.5%) cases, respectively. Fifteen (100.0%) of the

children reported for sexual abuse were also male. The number of children with recurrent crimes was 36 (39.6%) and the number of children with a single offense was 55 (60.4%) (Table I). Of the children with repeat offenses, 97.2% were male.

Table I: Children's crime types

Types of crime	Single crime (n=55)(n/%)	Recidivism (n=36)(n/%)
Theft	10 (11.0%)	23 (25.2%)
Injury	14 (15.3%)	2 (2.2%)
Violation of the inviolability of home and workplace	7 (7.7%)	9 (9.9%)
Sexual abuse	12 (13.2%)	3 (3.3%)
Terrorism-related crimes (membership, making propaganda, etc.)	8 (8.8%)	2 (2.2%)
Damage to property	5 (5.5%)	4 (4.4%)
Carrying weapons and ammunition without a license	3 (3.3%)	1 (1.1%)
Purchase and possession of narcotic drugs	2 (2.2%)	1 (1.1%)
Compromising security	1 (1.1%)	2 (2.2%)
Deprivation of liberty of the person	1 (1.1%)	-
Crime of fabricating a crime	1 (1.1%)	-
Cannabis cultivation for commercial purposes	1 (1.1%)	-
Entering a military restricted area	-	1 (1.1%)
Enabling prisoners to escape	-	1 (1.1%)

** Some children were referred for more than one criminal offense.*

Clinical features

It was found that 27 (29.7%) of the children referred for assessment had previously applied for psychiatric help and 13 (14.3%) of these children were taking psychiatric medication at the time of assessment. It was found that 80 (87.9%) of the children had normal intelligence, 7 (7.7%) had mental retardation and 4 (4.4%) had borderline intelligence. Mental status examination of the children revealed that 38 (41.8%) had active psychiatric disorders, while 53 (58.2%) had no active psychiatric disorder. Of the 38 patients with psychiatric disorders, 22 (57.9%) had more than one psychiatric disorder. The most common psychopathologies were ADHD in 19 (20.9%), CD in 17 (18.7%) and substance use disorder (SUD) in 9 (9.9%) cases (Table II). 41 (45.1%) children smoked cigarettes and 8 (8.8%) children consumed alcohol. None of the children who consumed alcohol consumed alcohol at a level that would warrant a diagnosis of alcohol use disorder. Although 16 (17.6%) children had used substances at least once in their lifetime, 9 (9.9%) children were currently diagnosed with SUD.

Table II: Psychiatric diagnoses

DIAGNOSIS	N (%)*
Attention Deficit Hyperactivity Disorder	19 (20.9%)
Conduct disorder	17 (18.7)
Substance use disorder	9 (9.9%)
Mental retardation	7 (7.7%)
Specific learning disorder	5 (5.5%)
Borderline intelligence	4 (4.4%)
Major depression	3 (3.3%)
Schizophrenia	2 (2.2%)
Post-traumatic stress disorder	1 (1.1%)
Kleptomania	1 (1.1%)
Articulation disorder	1 (1.1%)
Sleepwalking	1 (1.1%)

**Shows the distribution of diagnoses across all children. Some children received more than one diagnosis.*

Factors associated with recidivism

The relationship between gender and recidivism was analyzed by Chi-square test and no significant difference was found (p=1.000). No significant difference was found between the number of siblings of children with a single offense and children with recurrent offenses (p=0.670, Z=-426).Family history of crime, school attendance, employment status of parents, lifetime history of smoking, alcohol and substance use, presence of peers who were involved in crime and presence of psychiatric disorder in the child were found to be associated with recidivism (p<0.05) (Table III).

Table III: Factors associated with recidivism

Feature	Single crime (n=55) (n/%)	Recidivism (n=36) (n/%)	p value*	Phi coefficient
Family history of crime (present/absent)	5 (9.1%)/50 (90.9%)	10 (27.8%)/26(72.2%)	**0.024**	0.246
School attendance (yes/no)	35 (63.6%)/20(36.4%)	7 (19.4%)/29(80.6%)	**<0.001**	0.433
At least one parent is working (yes/no)	50 (90.9%)/5 (9.1%)	26 (72.2%)/10(27.8%)	**0.024**	0.246
Parental psychiatric illness (present/absent)	8 (14.5%)/47 (85.5%)	6 (16.7%)/30(83.3%)	0.776	0.029
History of smoking (yes/no)	19(%34.5%)/36(65.5%)	22 (61.1%)/14(38.9%)	**0.018**	0.261
History of alcohol use	1 (1.8%)/54 (98.2%)	7 (19.4)/29 (80.6%)	**0.006**	0.304
History of substance use (yes/no)	3 (5.5%)/52 (94.5%)	13 (36.1%)/23 (63.9%)	**<0.001**	0.394
Substance/cigarette/alcohol (history of use of at least one)	18 (32.7%)/37 (67.3%)	23 (63.9%)/13 (36.1%)	**0.005**	0.306
Presence of peers in complicity with the crime (present/absent)	23 (41.8%)/ 32 (58.2%)	25 (69.4%) /11 (30.6%)	**0.011**	0.271
Psychiatric disorder in the child (present/absent)	13 (23.6%)/42 (76.4%)	25 (69.4%)/11 (30.6%)	**<0.001**	0.454

