



Exploring gender issues in the development from conduct disorder in adolescence to criminal behaviour in adulthood

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ABSTRACT

Using results from a large Norwegian follow-up study of former adolescent psychiatric in-patients we have traced the progression from mental disorders requiring hospitalisation in adolescence to registered criminal behaviour in adulthood, particularly highlighting gender differences. A nationwide representative sample of 1095 adolescent psychiatric inpatients (46% females) was followed up 15–33 years after admission to the National Centre for Child and Adolescent Psychiatry in Oslo, Norway. In adolescence 45% fulfilled the DSM-IV criteria for a disruptive behaviour disorder. At follow-up, 63% of the males and 39% of the females had a criminal record. Among females, psychoactive substance use disorder in adolescence seemed to be a *sine qua non* for later registered criminality, with intravenous drug use a potent risk factor for life-course-persistent criminality. The same strong association between drug use and criminality was not found in males. Factor analysis demonstrated that while the DSM-IV Conduct Disorder criteria structure was similar across genders, the prevalence of the various forms of expression was different in males and females. The differences between individuals with violent and non-violent crimes were more substantial in males than in females. There were marked gender differences in the criminal profiles observed, with the females' criminal career developing in a less serious manner than in males: females had later criminal debut, a lower number of acts on record, less diverse criminal behaviour, and an escalation in the severity of offences over time was less frequently encountered. However, secular trend analyses indicated that gender differences had diminished over the last several decades, with females "catching up" with their male counterparts. Overall, the results demonstrated important qualitative and quantitative gender differences in the criminal behaviour of former adolescent psychiatric in-patients. The results may be of use in prevention.

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1. Introduction

In spite of the introduction of a number of prominent theories (Farrington, 1994; Lacourse et al., 2002; Lahey, Waldman, & McBurnett, 1999; Loeber & Hay, 1997; Moffitt, 1993; Stattin & Magnusson, 1996; Tolan, Guerra, & Kendall, 1995; Tremblay, 2000), our understanding of antisocial development is still fragmentary.

A persistent finding in the literature is the higher rates of problem behaviour seen among males than among females, across the lifespan (Cook & Laub, 1998; Rutter, Giller, & Hagell, 1998). Even toddlers 17 months of age show marked gender differences in physical aggression (Baillargeon et al., 2007). The mechanisms underlying this consistent finding are poorly understood. Is the genetic vulnerability for, and are the developmental paths leading to, antisocial and violent behaviour fundamentally different in males and females, or are the differences more of a quantitative than a qualitative nature (Broidy

et al., 2003)? Gender differences could be biologically or socially driven. It has been argued that gender differences emerge because parents and society selectively encourage traditional sex-type behaviours, such as shyness and fearfulness in girls, and discourage non-sex-type behaviours, such as assertive and risk-taking behaviour in girls (Keenan & Shaw, 1997). A better understanding of the mechanisms that lead to and sustain criminal behaviour is an important first step towards more efficient, gender specific preventive strategies and intervention techniques targeting these specific mechanisms.

Research in the field has primarily concentrated on boys. Moffitt (1993) has proposed and received much support for a distinction between adolescence-limited and life-course-persistent delinquent behaviour. In this model, life-course-persistent criminal behaviour is seen as a cumulative interaction between the child's neuropsychological problems and a criminogenic environment, culminating in a deviant personality. Adolescence-limited antisocial behaviour, on the other hand, is seen as originating in a contemporary maturity gap that encourages teenagers to mimic antisocial behaviour in ways that are normative and ultimately adjustable. This model, which originally was developed for boys, has now been extended to include girls (Moffitt & Caspi, 2001). Also in Lahey et al.'s (1999) integrative causal model for the development of antisocial behaviour, age of onset is a key element.

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A research-founded theory which lately has received much attention and acclaim is Loeber and Hay's (1997) tripartite model, in which they propose three pathways in delinquent developments: an overt pathway, a covert pathway, and an authority conflict pathway. This theory has received support from some longitudinal studies (Tolan & Gorman-Smith, 1997). It was originally developed for boys but its applicability for girls has recently been tested and confirmed (Gorman-Smith & Loeber, 2005). The study found a general consistency in patterns in girls and boys but with differences in frequency and predictive factors.

Both researchers and clinicians agree that there is a larger variability in girls' delinquent development (Hoyt & Scherer, 1998). Broidy et al. (2003), in a large study using data from 6 sites and 3 countries, found that, while there was a strong continuity in problem behaviour among boys, there was no clear linkage between childhood physical aggression and adolescent offending in females. Eley, Lichtenstein, and Stevenson (1999) found that while genetic factors had a strong influence on the development of aggressive antisocial behaviour in both genders, non-aggressive antisocial behaviour was, on the other hand, significantly influenced by the shared environment, and more so in males than in females. Keenan and Shaw (1997) point to the fact that communication skills develop earlier in girls than in boys. They suggest that this is one of the reasons why girls are easier to socialize at an early age and that these differences play a role in creating gender differences in antisocial behaviour. Silverthorn and Frick (1999) have suggested that in girls a delayed-onset pathway to antisocial behaviour may be the most prevalent. They propose that the factors known to contribute to antisocial behaviour, such as cognitive and neuropsychological deficits, a dysfunctional family, and a callous and unemotional interpersonal style, lead to antisocial behaviour in girls as well as in boys, but with a later age of onset.

