



Childhood behavior problems and fighting in early adulthood: What factors are protective?



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ABSTRACT

Purpose: To identify factors that protected children with high externalizing problems at age 11–12 from fighting six to eight years later.

Methods: Regression models were used to identify risk-based and interactive protective factors against fighting at ages 17–18 and 19–20, among approximately 1100 Australian Temperament Project participants. To determine whether protective factors were developmentally-sensitive, analyses were repeated at four time points spanning ages 11 to 20.

Results: A number of protective factors were identified, however, few remained significant after controlling for other protective factors and demographic variables. Among high-risk youth, high self-control was consistently associated with lower levels of fighting at 19–20 (and to a lesser extent, 17–18). Positive relationships with teachers in early adolescence also emerged as a risk-based protective factor against fighting (at 19–20). Additionally, both factors appeared to moderate the influence of childhood behavior problems on subsequent fighting, exhibiting protective-enhancing effects. High responsibility and supportive peer relationships in late childhood were also found to be significant risk modifiers, with responsibility having a protective-enhancing effect against fighting, and peer relationships, a protective-stabilizing pattern.

Conclusions: Self-control was the most influential protective factor in reducing the risk of fighting at 17–18 and 19–20 for those with high childhood externalizing problems.

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1. Introduction

Several recent homicides resulting from fist-fights, including cases in which victims were killed by a single punch to the head, have focused attention on the problem of youth violence in Australia (Pilgrim, Gerostamoulos, & Drummer, 2014). Although rates of assault and homicide victimization are lower in Australia than in the United States or England and Wales (United Nations Office on Drugs and Crime, UNDOC, 2013; Van Dijk, van Kesteren, & Smit, 2008), interpersonal violence is a leading cause of hospitalization and morbidity among young Australian males (Eldridge, 2008). Self-report studies indicate that fighting – the most common form of interpersonal violence – is common among Australian boys with levels comparable to those recorded in the US (Forrest, Edwards, & Vassallo, 2014; McMorris, Hemphill, Toumbourou, Catalano, & Patton, 2007; Vassallo et al., 2002). Unarmed physical fights account for one in four homicides in Australia and kill more people than firearms (Chan & Payne, 2013).

Effective prevention of youth violence requires a range of strategies based on a sound understanding of the development of violent behavior

(Farrington & Welsh, 2007). Prior studies have found that many of the same risk factors that have emerged in international research studies (e.g., Hawkins et al., 1998; Lipsey & Derzon, 1998) also predict involvement in violence in Australia (Bor, McGee, & Fagan, 2004; Forrest & Edwards, 2015; Hemphill et al., 2009; Vassallo et al., 2002). For example, children with hyperactivity, conduct problems, and antisocial friends are consistently more likely than their same-age peers to engage in a range of offenses as adolescents and young adults (Bor et al., 2004; Forrest & Edwards, 2015; Hemphill et al., 2009; Vassallo et al., 2002). Conversely, children who are able to control their emotions or show high levels of self-control are less likely than their peers to engage in violence and risk becoming embroiled in crime throughout their lives (Hemphill et al., 2009; Vassallo et al., 2002).

Although the presence of risk factors and the absence of protective factors are linked to higher rates of involvement in violence, the majority of youths thought to be at risk of violence and antisocial behavior abstain from violence altogether (Farrington & Welsh, 2007; Forrest & Edwards, 2015; Loeber & Stouthamer-Loeber, 1998). Even high-risk youth who engage in violence eventually desist from it, with many abandoning violence in late adolescence and early adulthood (Laub & Sampson, 2007). This implies that identifying the factors that help protect at-risk youth from engaging in violence (or enable them to desist) is critical to the task of preventing youth violence. Nonetheless, most

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research on the risk and protective factors for violence has concentrated on factors that place children and young people at risk of violence in the first place, at the expense of factors that mitigate their influence. Other studies have defined protective factors somewhat narrowly as the opposite of risk – factors that predict positive outcomes such as non-violence or pro-social behavior (Losel & Farrington, 2012). By contrast, less attention has been placed on the influence of risk-based protective factors that constrain violence among at-risk youth or interactive protective factors that modify the influence of the risk factors already present in their lives (Losel & Farrington, 2012; Tfofi, Bowes, Farrington, & Lösel, 2014).

The purpose of this paper is to help overcome these shortcomings by exploring the role of key protective factors in the development of youth violence in the Australian context. Using the results of the Australian Temperament Project (ATP), one of the longest running longitudinal studies of human development in Australia, we investigate the relationships between a range of protective factors and subsequent involvement in physical fighting. First, we identify the influence of key risk-based factors that relate to the probability of violence among those at greatest risk of it – children with either significant hyperactivity or aggression. We focus on childhood aggression and hyperactivity because both traits are implicated in the development of violent behavior (Herrenkohl et al., 2000; Nagin & Tremblay, 1999). Second, we investigate the extent to which the same protective factors might moderate the effects of aggression and hyperactivity on subsequent involvement in violence. The results of these analyses are useful for identifying possible interactive risk factors that reduce the impact of the risks that children already face. Finally, we compare the relative influence of those protective factors on subsequent violence among at-risk youth as measured at different stages of development (11–12, 13–14, 15–16 and 19–20 years). Given that many of the risk factors that help distinguish adolescent and young adult violent offenders from their peers in late childhood are not necessarily the same factors that can differentiate them in early adolescence (e.g. Lipsey & Derzon, 1998), it is important to determine whether risk-based and interactive factors are more critical at specific stages of development than at others. Temporal differences in risk-based or interactive protective factors could indicate opportunities for interventions that are likely to be more effective at some stages of the life-course than others.