** Chi-square test was applied*

DISCUSSION

The problem of juvenile delinquency is a social problem that has attracted a great deal of attention worldwide and is also a public health problem. Most young people who engage in antisocial behavior and/or delinquency have a number of interrelated risk factors that encourage or cause such behavior[12].In this study, we found that a significant proportion of children were male, almost half of the children did not attend school and were involved in crime with others, more than a third of children had recurrent offenses, almost all children with recurrent offenses were male, and the most common psychiatric disorders in children were ADHD and DB. In addition, the presence of a criminal history in the family, the child's school attendance, the parents' employment status, lifetime use of smoking, alcohol, and drugs, the presence of peers involved in the crime, and the presence of psychiatric disorders in the child were found to be factors associated with recidivism. Research shows that male adolescents are more likely to engage in criminal behavior than female adolescents. Intercalarily, male adolescents are significantly more likely than female adolescents to engage in both violent and non-violent criminal behavior[13]. Many studies have consistently reported that delinquent behavior is more

common in boys, that being male is one of the risk factors for delinquent behavior in children and adolescents, and that this behavior begins on average at the age of 14 and peaks at the age of 17 and 18[8,10]. This difference between the genders can be explained by the fact that men are exposed to more risk factors, such as failure at school, peers with criminal behavior and abuse[14]. In addition, the higher prevalence of psychiatric disorders such as ADHD and DB in boys may contribute to the higher incidence of criminal behavior in boys. In this study, 95.6% of children involved in delinquency were male and this finding is consistent with previous studies[15]. According to these findings, delinquent behavior in boys is more pronounced than delinquent behavior in girls during adolescence.

A psychiatric disorder was present in 41.8% of the cases in our study, and recidivism in children was associated with psychiatric disorders. Moreover, the most commonly identified psychiatric disorders in children were ADHD, CD and SUD respectively. A total of 12.1% of cases had an intelligence level below the norm (mild mental retardation or borderline intelligence). There is a reciprocal relationship between delinquency and psychiatric disorders and the prevalence of psychiatric disorders is reported to be higher in young people with delinquent behavior than in the general population[2,16]. However, some psychiatric symptoms that are common in young offenders are reported to increase the risk of aggressive and delinquent behavior. These symptoms include, in particular, emotional symptoms such as anger and impulsivity[17]. Young people diagnosed with disruptive behavior disorders and ADHD are more likely to exhibit aggressive behaviors, and the comorbidity of these disorders is associated with chronic and recurrent criminal behavior. It is emphasized that there is a link between substance abuse and criminal behavior and that the risk of criminal and aggressive behavior increases in young people with substance abuse[17]. In addition, children with ADHD are more likely to commit crimes in adolescence compared to the general population, and delinquent behavior is found to become more persistent and severe, especially in the presence of comorbid CD[4]. In a study of 55 adolescent patients conducted in Turkey, it was found that 67.3% of patients had at least one and 45.5% had two or more comorbid psychiatric disorders. The most common psychiatric disorders reported were ADHD and mood disorders[16]. Studies conducted in other countries have also shown that the prevalence of psychiatric disorders in children with delinquent behavior is higher than in the general population. The most common psychiatric disorders are ADHD, CD and anxiety disorders[18,19]. In a large sample study, it was found that the most common psychiatric diagnoses were alcohol use disorder, ADHD and CD. In addition, the association of alcohol use disorder with disruptive behavior disorders (ADHD, CD) was reported to increase the risk of recidivism[20]. There is a parallel increase in substance use and antisocial behavior. Drugs and alcohol are substances that affect behavioral control and play an important role in crimes committed and the adoption of high-risk behaviors. Substance use has been found to increase delinquent behavior 8.2 times in children[21]. Researches indicates that young people who use substances often have a delinquent peer group and that young people who exhibit violent behavior start using substances earlier. Secondly, the link between delinquent peer group and substance use facilitates the adoption and maintenance of delinquent behaviors[12]. Thirdly, in order to avoid withdrawal symptoms, young people may engage in various criminal behaviors to obtain the substance. In our country, four-fifths of children who engage in criminal behavior smoke cigarettes, and the use of addictive

substances such as cannabis and heroin has increased significantly in this population in recent years. It is also reported that there is a positive correlation between the increase in the number of children exhibiting criminal behavior and smoking and drug use[22]. Involving offenders with known psychiatric and substance abuse diagnoses in the treatment and rehabilitation process can have a positive impact on children's delinquent behavior. This measure can be a protective factor that prevents these children from recidivism.

