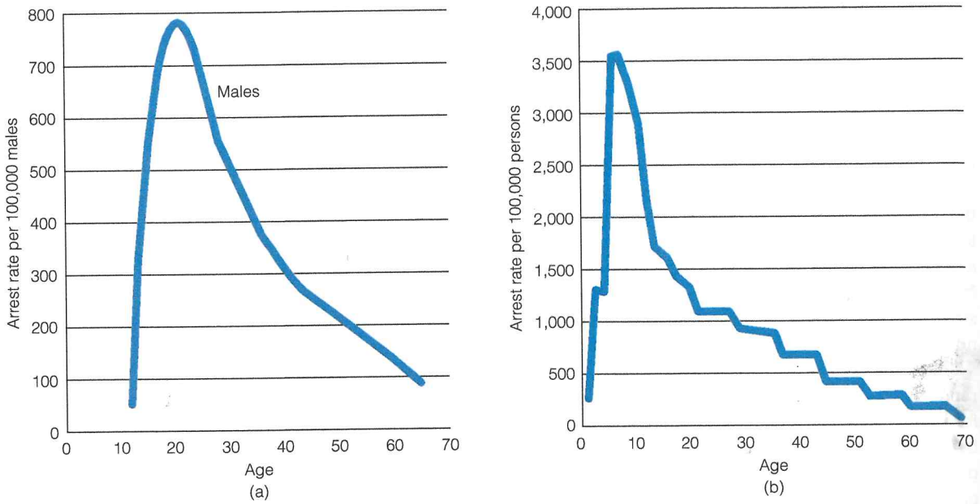

Figure 12 • **Age–Crime Relationship in (a) 1842 and (b) 1992** Why does crime peak in the late teens?
Source: Gottfredson & Hirschi (1990), p. 125; Osgood (2009)

tent over a period of greater than 150 years. **Figure 12** shows the age–crime relationship at two points, one in the 1840s and one relatively recent. At any point before, after, or in between these times, in most countries, the pattern would look very similar (Eisner, 2002; Gottfredson & Hirschi, 1990; Wilson & Herrnstein, 1985). Adolescents and emerging adults are not only more likely than children or adults to commit crimes but also more likely to be the victims of crimes (Cohen & Potter, 1999; Eisner, 2002).

Watch the **Video** Risk Taking and Delinquency at **MyDevelopmentLab**

What explains the strong and consistent relationship between age and crime? One theory suggests that the key to explaining the age–crime relationship is that adolescents and emerging adults combine increased independence from parents and other adult authorities with increased time with peers and increased orientation toward peers (Wilson & Herrnstein, 1985). A consistent finding of research on crime is that crimes committed by young people in their teens and early twenties usually take place in a group, in contrast to the solitary crimes typical of adult offenders (Dishion & Dodge, 2005). Crime is an activity that in some adolescent cliques is encouraged and admired (Dishion et al., 1999). However, this theory does not explain why it is mainly boys who commit crimes, and girls, who also become more independent from parents and more peer-oriented in adolescence, rarely do.

Most surveys find that over three-fourths of adolescent boys commit at least one criminal act some time before the age of 20 (Loebert & Burke, 2011; Moffitt, 2003). However, there are obvious differences between committing one or two acts of minor crime—vandalism or underage drinking, for example—and committing crimes frequently over a long period, including more serious crimes such as rape and assault. Ten percent of young men commit over two-thirds of all offenses (Broidy et al., 2003). What are the differences between adolescents who commit an occasional minor violation of the law and adolescents who are at risk for more serious, long-term criminal behavior?

Terrie Moffitt (2003, 2007) has proposed a provocative theory in which she distinguishes between *adolescence-limited* delinquency and *life-course-persistent* delinquency. In Moffitt's view, these are two distinct types of delinquency, each with different motivations and different sources. However, the two types may be hard to distinguish from one another in adolescence, when criminal offenses are more common than in childhood or

adulthood. The way to tell them apart, according to Moffitt, is to look at behavior before adolescence.

Life-course-persistent delinquents (LCPDs) show a pattern of problems from birth onward. Moffitt believes their problems originate in neuropsychological deficits that are evident in a difficult temperament in infancy and a high likelihood of attention-deficit/hyperactivity disorder (ADHD) and learning disabilities in childhood. Children with these problems are also more likely than other children to grow up in a high-risk environment (e.g., low-income family, single parent), with parents who have a variety of problems of their own. Consequently, their neurological deficits tend to be made worse rather than better by their environments. When they reach adolescence, children with the combination of neurological deficits and a high-risk environment are highly prone to engage in criminal activity. Furthermore, they tend to continue their criminal activity long after adolescence has ended, well into adulthood.

The **adolescence-limited delinquents (ALDs)** follow a much different pattern. They show no signs of problems in infancy or childhood, and few of them engage in any criminal activity after their mid-twenties. It is just during adolescence—actually, adolescence and emerging adulthood, ages 12 to 25—that they have a period of occasional criminal activity, breaking the law with behavior such as vandalism, theft, and use of illegal drugs.

Street children in Honduras examine watches they have stolen. What distinguishes the two types of delinquency?

