# *AGGRESSION IN INPATIENT ADOLESCENTS*
## *The Effects of Gender and Depression*

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*Differences in aggressive behavior were examined in a primarily White sample of 84 thirteen- to seventeen-year-old depressed and nondepressed adolescent inpatients. Results indicate that depression and gender interact significantly; females with depression demonstrated more physical aggression than nondepressed females, and males with depression demonstrated less aggression than nondepressed males. These results indicate that depression is a greater risk factor for physical aggression in treatment-seeking female, compared to male, adolescents.*

***Keywords:*** *gender; depression; aggression*

**Research indicates a link** between clinical depression (persistent depressed or irritable mood, or loss of interest and pleasure in activities as well as other symptoms such as low self-worth, problems with sleep or appetite, and recurrent thoughts of death; American Psychiatric Association, 1994) and aggressive behavior (behavior intended to cause pain, physical or psychological harm or injury, or physical distraction; Salkind, 2002) in adolescents. For example, results of a recent study (Knox, King, Hanna, Logan, & Ghaziuddin, 2000) indicate that treatment-seeking adolescents with depression engage in markedly high levels of aggressive acts. This supports prior findings that indicated higher levels of aggressive behavior and conduct disorder (a pattern of behavior involving violation of the rights of others including aggression, property destruction, deceitfulness, theft, and serious

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violations of rules; American Psychiatric Association, 1994) in depressed children and adolescents (Kazdin, Esveldt-Dawson, Unis, & Rancurello, 1983; McCracken, Cantwell, & Hanna, 1993). Further, research has indicated that future aggressive behavior is heightened in adolescents with pre-existing depression (Schubiner, Scott, & Tzelepis, 1993).

Several studies have examined aspects of comorbidity of depression and conduct disorder in adolescents (e.g., Harrington, Fudge, Rutter, Pickles, & Hill, 1991; Kovacs, Paulauskas, Gatsonis, & Richards, 1988; McCracken et al., 1993). Research by Kovacs et al. (1988) and others (Biederman, Faraone, Mick, & Lelon, 1995) indicates that conduct disorder will develop in a significant proportion of depressed adolescents. For most (62%) of the adolescents with comorbid depression and conduct disorder in the Kovacs study, conduct disorder developed as secondary to the depressive disorder. Of course, conduct disorder is not limited to physical aggression; in the Kovacs study, only 48% of the youth with conduct disorder demonstrated clinically significant involvement in physical aggression (physical fighting). Results of such studies therefore cannot be directly applied to our understanding of youth violence and aggression.

To better understand links between physical aggression and depression in adolescents, studies must specifically evaluate aggressive behavior. However, few studies have focused evaluations specifically on physical aggression in depressed adolescents. Nevertheless, the study of physically aggressive behavior in adolescents is crucial to prevention and intervention efforts addressing youth violence, a problem which has been identified as a vital public health issue in the United States (Department of Health and Human Services, 2001; Federal Interagency Forum on Child and Family Statistics, 1998). Youth violence has a significant impact not only on the physical well-being of victims of violence but also on the emotional functioning (Gorman-Smith & Tolan, 1998; Schwab-Stone et al., 1999), school attendance (U.S. Department of Justice, 1991), and academic functioning (Schwab-Stone et al., 1995) of victims and the many youths who are exposed to such violence. Given the significant, negative societal impact of youth violence, it is imperative to identify risk factors for physical aggression in adolescents so that these problems may be prevented.

Adolescence is a period of heightened risk for aggression; a sharp incline in antisocial behavior occurs between ages 7 and 17, and the prevalence and incidence of most types of criminal offenses, including violent crime, peak at approximately age 17 (Moffitt, 1993). According to Moffitt (1993) a characteristic of the developmental stage of adolescence is a strong susceptibility to peer influences. In American culture, these influences often serve to promote aggressive behavior. During this stage, aggressive behavior provides the youth with an increased sense of power and independence. Such behavior neutralizes feelings of inadequacy that are often present during adolescence. In many individuals, this behavior is stage-limited; that is, it arises in adolescence and diminishes in adulthood. For a smaller percentage of youths who are considered early initiators of violence, aggressive behavior begins in childhood and escalates or persists sometimes into adulthood. In both developmental trajectories, aggressive/violent behavior can be highly problematic during adolescence.