Adolescence is a time of searching for identity, when interactions with peers become more frequent and parental conformity diminishes over time. One of the main challenges for adolescents is the pressure to conform to the norms and expectations of their peers. Peer influence has been identified as an important factor in delinquent behavior among adolescents. Exposure to antisocial peers in early adolescence is a strong predictor of later violent behavior and serious delinquency[23]. The results showed that 52.7% of the children in our study committed the alleged crimes together with others and the presence of peers who participated in the crime was associated with the recurrence of the crime. In a study conducted with male adolescents with criminal behavior, it was reported that 88.0% of the cases acted together with their peers[10]. A meta-analysis examining the effects of peer influence on delinquency found that a composite measure of peer relationships (including association with delinquent peers, gang membership, and peer rejection) predicted persistent lifetime delinquency compared to a trajectory restricted to adolescence[24]. The effect of peer influence on juvenile delinquency is consistent with the results of our study, and the relationship with deviant peers, the experience of serious and violent criminal behavior, and the desire for social status and acceptance may contribute to this relationship.

In our study, the presence of a criminal family history and parental occupational status were found to be associated with recidivist behavior. It is claimed that environmental factors are more effective than individual factors in the development of criminal behavior in children. Children whose behaviors and attitudes develop through modeling, which is one of the ways they learn socially, can be negatively affected by the presence of people with criminal behavior in their parents[25,26]. Delinquent behavior can develop in a child because the child learns delinquent behavior from people who exhibit delinquent behavior in the family, or because the child perceives delinquency as normal behavior[27]. Studies have reported high rates of delinquency and psychiatric disorders in the parents of children who exhibit delinquent behavior[28,29]. Good parenting skills can help foster a sense of security and belonging, as well as promote values such as respect, responsibility and psychological resilience. Children and young people who lack parental guidance and support can lead to an increased likelihood of the child engaging in criminal behavior. In addition, the child may be more likely to engage in criminal behavior due to lack of access to resources or opportunities to help them avoid the temptations of crime, such as education or employment.

One of the most common characteristics of children with delinquent behavior is that they do not like school or do not attend school[5]. During the assessment, it was found that a significant proportion of the cases (53.8%) did not attend school and dropping out of school was significantly associated with recidivism. It has been reported that problems experienced at school contribute to the progression of delinquent behavior in children and that school dropout is an important risk factor for delinquent behavior of children[4,8,30]. Truancy or dropping out of school can pave the way to delinquency as it creates time and opportunity

for antisocial behaviors; low school performance can accelerate the development of antisocial behaviors by affecting already low levels of self-esteem; all these are more common in a poor, disorganized sociocultural context with little supervision[12]. Studies conducted with children with delinquent behaviors in Turkey support that academic failure and dropping out of school are seen at high rates and that dropping out of school is a risk factor for delinquent behaviors[9,31]. The school is a place where both social skills are learned and education is imparted to children. It is believed that ensuring school attendance can play an important role in reducing delinquent behavior in children[9]. School can play a protective role against criminal behavior by providing social control and contributing to the development of reasoning and problem solving skills[16]. This is because students who miss school are more likely to be separated from peers, school staff and other adults who can be a positive influence, and are more likely to be exposed to negative influences. Children may also fall behind in school, which can lead to feelings of hopelessness and an increased likelihood of criminal behavior.

The limitations of the present study include retrospective examination of the data, the relatively low number of cases, and the fact that the data consisted of cases referred within a one-year period. The fact that no clinical scale was used in the study and the majority of the subjects were male are among the other limitations of the study. Therefore, the data obtained cannot be generalized to all children with delinquent behavior and it is recommended to conduct studies with larger samples in this field. It shows that comorbid mental disorders increase the risk of recidivism and that cases who dropped out of school (or never attended school) may be in the vulnerable group in terms of recidivism. Risk factors associated with childhood delinquency are also among the important risk factors for recidivism. There is a need to develop preventive mental health services for the detection and treatment of psychopathologies in children and adolescents at risk for delinquent behavior and to determine protective measures for familial, environmental and individual risk factors for children with delinquent behavior.

** A brief summary of the study was previously presented as an oral presentation at the 32nd National Child and Adolescent Psychiatry and Mental Health Congress (10-13 May, 2023, Istanbul).

Ethics Committee Approval: Approval for the study was obtained from the local ethics committee (dated 14/10/2022 and numbered 257) and the study was conducted in accordance with the ethical standards of the Declaration of Helsinki.

Conflict of Interest: The authors declared no conflicts of interest.

Financial Disclosure: The authors declared that this study has received no financial support.

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