Researchers in the field have often excluded females from their studies, apparently expecting that criminal activity among females is simply a subset or minor variation of criminal behaviour among males. Female criminality should however be explored in its own right. There may be important lessons to learn from this. Broidy et al. (2003) suggest that future research should be particularly interested in factors that inhibit later delinquent development in girls exhibiting serious disruptive behaviour in childhood. They hypothesise (p. 237) that: "The socialisation patterns and interpersonal networks of female adolescents may work to inhibit delinquency among girls with a history of disruptive behaviour but may foster other deviant outcomes more consistent with the female role such as alcohol or drug abuse, disordered eating, depression, or early pregnancy". There is an obvious need for research exploring early manifestations of delinquent behaviour in girls and follow-up studies focusing on factors influencing the diversion into positive and negative trajectories towards young womanhood.

In an attempt to address some of the above issues, we present a handful of articles written by the first author and collaborators on a large long-term follow-up of former adolescent psychiatric in-patients (Janson & Kjelsberg, 2006; Kjelsberg, 1999, 2002a,b, 2004, 2005; Kjelsberg & Dahl, 1998, 1999). Our aim is to systematically re-visit these research reports, in order to highlight results that demonstrate important differences – and unexpected similarities – between genders in the development from adolescent behaviour problems to adult criminal behaviour.

2. Material and methods

The original study consisted of a consecutive cohort of all patients admitted to the National Centre for Child and Adolescent Psychiatry in Oslo, Norway, during the years 1963–1981. The hospital was the only in-patient facility for adolescent psychiatric in-patients in the country at the time. No regional admission rules were in force; hence the sample can be considered nation-wide.

A total of 1095 patients, 588 males and 507 females, 86% of the original sample, could be unequivocally identified by personal identification numbers needed for a subsequent record linkage. Mean age at admission was 15 years, and the follow-up was conducted 15 to 33 (SD=5.5, mean=25) years after first hospitalisation. A total of 149 patients (13.6%) were dead at follow-up.

Based on detailed hospital records all patients were re-diagnosed according to the diagnostic criteria in DSM-IV (American Psychiatric Association, 1994) and assigned to one of the following 8 diagnostic groups, depending on the clinically most important diagnosis at index hospitalisation in adolescence:

1. Disruptive behaviour disorder without psychoactive substance use disorder – 29%
2. Disruptive behaviour disorder with co-morbid psychoactive substance use disorder – 22%
3. Personality disorder – 15%
4. Psychotic disorder – 9%
5. Mood disorder – 7%
6. Anxiety disorder – 6%
7. Organic disorder – 5%
8. Residual disorders – 8%.

The use of personality disorder diagnoses in adolescence is controversial. As recommended by DSM-IV (American Psychiatric Association, 1994), a diagnosis of personality disorder was only given if the patient's maladaptive personality traits appeared to be pervasive, not likely to be limited to the particular developmental stage, and present for at least 1 year.

The criminal activity of the study population was monitored by linkage of the patient list to the Norwegian Crime Register at follow-up. The register is based on personal identification numbers and includes all persons who have been convicted of criminal offences and misdemeanour. Once registered, nobody is removed from the register. The register is of good quality and all patients, including those who were deceased, could be reliably checked against it.

For a comprehensive description of the study population we refer to a summary article (Kjelsberg & Dahl, 1998). The results presented here do all refer to this study population, with one modification. In the 2005 article (Kjelsberg, 2005), only patients fulfilling the DSM-IV criteria for a conduct disorder were included and supplemented with a more recent cohort of 111 conduct disordered patients hospitalised during the years 1987–1990. This was done in order to be able to analyse secular trends in criminal activity in conduct disordered adolescents over a longer time span: 1963–1990.

3. Results

In the following presentation, results are grouped according to the research articles where they were first published. For further details, please refer back to the original articles.

3.1. Factors predicting criminal development (Kjelsberg & Dahl, 1999)

At follow-up 15 to 33 years after psychiatric in-patient treatment in adolescence, 569 of the 1095 patients monitored (52%) had a criminal record. While as many as 63% of the 588 male patients had a criminal record at follow-up, significantly fewer (39%) of the 507 females did so (Chi square 65.0, $p < .001$). Among those with a criminal record, both males and females had frequently been convicted of crimes against property (84% and 77%, respectively) and drug offences (39% and 41%, respectively). Violent crimes were, however, much more frequent among convicted males (51%), compared with convicted females (18%). No females had been convicted of sex offences.

The results were subjected to Kaplan–Meyer survival analyses and subsequent Cox regression, in order to elicit significant and independent predictors for delinquent behaviour. Male gender as such was a

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