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LETTER TO THE EDITOR

Beyond the diagnosis of conduct disorder: The need for clinical formulation in justice-involved adolescents

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Dear Editor,

Justice-involved adolescents occupy a clinically and socially important position at the intersection of child and adolescent psychiatry and forensic psychiatry. Conduct disorder, attention-deficit/hyperactivity disorder (ADHD), depression, trauma-related symptoms, and substance use problems are common in this population (1). However, interpreting these findings solely within a narrow conduct disorder framework may be clinically limiting. Externalizing behavior can reflect the combined influence of developmental, traumatic, neurodevelopmental, and psychosocial factors. The specific gap addressed here is therefore not an absence of guidance on these domains, but a gap in their integration into routine practice. In child and adolescent forensic psychiatry, assessment may remain offense-centered, with relevant developmental and psychosocial information recorded as parallel diagnoses or risk factors rather than synthesized into a child-centered clinical formulation. The distinction we emphasize is between multidimensional assessment and clinical formulation: the former identifies relevant domains, whereas the latter explains how they interact in the individual case and translates them into prioritized, modifiable intervention targets. Accordingly, this Letter focuses on how established trauma-informed, neurodevelopmental, educational, and psychosocial principles can be integrated into a concise, action-oriented clinical formulation to guide intervention.

A diagnosis of conduct disorder, by itself, does not explain why offending behavior began, why it persists, or which intervention is most likely to reduce future risk. When conduct problems are assessed, developmental level, learning capacity, emotional maturity, comorbid mental health difficulties, and the adolescent's educational and social care needs should be considered together (1–3). Similar externalizing behaviors may arise through different developmental and psychosocial pathways, including ADHD-related impulsivity, learning difficulties, trauma-related hyperarousal, substance use, adverse peer dynamics, family violence, school disengagement, and social disadvantage (1, 2, 4–6). When these pathways are not incorporated into a clinical formulation, diagnosis may become a static label rather than a clinically useful guide to intervention.

Trauma-informed approaches offer an important perspective in this context. Adverse childhood experiences are prevalent among justice-involved youth and have been associated with recidivism risk; however, this relationship should be understood as probabilistic rather than deterministic (4). Trauma-

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informed practice does not excuse harmful behavior. Rather, it seeks to understand how such experiences may affect emotion regulation, threat perception, attachment security, and problem-solving skills. At the same time, the evidence base for trauma-informed interventions remains limited, and findings should be interpreted cautiously given the heterogeneity of study designs (5). Attributing every harmful behavior to trauma may obscure individual agency and developmentally appropriate accountability. Trauma-informed care should therefore be embedded within a balanced formulation that also recognizes the individual and social consequences of behavior.

Neurodevelopmental and educational factors also require careful assessment. ADHD, intellectual disability, specific learning disorders, speech and language difficulties, traumatic brain injury, and fetal alcohol spectrum disorder are overrepresented in youth justice settings and may affect an adolescent's ability to understand legal processes, regulate behavior, or respond to standard interventions (2). School disengagement may reduce exposure to a structured and protective environment, while substance use may exacerbate impulsivity, susceptibility to peer influence, emotional dysregulation, and poor treatment adherence (6). These factors do not directly determine offending behavior, but they shape its clinical meaning and may help identify modifiable intervention targets.

This multidimensional perspective can be translated into practice through a brief, structured, and feasible assessment framework. Such an assessment should include urgent and modifiable domains, such as suicide risk, trauma-related symptoms, substance-related harms, untreated ADHD, learning needs, school exclusion or disengagement, family violence, and protective factors. Brief screening instruments may complement the clinical interview, provided that their validity, cultural appropriateness, and feasibility in forensic settings are carefully evaluated. Multidimensional assessment, however, is not equivalent to clinical formulation. A checklist can establish the presence of trauma exposure, ADHD, substance use, school disengagement, and family adversity; formulation asks how these factors interact in a particular adolescent and which should alter management. To make this formulation clinically usable, the 5P model can organize findings into presenting factors (the index behavior and current risks), predisposing factors (neurodevelopmental vulnerabilities, trauma history, and learning difficulties), precipitating factors (recent stressors, intoxication, or peer conflict), perpetuating factors (untreated symptoms, ongoing substance use, school disengagement, or family instability), and protective factors (supportive relationships, school attachment, treatment engagement, and personal strengths). The 5P model is not proposed here as a novel framework; rather, its value in this context lies in converting established assessment domains into an explanatory and intervention-oriented synthesis. For example, in an adolescent with ADHD and conduct disorder, a 5P formulation identifying peer victimization as a precipitating factor and school disengagement as a perpetuating factor may shift management from diagnosis-focused treatment alone toward coordinated psychiatric care, school reintegration, family intervention, and cross-sector risk management. Each domain should be considered at both individual and environmental levels. The formulation should then conclude with a small number of prioritized, modifiable targets, such as immediate risk management, treatment of comorbid conditions, educational assessment, family intervention, or substance use treatment, so that it functions as an intervention map rather than a descriptive list.