2. Method

2.1. Participants

Participants were members of the Australian Temperament Project (ATP), a longitudinal study following the psychosocial development of a large cohort of children born in the state of Victoria, Australia, between September 1982 and January 1983 (Prior, Sanson, Smart, & Oberklaid, 2000). The initial sample comprised 2443 infants (aged 4–8 months) and their parents, who were recruited through Maternal and Child Health Centres during a two-week period in 1983, and provided a representative sample of the state (Prior et al., 2000).

Fifteen waves of data have been collected to date, predominantly via mail surveys, and a sixteenth data collection wave (at 31–32 years) is currently underway. Parents, Maternal and Child Health nurses, primary school teachers, and the young people themselves, have acted as informants at various stages.

Approximately two-thirds of the sample was still participating at 19–20 years, although there were fewer immigrant families and families experiencing socioeconomic disadvantage participating at that stage relative to commencement. There were no significant differences between the retained and no-longer-participating subsamples on any of the infancy characteristics measured at the study's commencement (Ruschena, Prior, Sanson, & Smart, 2005).

We use data from waves 9 to 13 when participants were aged 11–12 (1994), 13–14 years (1996), 15–16 (1998), 17–18 (2000) and

19–20 years (2002), respectively. Only participants with complete data on externalizing problems at age 11–12 years, and physical fighting at 17–18 years ($n = 1,125$) and/or 19–20 years ($n = 1,033$) were included in the analyses.

2.2. Measures

2.2.1. Externalizing problems at 11–12 years

Externalizing problems were assessed at 11–12 years using the 'Hostile-Aggressive' and 'Hyperactive' subscales of the parent form of the Child Behavior Questionnaire (Rutter, Tizard, & Whitmore, 1970). Parents were asked to report the extent to which their child exhibited aggressive and hyperactive behavior within the preceding two weeks, using a three-point scale 0 = does not apply, 1 = applies somewhat and 2 = certainly applies. Items included: "often destroys" others belongings" (Hostile-Aggressive scale), "frequently fights with other children" (Hostile-Aggressive scale) and "very restless, often running about and jumping up and down. Hardly ever still" (Hyperactive scale). Participants were classified as at-risk and exhibiting high levels of externalizing problems at 11–12 years if they scored one standard deviation or more above the mean on at least one of these scales.

2.2.2. Physical fighting at 17–18 and 19–20 years

At ages 17–18 and 19–20, participants were asked to indicate the frequency with which they had "got into physical fights with other people" during the previous twelve months. This item formed part of a broader measure of antisocial behavior adapted from Elliott and Ageton's (1980) Self-Report Delinquency Scale. At 17–18 years, responses were made on a four-point scale (0 = not at all, 1 = once, 2 = twice, and 3 = more often). This was extended to a six-point scale at 19–20 years, to allow greater differentiation between respondents who engaged in more frequent fighting (0 = not at all, 1 = 1–2 times, 2 = 3–4 times, 3 = 5–6 times, 4 = 7–9 times, 5 = 10+ times).

2.2.3. Control factors and protective factors

A number of control variables and potential protective factors were included in the analyses. These encompassed individual attributes (e.g., social skills), family factors (e.g., parenting style and practices) and social factors (e.g., relationships with peers and teachers). Due to the large number of variables under investigation, it is not possible to provide full details of these measures here. However, a summary is provided in Table 1. Further details are available from the authors, upon request.

2.3. Statistical analysis

Ordinary Least Squares (OLS) regression analyses were used to identify factors that might protect at-risk children from engaging in violence as young adults. Risk-based protective factors were identified by separately examining the associations between each protective factor and physical fighting at 17–18 and 19–20 years, among the subsample of at-risk children. Separate analyses were performed using protective factors at four time points spanning late childhood to early adulthood (ages 11–12, 13–14, 15–16 and 19–20). Each protective factor was included in a separate OLS regression model adjusting for child sex, family socio-economic status when children were 11–12 years and whether one or both parents were born overseas in a non-English speaking country. To test the independent influence of each protective factor, multivariate regressions were run for each of the four time points for all available protective factors and control variables.

To identify interactive protective factors, we then interacted at-risk status at 11–12 years – an indicator of high externalizing problems – with each protective factor to see if the protective factor operated in a substantially different fashion in predicting subsequent physical fighting for participants with high externalizing behavior problems and those without. Regression models were adjusted for child sex, family socio-economic status at age 11–12 and whether the child had one or

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