Clinically differentiating life-course-persistent and adolescence-limited conduct problems: Is age-of-onset really enough?

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One important subtyping of behavior problems is Moffitt's (1993) “life-course-persistent” (LCP) and “adolescent limited” (AL) categories of antisocial behavior, which she differentiated in terms of high impulsivity, poor academic performance, and aggression. These problems may be exacerbated by the cumulative effects of chronic stress. Copious evidence has documented validity and developmental differences between these subtypes, whereas far fewer data exist regarding their clinical utility, in spite of the Diagnostic and Statistical Manual's nomenclature including corresponding subtypes based on age-of-onset of behavioral symptoms. The present study evaluated how well age-of-onset based subtyping identifies distinct developmental patterns of antisocial behavior corresponding to Moffitt's subtypes in terms of risk factors and gender between LCP and AL in a prospective sample of chronically stressed youth. A computerized assessment tool (ALEXSA©) was used to obtain data from 1147 youth aged 8-16. Implications for clinical assessment and intervention strategy, particularly with stressed youth, are discussed.

Moffitt (1993) specified two subtypes of antisocial behavior (AB). “Life-course-persistent” (LCP) begins in childhood, remains prevalent across the lifespan, and is consequent to vulnerabilities in many different areas, ranging from neurodevelopmental deficits to traumatic experiences and family dysfunction (Moffitt & Caspi, 2001). “Adolescence-limited” (AL) occurs only during adolescence, serves to win peer approval, and demonstrates coming-of-age independence (Moffitt, Caspi, Harrington, & Milne, 2002). Moffitt's taxonomy has been supported in subsequent studies (e.g., Tibbetts & Piquero, 1999). Evidence also suggests a “childhood-limited” subtype in which conduct problems dissipate by adolescence (Moffitt et al., 2008) and one with comorbid antisocial behavior and substance use, beginning in adolescence and continuing into adulthood (Armstrong & Costello, 2002; Ridenour et al., 2008).

Moffitt et al. (2008) outlined the need for research on the clinical utility of age-of-onset based subtypes in diagnosing conduct disorder. Age-of-onset has classically served to illuminate etiological factors that contribute to antisocial behavior. Age criteria are used when organizing referrals to specialized services (e.g., from teachers or police), are helpful for identifying missing and delayed developmental tasks, and inform selection of intervention targets based on salient stressors (e.g., childhood family problems versus adolescent peer problems).

However, given the additional constraints on and challenges to care in high-risk populations, assessment of the subtypes in these populations (and their clinical utility) is needed to understand when and where collecting age-of-onset data merits the requisite clinical effort and time (i.e., collecting records from multiple providers and agencies, gathering reports from varied caregivers, and comparing these sources for consistency). Additionally, longitudinal studies are needed of community, clinical, and public service recipient samples, and translational evidence is needed to evaluate and adapt assessment techniques into convenient and effective clinical tools (for example, clinicians rarely have time to use timeline follow-back methods to maximize accuracy of estimated age-of-onset). Importantly, others have demonstrated that the age-of-onset distinction is fully accounted for by more clinically meaningful subtyping based on aggressive and rule-breaking behavior (Burt, Donnellan, Iacono, & McGue, 2011). Thus, subtyping based on other criteria (e.g., risk factor intensity) may be more proximal to use for diagnosis. This study aimed to present evidence relevant to these gaps in the literature, with one goal of assessing whether age-of-onset is the most appropriate and useful diagnostic tool for conduct disorder subtyping, particularly for clinicians who work with youth in high-risk populations.
1. Risk and protective factors for conduct problems

Risk and protective factors respectively exacerbate or alleviate the effects of existing stressors and are expected to differentiate LCP and AL subtypes. Treatment strategies to curb antisocial behavior typically include reducing risk factors and/or bolstering protective factors. Descriptions follow of the factors investigated here that are most relevant to Moffitt’s subtypes, with information about how these factors are likely to present in chronically stressed youth.

1.1. Social contagion

LCP youth are frequently rejected by normative peers and network with other rejected youth who exhibit antisocial behavior (Coe & Dodge, 1998). This may happen early on if youth have experienced physical and emotional abuse from parents, setting them up to be victimized by peers (Lev-Wiesel & Sternberg, 2012). AL youth, in contrast, often first engage in deviance after observing peers using antisocial behavior to ‘fit in’ or cope with stress (Moffitt, Caspi, Dickson, Silva, & Stanton, 1996). Thus, LCP youth are expected to have more delinquent peers throughout the lifespan, whereas AL youths’ number of deviant friends is expected to increase during adolescence. Deviant affiliations may be particularly detrimental if chronic abuse or other family stressors prevent the child from ever forming any healthy peer relationships, delinquent behavior results in expulsion (i.e., limiting contact with normative peers), or positive former friends begin to avoid a deviant peer, reducing his or her social acceptance. LCP youth may experience this bidirectional cycle multiple times as they distance themselves further from normative peers. AL youth tend to return to normative behavior in early adulthood, as they realize the negative effects of their behavior patterns on future goals (Moffitt et al., 1996).