This approach is also consistent with the principles underlying diversion programs. When appropriately structured, diversion can connect young people with mental health services, substance use treatment, educational support, family interventions, restorative practices, and social protection mechanisms. Such pathways may reduce unnecessary exposure to formal judicial proceedings while supporting public safety (7, 8).

The Turkish context makes this formulation perspective particularly timely. Recent child-centered justice initiatives in Turkiye emphasize protective and restorative approaches, community-based measures, and stronger intersectoral coordination for children in judicial processes (9). The Child Justice Center model also aims to conduct child-related judicial procedures in child-friendly settings and integrate judicial, psychosocial, educational, health, and social service responses (10). These reforms create a context in which clinical formulation can serve as an operational bridge between psychiatric assessment and justice, educational, health, and welfare pathways. Its practical contribution is not to introduce another assessment domain, but to provide a common clinical logic for translating psychiatric findings into coordinated decisions across these sectors. In this sense, the approach proposed here is not a new trauma-informed or neurodevelopmental framework, but a concise method for integrating established domains into a

child-centered, intervention-oriented formulation. In Turkiye, such a formulation could inform treatment priorities, psychiatric referrals, and recommendations for health, counseling, or educational measures. However, the proposed 5P-based approach remains a pragmatic framework whose impact on clinical or justice outcomes has not yet been empirically established.

In conclusion, the central issue is not whether justice-involved adolescents should receive trauma-informed, neurodevelopmentally sensitive, and multidisciplinary assessment; these principles are already well established. The more specific challenge is ensuring that such information does not remain a collection of diagnoses and risk factors organized around the offense. A child-centered clinical formulation should integrate these findings into an explanatory account of the adolescent's behavior and translate that account into a limited number of prioritized, modifiable intervention targets. In this sense, moving beyond conduct disorder means moving from diagnostic description toward clinically actionable formulation while preserving developmentally appropriate accountability.

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REFERENCES

1. Beaudry G, Yu R, Långström N, Fazel S. An updated systematic review and meta-regression analysis: mental disorders among adolescents in juvenile detention and correctional facilities. J Am Acad Child Adolesc Psychiatry 2021; 60:46-60. [CrossRef]
2. Holland L, Reid N, Smirnov A. Neurodevelopmental disorders in youth justice: a systematic review of screening, assessment and interventions. J Exp Criminol 2023; 19:31-70. [CrossRef]
3. National Institute for Health and Care Excellence. Antisocial behaviour and conduct disorders in children and young people: recognition and management. Clinical guideline CG158. London: NICE; 2013. Available at: https://www.nice.org.uk/guidance/cg158. Accessed September 08, 2026.
4. Astridge B, Li WW, McDermott B, Longhitano C. A systematic review and meta-analysis on adverse childhood experiences: Prevalence in youth offenders and their effects on youth recidivism. Child Abuse Negl 2023; 140:106055. [CrossRef]
5. Malvaso CG, Day A, Boyd CM. The outcomes of trauma-informed practice in youth justice: an umbrella review. J Child Adolesc Trauma 2024; 17:939-955. [CrossRef]
6. Goldman PN, Wilson JD. Implementation of substance use services to justice-involved youth: examining barriers, facilitators, and best practices. J Correct Health Care 2023; 29:347-354. [CrossRef]
7. United Nations Children's Fund. Mental health and psychosocial support for children in the justice system. Reimagine Justice for Children Technical Brief 2. New York: UNICEF; 2025. Available at: https://www.unicef.org/documents/reimagine-justice-children-technical-briefs. Accessed September 08, 2026.
8. UNICEF Regional Office for Europe and Central Asia. Diversion of children in conflict with the law from formal judicial proceedings in Europe and Central Asia. Advocacy Brief on Child Justice. Geneva: UNICEF; 2022. Available at: https://www.unicef.org/eca/media/27691/file/Five%20Advocacy%20Briefs%20on%20Child%20Justice%20%26%20%20Child%20Friendly%20Justice%3A%20Diversion%20measures.pdf. Accessed September 08, 2026.
9. UNICEF Türkiye. UNICEF, European Union and Ministry of Justice launch a new project to advance child-friendly justice in Türkiye. 2025 Nov 18. Available at: https://www.unicef.org/turkiye/en/press-releases/unicef-european-union-and-ministry-justice-launch-new-project-advance-child-friendly. Accessed September 08, 2026.
10. Republic of Türkiye Ministry of Justice, Department of Judicial Support and Victim Services. Child Justice Center (ÇAM): purpose and benefits. Ankara: Ministry of Justice. Available at: https://magdur.adalet.gov.tr/Home/SayfaDetay/cocukadaletmerkezinedir. Accessed September 08, 2026.