

ANTISOCIAL & AGGRESSIVE BEHAVIOR

- ASB in children and adolescents can fall into two primary categories in the DSM-IV-TR
 - Conduct Disorder (CD)
 - Oppositional Defiant Disorder (ODD)
- Official rates of ASB have fallen since the 1990's, but still much higher in US than in other industrialized nations

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DEFINING THE PROBLEM

- Legal perspective
 - "Delinquency" in children, "criminal" acts as adults
 - Can be just one act, not a series of acts
 - Official (what they got caught for) versus selfreported (what they admit to doing)

DEFINING THE PROBLEM

- Empirical, psychological perspective
 - Externalizing (acting out) versus internalizing (acting in) behaviors
 - ASB are in the externalizing, disruptive, actingout arena
 - Aggression and ASB, not ADHD-type behaviors
 - Frequently co-occur, but distinctly different

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DEFINING THE PROBLEM

- Diagnostic perspective
 - ODD and CD as disruptive behavior disorders in children / adolescents
 - ASPD for adults
- Developmental perspective
 - Examines development of callous / unemotional traits in childhood, and how it relates to traits of psychopathy in adults

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Types of Aggression & ASB

- Verbal vs. physical
 - Physical emerges earlier with peak during preschool years, verbal shows later onset
 - High levels of physical during middle childhood may warrant clinical attention, as may early emergence of verbal aggression
 - Physical aggression may become violent in later development

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TYPES OF AGGRESSION & ASB

- Instrumental (goal-directed) vs. hostile (inflicting pain is the goal)
- Proactive (bullying) vs. reactive (retaliatory)
 Highly related, but use evidence different kinds of processing deficits

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TYPES OF AGGRESSION & ASB

- Direct vs. indirect / relational – Indirect seen more often in females
- Broadly, overt vs. covert
 - Overt is the above categories, covert relates more to lying, stealing, destroying property, etc.

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ASB DIAGNOSTIC HISTORY

• Research on differences in ASB children for over 60 years

Early focused on "undersocialized" versus "socialized" behaviors

- DSM-III changes included
 - Operational criteria for CD
 - Four subtypes: Socialized vs. undersocialized and
 - aggressive vs. nonaggressive
 - Introduced a mild version called "oppositional disorder"

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ASB DIAGNOSTIC HISTORY

- DSM-III-R changed significantly
 - Increased number of symptoms needed
 - Subtypes became group/socialized type,
 - solitary/aggressive, and undifferentiated
 - "Oppositional disorder" was renamed ODD
- DSM-IV-TR kept these two categories separate, introduced several other differences

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ODD FEATURES

- Recurrent pattern of negativistic, defiant, disobedient, and hostile behavior towards authority figures
- Occurs outside of normal developmental levels and lead to impairment in functioning

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DSM-IV-TR CRITERIA

- Displaying four (or more) of these behaviors consistently over at least a six month period
 - Often loses temper
 - Often argues with adults
 - Often actively defies or refuses to comply with adults' requests or rules
 - Often deliberately annoys people
 - Often blames other for his or her mistakes or misbehaviors
 - Is often touchy or easily annoyed by others
 - Is often angry and resentful
 - Is often spiteful or vindictive

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DSM-IV-TR CRITERIA

- Behavior problems cause clinically significant impairment in social, academic, or occupational functioning
- Behaviors not part of a psychotic or mood disorder
- Criteria not met for Conduct Disorder or Antisocial
 Personality Disorder

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CD FEATURES

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- Repetitive and persistent pattern of behavior in which the basic rights of others or major ageappropriate societal norms or rules are violated
- Four main categories of symptoms
 - Aggressive conduct that threatens physical harm
 - Nonaggressive conduct that causes property damage
 - Deceitfulness or theft
 - Serious violations of rules

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DSM-IV-TR CRITERIA

- Have to have three (or more) of the following symptoms in past 12 months, with at least one in last 6 months
- Behavior problems cause clinically significant impairment in social, academic, or occupational functioning
- Criteria not met for Antisocial Personality Disorder if above age 18

Aggression to People and Animals

- Often bullies, threatens, or intimidates others
- Often initiates physical fights
- Has used a weapon that can cause serious physical harm to others

 A bat, brick, broken bottle, knife, gun
- Has been physically cruel to people
- Has been physically cruel to animals
- Has stolen wile confronting a victim
 Mugging, purse snatching, extortion, armed robbery
- Has forced someone into sexual activity

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def: caleb lack's DESTRUCTION OF PROPERTY Had deliberately engaged in fire setting with the intention of causing serious damage Has deliberately destroyed others' property (by means other than fire setting)

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DECEITFULNESS OR THEFT

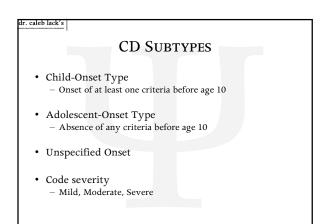
- Has broken into someone else's house, building, or car
- Often lies to obtain goods or favors or to avoid obligations

 "Cons" others
- Has stolen items of nontrivial value without confronting a victim