Racial and cultural factors appear to relate to the risk for violence among adolescents. Roughly half of all juvenile offenders and juvenile murderers are White (Snyder & Sickmund, 1995); this racial category therefore poses a high risk for violence. It should also be noted that youth in the United States of America appear to be at particularly high risk for violent behavior. Interpersonal violence is very much a part of contemporary American culture, and cultural norms guide the behavior of adolescents. In the United States, aggression among youth is promoted by many cultural forces including the media, gender-role socialization (for males), and cultural ideals that encourage competition and individualism (Moeller, 2001).

Another factor that may relate to the risk for aggressive behavior is gender. Findings from research conducted over the past few decades have suggested gender differences in physically aggressive behavior, with males demonstrating higher levels of aggression than females (e.g., Casper, Belanolf, & Offer, 1996; Rutter & Giller, 1983). Results of American studies indicating gender differences in aggression have cited a cultural norm in the United States that encourages aggression in males. An explanation can be gleaned from the "self-in-relation" model (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). This model posits that the development of the selves of females tend to be defined

largely through relations with others. Self-esteem is viewed as the degree to which girls feel they are successfully developing and maintaining relationships with important others. If emotional connections are severed and characterized by aggression then higher levels of self-esteem will not be realized in these girls and depression may result. In contrast, the selves of males tend to be based to a greater degree on autonomy and separateness. This may allow for less of a negative association between self-esteem and aggression and for greater acceptability and likelihood of behaviors such as aggression.

It should be noted, however, that more recent studies indicate that gender differences in aggressive behavior may be decreasing (Campbell, Sapochnik, & Muncer, 1997; Knox et al., 2000). There is some debate over whether the pathways to violence differ by gender or whether there are similar causes for aggression but different levels of protective or risk factors present in males and females (Stueve, O'Donnell, & Link, 2001). Different pathways or risk factors are indicated in recent research. For example, there are indications that female aggression is characterized by a later (adolescent) onset than male aggression (Loeber & Hay, 1997).

Another risk factor that may differ by gender is depression. A large proportion (78%) of the Knox et al. (2000) sample of depressed adolescents with high levels of aggression was female. This finding begets the question of whether depression is a risk factor for female aggression. Research on adult samples has formulated aggression as relatively instrumental or expressive in nature (e.g., Campbell, Muncer, McManus, & Woodhouse, 1999). These studies have demonstrated significant gender differences, with males representing their aggression as an act with the objective of taking control over others (instrumental representation). In contrast, females were more likely to represent their aggression as a loss of control over themselves, for example, when overcome by negative emotion (expressive representation). The effect size for this gender difference is large ($d$ = .842; Campbell et al., 1999). Extrapolating from these findings, one might hypothesize that negative affect such as the depressed, irritable mood characteristic of depressive disorders in adolescents may be a risk factor for aggressive behavior characterized by an expressive representation. If females are more likely to demonstrate expressive aggression then aggression may be more prevalent in depressed than

nondepressed females; whereas for males, this may not be the case. In a study using a sample of adults (ages 18 to 40 years; Bjork, Dougherty, & Moeller, 1997), level of depressive symptoms was positively associated with aggressive responses in women but not in men. In a study of childhood aggression, children who engaged in gender-nonnormative forms of aggression (e.g., overt physical aggression in females) demonstrated significantly more social-psychological maladjustment than those who engaged in gender-normative forms of aggression (Crick, 1997). Loeber and Stouthamer-Loeber (1998) described a "gender paradox" in which females who meet criteria for gender-nonnormative disorders, such as behavior disorders characterized by aggression, tend to be at higher risk for psychological problems in general. Accordingly, higher levels of psychological maladjustment such as depression may be associated with aggression in adolescent females but not in males.