1.2. School protection

Positive school performance is a potential protective factor against conduct problems, due to involvement with school activities and focus on achievement. However, schools can be a place of estrangement for adolescents who fail to make these connections or have poor cognitive skills. Additionally, youth raised in intellectually poor or chaotic environments may be at a learning disadvantage early on, and their neighborhood schools may not be academically challenging (Evans & Kim, 2012). Moffitt (1993) theorized that poor school performance caused by neurological and cognitive deficits contributes to LCP conduct problems. However, improving academic skills does not always lead to reductions in antisocial behavior (Patterson, Dearyshe, & Ramsey, 1989). AL youth may recognize the importance of school and reverse their behavior, potentially in time to permit access to higher education (Moffitt, 1993). LCP youth, on the other hand, are plagued by continuing barriers (e.g., lack of family support, likely no “college fund”) that preclude their pursuit of an advanced degree.

1.3. Disinhibition and self-management

Although Moffitt (1993) originally posited that only LCP antisocial behavior results from disinhibition, more recent research suggests that AL youth may also share this risk factor at a subclinical level or only in a subset of individuals (Muscatello et al., 2014). In particular, adolescents under chronic stress may lack the support or skills needed to concentrate on difficult tasks and make long-term plans (e.g., applying to college), giving greater incentive to follow immediate impulses instead (Evans & Kim, 2012). Chronic stress seems to disrupt top-down emotional control and increase amygdala sensitivity to negative stimuli (Evans & Kim, 2012), increasing the likelihood that youth under stress may react impulsively to their problems (e.g., initiating a fight with a bully; lying to get out of trouble; running away from a stressful home). Thus, youth who lack positive coping strategies may respond with frustration, leading to anxiety, depression, and low self-esteem (Boyes, Hasking, & Martin, 2015) and perpetuating their estrangement from family, peers and institutions. LCP youth may not develop emotion regulation skills in childhood as a result of harsh parenting and poor relationships with peers, whereas AL youth may eventually pick up these skills or reduce their antisocial behavior in pursuit of their goals (Moffitt et al., 1996).

1.4. Family conflict and parental monitoring

Parents may skew offspring’s perceptions of social bonds by using harsh and inconsistent discipline, limiting positive interactions, and inadequately monitoring the child (Patterson et al., 1989). Poor coping may be modeled by stressed parents, and LCP youths’ well-being may suffer as a result of parental neglect. Moffitt (1993) argued that family conflict is more likely to affect LCP than AL youth, and early family problems can deleteriously affect neural, intellectual, and social development, particularly if attempts at coping backfire or cause more turmoil in the home (Wadsworth, 2015). In contrast, AL youth may use deviant behavior as a means of escape from strict parents or family conflict, but they are more likely than LCP youth to learn adaptive coping methods, likely as a result of greater contact with normative peers and the much more likely prospect of leaving the home and going off to college or moving away to start a new job (Moffitt, 1993; Moffitt et al., 1996).

2. Sex differences

Compared to boys, girls experience fewer childhood conduct problems, but their incidence increases during adolescence, suggesting a female-specific delayed-onset subtype of antisocial behavior (Silverthorn & Frick, 1999). Compared to girls, boys have more conduct problems that are likely to get noticed, including physical aggression, status offenses (e.g., underage alcohol use), and property offenses; girls are more prone to covert conduct problems such as shoplifting and fraud (Lahey et al., 2000). As a result, girls’ conduct problems may fly under the radar, particularly if they are not recognized and diagnosed early on. However, the gap between male and female rates of delinquent behavior has narrowed over the past two decades, even for violent crimes (Hipwell & Loeber, 2006), suggesting that the incidence of conduct disorder diagnoses for girls may be on the rise over the next few decades.

Given these trends, it is important for researchers to identify clear intervention targets for girls with conduct problems. Although, as stated above, many conduct disordered girls do not develop problems until adolescence, some girls with conduct problems struggle to adapt to social situations and meet developmental milestones as early as preschool (Keenan & Shaw, 1997), which can have long-lasting consequences if left unchecked as the child matures. For example, Ferguson and Woodward (2000) reported that girls’ conduct problems at age 13 correlated with poor academic performance, substance use, criminal offending, and internalizing and suicidal behavior and predicted negative outcomes at age 18. Notably, these findings were partially accounted for by childhood stressors (e.g., parental corporal punishment or substance use), indicating that chronic environmental risk factors are a key contributor to these poor outcomes.

3. Purpose of the present study

The present study prospectively tested in a chronically stressed sample (a) identification of Moffitt’s theorized subtypes using a clinical tool and age-of-onset of conduct problems, (b) Moffitt’s hypothesized differences between LCP and AL risk factors, and (c) the role of sex in distinguishing and intervening with LCP and AL youth. The study also tested differences between youth with and without conduct problems, both under chronic stress. The sample is fairly unique, as participants in
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