As we have seen earlier in the chapter, the brain is still a long way from maturity during adolescence. Does the immaturity of the brain help explain why rates of delinquency and some other types of risk behavior are higher in adolescence than at younger ages? This theory has been proposed by researchers who claim that neurological studies show that the brain's frontal lobe areas in charge of judgment and impulse control are not mature until at least the mid-twenties; consequently, during adolescence behavior is governed more by emotions and less by reason than in later years (Steinberg, 2010). However, other researchers dispute this conclusion (Fisher et al., 2010). Some studies have found that the brain development of adolescents who engage in risky behavior is actually *more* mature in some ways than in their less risk-prone peers (Berns et al., 2011). Others point out that rates of most types of risk behavior continue to increase into the early twenties; brain development also increases during this time, so immaturity of the brain cannot explain the increase in risk behavior during these years (Males, 2010). It should also be noted that boys and girls are highly similar in brain development during adolescence, yet boys commit far more crimes.

life-course-persistent delinquent (LCPD) delinquent who shows a pattern of problems from birth onward and whose problems continue into adulthood

adolescent-limited delinquent (ALD) delinquent who shows no evidence of problems prior to adolescence and whose delinquent behavior in adolescence is temporary

Delinquency has often proven to be resistant to change in adolescence, but one successful approach has been to intervene at several levels, including the home, the school, and the neighborhood. This is known as the *multisystemic approach* (Borduin et al., 2003; Henggler et al., 2007; Saldana & Henggler, 2006; Swenson et al., 2005). Programs based on this approach include parent training, job training and vocational counseling, and the development of neighborhood activities such as youth centers and athletic leagues. The goal is to direct the energy of delinquents into more socially constructive directions. The multisystemic approach has now been adopted by youth agencies in 32 states and 12 countries (Schoenwald et al., 2008). As **Figure 13** illustrates, programs using this approach have been shown to be effective in reducing arrests and out-of-home placements among delinquents (Alexan-

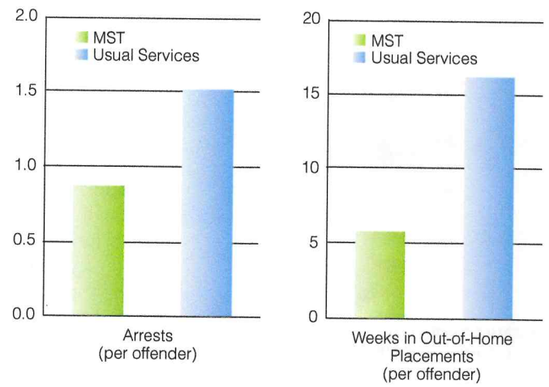

Figure 13 • **Multisystemic Approach to Delinquency** Why is MST more effective than other types of interventions for delinquency?
Source: Alexander (2001), p. 42.

der, 2001; Henggler et al., 2007; Ogden & Amlund, 2006). Furthermore, multisystemic programs have been found to be cheaper than other programs, primarily because they reduce the amount of time that delinquent adolescents spend in foster homes and detention centers (Alexander, 2001).

Depression

23 LEARNING OBJECTIVE Identify the different types and rates of depression and summarize the most effective treatments.

Do you remember feeling sad at times during your teen years? As we have seen earlier in the chapter, studies of adolescents' emotional lives have found that they experience sadness and other negative emotions much more frequently than do younger children or adults.

Psychologists make distinctions between different levels of depression (Compas et al., 1998). **Depressed mood** is a term for a temporary period of sadness, without any related symptoms. The most serious form of depression is **major depressive disorder** which includes a more enduring period of sadness along with other symptoms such as frequent crying, feelings of worthlessness, and feeling guilty, lonely, or worried. Major depressive disorder may also include symptoms such as difficulty sleeping and changes in appetite (American Psychiatric Association [APA], 1994).

Watch the Video Depression at MyDevelopmentLab

Although a diagnosis of major depressive disorder is relatively rare in adolescence, several studies find that adolescents have higher rates of depressed mood than adults or children (Compas et al., 1998; Petersen et al., 1993; Saluja et al., 2004). Rates of depressed mood rise steeply from age 10 and reach a "mid-adolescence peak" about ages 15 to 17, then decline in the late teens and twenties (Petersen et al., 1993).

A variety of studies have shown that the proportion of adolescents who report experiencing depressed mood within the past 6 months is about 35% (Petersen et al., 1993; Saluja et al., 2004). In contrast, rates of major depressive disorder among adolescents range in various studies from 3 to 7% (Achenbach et al., 1991; Cheung et al., 2005; Compas et al., 1993), which is about the same rate found in studies of adults. The most common causes of depressed mood tend to be common experiences among adolescents: conflict with friends or family members, disappointment or rejection in love, and poor performance in school (Costello et al., 2008; Larson & Richards, 1994).

One of strongest risk factors for all types of depression in adolescence and beyond is simply being female (Hammack et al., 2004). A variety of explanations have been proposed. Some scholars have suggested that body image concerns provoke depression. There is substantial evidence that adolescent girls who have a poor body image are more likely than other girls to be depressed (Graber et al., 2007; Marcotte et al., 2002; Wichstrom et al., 1999).

For adolescents as for adults, the two main types of treatment for depression are antidepressant medications and psychotherapy. Recent studies indicate that newly developed antidepressants such as Prozac are highly effective in treating adolescent depression (Bostic et al., 2005; Brent, 2004; Cohen et al., 2004; Emslie et al., 2002; Michael & Crowley, 2002). The combination of the newest medications and psychotherapy appear to be the most effective approach to treating adolescent depression. In one recent major study of 12- to 17-year-olds at thirteen sites across the United States who had been diagnosed with major depression, 71% of the adolescents who received both Prozac and psychotherapy experienced an improvement in their symptoms (Treatment for Adolescents with Depression Study Team, 2004, 2007). Improvement rates for the other groups were 61% for Prozac alone, 43% for psychotherapy alone, and 35% for the placebo group.

depressed mood enduring period of sadness, without any other related symptoms of depression

major depressive disorder clinical diagnosis that includes a range of specific symptoms such as depressed mood, appetite disturbances, sleeping disturbances, and fatigue