In addition, females may be particularly vulnerable to exacerbation of depression following aggressive acting out. During adolescence, gender-role socialization intensifies and females are expected to conform more strongly to the feminine sex role (Hill & Lynch, 1983; Wichstrom, 1999). Furthermore, at this time, affiliative orientation is intensified. During adolescence, females place greater importance on social relationships, spend more time with peers (Larson & Richards, 1991), and talk more about interpersonal issues (Raffaelli & Duckett, 1989). At the same time, socialization pressures prohibit anger and related behaviors such that many girls suppress anger (Cox, Stabb, & Hulgus, 2000). For American females, the feminine gender role is marked by a high degree of responsibility for maintaining and advancing emotional aspects of relationships (Bee & Bond, 2002). For many girls, aggression is at odds with the feminine gender role and the intensified relational orientation that occurs at adolescence. If girls engage in aggressive behavior, others (and themselves) may view this behavior as unseemly and may view them more negatively (Barber, Foley, & Jones, 1999). In fact, recent research has demonstrated that, for girls, physical aggression consistently results in peer rejection; whereas for boys, aggression can lead to either popularity or peer rejection (Rodkin, Farmer, Pearl, & Van Acker, 2000; Xie, Cairns, & Cairns, 1999). This rejection of aggressive girls may be particularly devastating because girls place greater importance on popularity than boys do

(Oldenburg & Kerns, 1997). As a result, aggressive girls may experience increased negative affect and decreased self-esteem, resulting in depression.

This study compares depressed inpatient youth to nondepressed inpatient youth to determine whether rates of aggression are higher in treatment-seeking adolescents with depressive disorders and whether these differences are gender-specific. Aggressive behavior in depressed and nondepressed adolescent inpatients at a psychiatric hospital was examined. We hypothesized that depression and gender will interact significantly such that females with depression will report more physical aggression than nondepressed females, whereas males will not demonstrate such differences.

## METHOD

### PARTICIPANTS

Our sample consisted of 84 adolescents, aged 13 to 17 years. The mean age of the sample was 14.64 years (*SD* = 1.35). The sample comprised 49 (58%) females and 35 (42%) males. All participants were inpatients at a child and adolescent psychiatric hospital. The majority of the sample was White (88.1%). Of the remaining participants, 6.0% were African American, 2.4% were Hispanic, and 3.6% were other or unknown. A full range of socioeconomic statuses (SES) was represented. Because data were not available for a large proportion (36%) of fathers or male caretakers (in many cases because they were not in the home), these data were dropped from the analysis. The mean socioeconomic index score (Stevens & Featherman, 1981), based on mothers' occupations, was 30.44 (e.g., sales clerk; *SD* = 16.87). Parent occupation scores ranged from 11.44 (textile worker) to 75.27 (engineer).

Inclusion criteria included inpatient status and age between 13 and 17 years. Exclusion criteria included mental retardation, pervasive developmental disorder, and psychoses other than major depressive disorder with psychotic features. The research design was approved by the institutional review board to ensure human participant protection.

**MEASURES**

In an attempt to delineate the relative onset of depression and aggression, we collected information on past depressive disorders and current aggression. The Diagnostic Interview for Children and Adolescents for the *Diagnostic and Statistical Manual for Mental Disorders*, fourth edition (DICA-IV) (Reich, Welner, & Herjanic, 1997) was used to identify past (lifetime) major depressive disorder and/or dysthymic disorder. The DICA-IV is a computerized, structured interview designed to identify psychiatric problems in children and adolescents. It is based on the *Diagnostic and Statistical Manual for Mental Disorders*, fourth edition (American Psychiatric Association, 1994). The DICA-IV has high 1 week test-retest reliability ($K = 0.71$) for past depression (Reich, 2000). Good validity has also been demonstrated (De la Osa, Ezpeleta, Oomenech, Navarro, & Losilla, 1997; Reich, 2000).