 Shoplifting, but without B&E; forgery

SERIOUS VIOLATIONS OF RULES

- Often stays out at night despite parental prohibitions – Beginning before age 13 years
- Has run away from home overnight at least twice while living in parental home
- Is often truant from school - Beginning before age 13 years



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VIABILITY OF CD AND ODD

- Both are divergent from ADHD

 Do show significant overlap in behavioral pattern and risk factors
- Different developmental course for
 - Diagnosed with ODD only
 - Diagnosed with ODD and then CD
 - Diagnosed only with CD

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VIABILITY OF CD AND ODD

- No strong evidence for discontinuity of symptoms in CD predicting course
- ODD is characterized by normal, developmentally appropriate behaviors
 - Often criticized for this fact in popular press
 Most with CD have ODD, but not all; most with ODD do not have CD

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VIABILITY OF CD AND ODD

- Number of possible symptoms in CD diagnosis guarantees heterogeneity of disorder

 Can have overt, covert, or mixed presentation
- DSM-IV included warnings not to ignore environmental context of aggressive behaviors

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PREVALENCE RATES

- With shifting diagnostic criteria over past 20 years, hard to get good long-term data
- Median estimates of 3% for ODD
 Range from 1-20%
- CD estimates from 1-10%, depending on criteria

SEX DIFFERENCES

- Initially, no sex differences in activity level, noncompliance, and other types of "difficult temperament" traits
- By elementary school, evident sex differences, with males showing more of every type of aggression
- May be that females' developmental course steers them more towards internalizing problems - May also be the differences in externalizing symptoms in females (e.g. sexual promiscuity, substance use, somatization)

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SEX DIFFERENCES

- ODD rates are equal in early childhood, but males predominate by early elementary years
- CD rates in childhood and preadolescence show a 4:1 malefemale ratio
 - Sex differences appear to disappear by adolescence
- Differences are notable in indirect/relational aggression, where females show much higher rates

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Comorbidity

- · Large amounts of comorbid problems in both ODD and CD
- ADHD
 - Associated with worse outcomes, such as more likely ASPD and higher levels of aggression
- Academic problems
 - Mediated by presence of ADHD in middle childhood "Snowball" effect

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er. caleb lack's RISK FACTORS - Difficult temperament - Hyperactivity (if co-occurs with CD) - Impulsivity - Substance use - Aggression - Early-onset of disruptive behaviors - Withdrawal - Low intelligence / executive function / information processing problems

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RISK FACTORS

• Family factors

- Parental substance use
- Modeling of antisocial/deliquent behavior by parents
- Parental history of mental problems, particularly father's ASB and mother's depression
- Peer factors
 - Rejection by peers
 - Association with delinquent peers/siblings

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RISK FACTORS

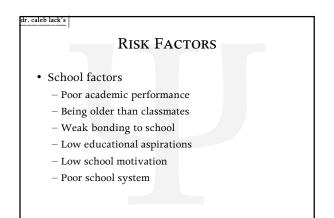
- Parenting practices
 - Poor parent-child relations
 Poor supervision / communication

 - Physical punishment
 - Parental neglect / abuse
 - Maternal nicotine use during pregnancy - Teenage / single parenthood
 - Disagreement on discipline among parents
 - Low SES / large family
 - Unemployed / poorly educated parents
 - High turnover of caretakers
 - Carelessness in allowing access to weapons

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RISK FACTORS

- Neighborhood factors
 - Neighborhood disadvantage or poverty
 - Disorganized neighborhood
 - Availability of weapons
 - Media portrayal of violence

dr. caleb lack's ASSESSMENT & DIAGNOSIS Structured or semi-structured clinical interview Should cover developmental and family history, DSM-IV ODD/CD symptoms, and symptoms of typical co-morbid problems E.g. ADHD, LDs, anxiety/mood disorders, etc. Parent, teacher, and self-reports of behavior Good scales to use include BASC and CBCL for overall screeners Due to high co-morbidity with ADHD, may want to use specific measures (e.g. Conners')

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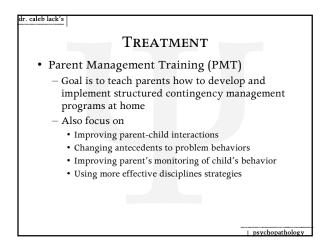
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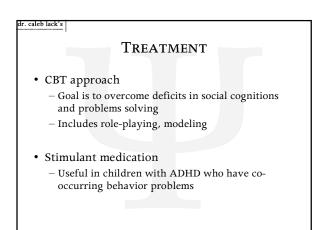
TREATMENT Treatment outcomes are much better for ODD than for CD Effective treatments are based on operant conditioning and social-cognitive learning principles Four empirically supported treatments

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TREATMENT

- Contingency management programs
 - Establish clear behavioral goals to shape towards appropriate behavior
 - Monitor the child's progress toward goals
 - Reinforce appropriate steps towards those goals
 - Provide consequences for inappropriate behavior





TREATMENT

• Multisystemic therapy (MST)

- Grows out of a family systems approach
- Intensive treatments that see problems in children's behavior as stemming from a larger family context
- Focuses on the role of the misbehavior in the family, then adjusting how the family responds and reacts to both the child and each other

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