To limit findings to acts of physical aggression, we used scores on the Physical Aggression (Assault) subscale of the Buss Durkee Hostility Inventory, adapted version (BD) (Boone & Flint, 1988; Buss & Durkee, 1957), in these analyses. The BD is a self-report measure of aggressive behavior. The scale includes 10 items addressing physical aggression toward friends and strangers. Items include "I hit when I'm bugged and pestered by friends" and "When I really lose my temper, I'm likely to hit strangers." Adequate internal consistency of the scale has been demonstrated (Boone & Flint, 1988; Knox et al., 2000). Good construct and concurrent validity have also been demonstrated; the BD correlates significantly and positively with adolescent males' scores on the Conflict Tactics Scale and with adolescent males' and females' scores on the Brown-Goodwin Assessment for Lifetime History of Aggression, adapted version (Boone & Flint, 1988; Knox et al., 2000). The scale discriminates between institutionalized aggressive and noninstitutionalized nonaggressive adolescents (Boone & Flint, 1988).

Because conduct disorder and bipolar disorder may relate to differences in aggression in depressed youth, we also gathered data on these disorders. These diagnoses were made using *DSM-IV* (American Psychiatric Association, 1994) criteria by Wun Jung Kim, a board-certified child and adolescent psychiatrist.

### PROCEDURES

We drew the sample from consecutive admissions to the psychiatric adolescent inpatient unit over the course of 1 year. We obtained written informed consent from the adolescents' parents or legal guardians who agreed to participate, and we obtained written assent from adolescents. Adolescent participants were interviewed in the inpatient unit and parents and legal guardians completed study measures prior to or after visits to the unit. The measures were presented in a counterbalanced order. For adolescents with reading difficulties, all materials, including the DICA-IV and the questionnaires, were read aloud by the interviewer.

### DATA ANALYSIS

Descriptive statistics were computed to evaluate the prevalence of aggressive behavior in the participants. We used ANOVAs to examine differences in physical aggression in groups with and without conduct disorder and bipolar disorder. We utilized an ANCOVA to determine whether depression and gender interact significantly. For this analysis, bipolar disorder was the covariate. We used independent samples *t* tests to examine within-gender differences between groups of depressed and nondepressed youths.

## RESULTS

Table 1 depicts aggression scores for depressed and nondepressed females, males, and the total sample. Males and females did not differ significantly in number of inpatient hospitalizations, age, or SES ($p > .05$). Males and females also did not differ significantly in the total amount of physical aggression, physical aggression toward strangers, or physical aggression toward friends ($p > .05$).

Of the total sample, 41 participants (48%; 25 females, 16 males) had a history of depression (major depressive disorder or dysthymia or both). Because conduct disorder and bipolar disorder may relate to aggression in a sample of depressed youth, we also calculated frequencies for these variables. Six participants (7.1%; 6 males, 0 fe-

**TABLE 1**

**Means and Standard Deviations of Scores on Aggression Measure by Gender and by Presence or Absence of Past Depression**

| | *Male* | | | | *Female* | | | | *Total* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Depressed* | | *Nondepressed* | | *Depressed* | | *Nondepressed* | | *Depressed* | | *Nondepressed* | |
| *Physical Aggression* | M | SD | M | SD | M | SD | M | SD | M | SD | M | SD |
| Friends | 4.81 | 6.52 | 9.79 | 10.73 | 7.08 | 7.58 | 3.00 | 4.27 | 6.20 | 7.19 | 6.00 | 8.43 |
| Strangers | 3.50 | 6.86 | 8.37 | 9.13 | 7.00 | 8.85 | 2.96 | 6.08 | 5.63 | 8.22 | 5.35 | 7.96 |
| Total | 8.31 | 10.93 | 18.16 | 18.93 | 14.08 | 14.91 | 5.96 | 7.41 | 11.83 | 13.65 | 11.35 | 14.88 |

NOTE: Depressed male $n = 16$; nondepressed male $n = 25$; depressed female $n = 19$; nondepressed female $n = 24$.

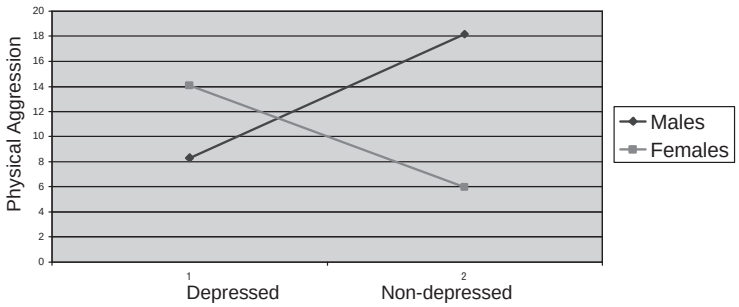


**FIGURE 1: Physical Aggression in Depressed and Nondepressed Adolescents by Gender**

males) had comorbid conduct disorder, and 16 (19.0%; 8 males, 8 females) had bipolar disorder. ANOVA results revealed no significant main effect of conduct disorder or bipolar disorder, and no interaction, on report of physical aggression.

Because results indicated that bipolar disorder may influence levels of aggression, an ANCOVA was used with bipolar disorder (presence vs. absence) as the covariate. As hypothesized, ANCOVA results indicate a significant gender by depression interaction ($F = 10.37$; $p < .01$) for scores on the BD Physical Aggression subscale. Main effects of gender and depression were not significant. The covariate (bipolar disorder) was significant ($F = 5.09$; $p > .05$).

Post-hoc *t* tests, using estimated marginal means, indicate that depressed females reported significantly more aggressive behavior than nondepressed females ($t = 2.33$; $p < .05$). Depressed males differed significantly from nondepressed males ($t = –2.25$; $p < .05$). The difference for males was in the opposite direction of the difference for girls (see Figure 1). That is, males with depression reported significantly lower levels of aggression than nondepressed males.

## DISCUSSION

This study compares primarily White depressed inpatient youth to primarily White nondepressed inpatient youth to determine whether rates of aggression are, in fact, higher in treatment-seeking adolescents

with depressive disorders and whether these differences are gender-specific. Factors such as developmental level, cultural forces, and treatment-seeking status indicate that the sample was at particularly high risk for aggression. These results indicate that depression may be a greater risk factor for aggressive behavior for female, as compared to male, adolescents with psychiatric disturbance. This finding appears in a sample of inpatient youth who are hospitalized due to serious risk of harm to oneself or others, or due to serious psychiatric disturbance. Frequently, depressed youth are hospitalized because they pose a serious risk of harm to themselves, whereas nondepressed youth are hospitalized for severe aggression (i.e., serious risk of harm to others) and related issues. Thus, one might expect a depressed inpatient sample to be less aggressive than other inpatients, and this appears to be the case for males. However, for females, these findings indicate the reverse; depressed female inpatients were found to be more aggressive than nondepressed female inpatients. This finding is consistent with recent research findings and indicates that depression may be a risk factor for aggression in adolescent females.

These findings are in contrast to past work by Gjerde (1995), who found the opposite pattern: Depressed females tended to be reserved and introspective in contrast to depressed males, who were found to be angry and more apt to engage in aggression. The differences between the samples may account for these apparently contrary findings. This sample is made up of inpatient youth with serious emotional disturbance, whereas Gjerde's was a nonclinical sample. Further, because Gjerde's sample was collected a decade earlier, there may be a cohort effect. It is clear that adolescent aggression has increased in recent years. This may reflect a cultural shift for American adolescents; aggression is now very common in the media and other socialization influences predominant in American society and the relationship of these factors with aggression has been clearly demonstrated (e.g., Anderson & Bushman, 2002). This increase in aggression appears to be particularly true for females with severe emotional disturbance (Tardiff, Narzuk, Loen, Portera, & Weiner, 1997).

Aggression may be more prevalent in depressed than nondepressed females because females are more likely to demonstrate expressive (as opposed to instrumental) aggression in response to a depressed or irritable mood. More broadly, as has been implicated by Loeber and

Stouthamer-Loeber (1998), females with high levels of aggressive behavior may also demonstrate generally high levels of psychological maladjustment. Further research is needed to clarify whether aggression is related to generally heightened levels of psychological disturbance or more specifically to depression.

There are indications that female aggression is characterized by a later (adolescent) onset than aggression in males. The onset of physical aggression in females may coincide with the onset of depressive disorders during adolescence, which occurs in a substantial proportion of females. It is also possible that this sample was made of females with internalizing symptoms that were undertreated or remained untreated until symptoms were exacerbated or externalized. That is, this sample may be made of females with long-standing depression that had remained untreated and worsened, leading to the development of aggressive behavior problems. It is also possible that the presence of aggressive behavior leads to depression in adolescent females. Previous research has indicated that physically aggressive girls may experience more rejection from others and increased levels of maladjustment, possibly due to the fact that the aggression is considered atypical for females, and such behavior defies the mandates of gender-role socialization which is intensified at this stage. Longitudinal research is needed to address these questions.

#### LIMITATIONS

The lack of gender differences in aggression could reflect a selection bias related to reasons for admission for inpatient hospitalization and gender-role expectations. Adolescents who demonstrate symptoms that are considered unusual for their genders may be more likely to be hospitalized. That is, males (who may typically be expected to engage in more externalizing behavior) may be considered more troubled when demonstrating significant internalizing symptoms. In contrast, females (who may be expected to demonstrate more internalizing symptoms) may be judged to be more psychiatrically disturbed when demonstrating significant externalizing symptoms such as aggression. For these reasons, females may be more likely to be admitted if demonstrating aggression and males may be more likely to be admitted if demonstrating other symptoms. Such a selection bias would

even out gender differences in aggression that may be present in a nonclinical or outpatient sample.

We attempted to address in this study the direction of influence of aggression and depressive disorders by focusing on past depressive disorders and current aggression. However, it should be noted that we collected self-reports of these symptoms (past depression and current aggression) not longitudinally but rather concurrently, and therefore strong conclusions about the relative onset of aggression and depression cannot be made. Further research using longitudinal methods is needed to clarify this issue.

This sample was made up of adolescents hospitalized in a psychiatric unit. Lewis, Shanok, Cohen, Kligfeld, and Frisone (1980) reported that adolescents admitted to psychiatric and juvenile correctional facilities did not differ significantly in terms of psychopathology but they did differ in race and SES, with a higher proportion of White adolescents in the former group. Overrepresentation of White individuals is not uncommon in adolescent inpatient psychiatric programs and therefore these findings are likely representative of that group. However, the generalizability of these findings is likely limited to primarily that group. Whether different relationships exist between depression and aggression for White and minority adolescent girls and whether such differences therefore result in different patterns of referral to treatment or the penal system needs to be further investigated.

The results indicating an interaction between gender and depression were significant with bipolar disorder covaried out of the analysis. It should be noted, however, that some of the youths in this study may develop bipolar disorder in the future. Whether this group will differ in future aggression is unknown. Long-term follow-up of the sample is necessary to clarify this issue.

### CLINICAL IMPLICATIONS

These findings have implications for the referral and treatment of primarily White adolescent females such that depression may be considered a risk factor for aggression in treatment-seeking female adolescents. In contrast, treatment-seeking males with a history of depression may be at lower risk for aggressive acting out than their nondepressed, treatment-seeking male counterparts.

Past research demonstrates a trend toward the undertreatment of female adolescents with psychiatric disorders (Cuffe, Waller, Cuccaro, Pumariega, & Garrison, 1995). These results may be reflective of delayed treatment of females, suggesting the need for early detection and treatment of disorders for female youth. Missing depressive symptoms in adolescent females may pose a risk for both the worsening of depressive disorder and future aggression. Screening depressed youths for aggressive behavior will also be crucial to efforts designed to prevent or reduce youth violence. These results also suggest the need for careful screening of aggressive females, such as those in juvenile detention facilities, for depression. Particularly in the United States, where youth violence has become a serious public health issue, it is essential that risk factors such as depression be better understood and utilized in the identification and treatment of adolescents at risk for aggression. Further, it is imperative that clinicians are cognizant of the apparently increasing problem of female adolescent aggression in the United States and that they utilize emerging evidence of a distinct pathway for female aggression in understanding and treating this problem.

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