Early Identification and Treatment of Antisocial Behavior

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KEYWORDS

• Antisocial behavior • Early identification • Treatment • Callous-unemotional traits
• Emotional regulation • Diagnosis

KEY POINTS

- Individuals most likely to show severe and persistent antisocial behavior often begin showing severe conduct problems early in childhood.
- Callous-unemotional (CU) traits are characterized by a lack of guilt, a lack of empathy, a restricted display of affect, and a failure to put forth the effort to succeed in important activities.
- The level of CU traits seems to differentiate subgroups of children and adolescents with serious conduct problems who differ in the severity and persistence of their antisocial behavior.
- The level of CU traits also seems to differentiate subgroups of children and adolescents with serious conduct who have different causes to their behavior problems.
- Treatment is enhanced when it is tailored to the unique characteristics of antisocial youth with and without elevated CU traits.

INTRODUCTION

Antisocial behavior in children and adolescents is generally defined by behavior that violates the rights of others, such as aggression, destruction of property, and theft; or behavior that violates major age-appropriate societal norms or rules, such as truancy and running away from home.[1] Serious and persistent patterns of antisocial behavior in children and adolescents form the diagnostic criteria for conduct disorder (CD),[1] and CD is a critical mental health concern for several reasons:

- It is highly prevalent with a worldwide prevalence among children and adolescents ages 6 to 18 estimated at 3.2%.[2]

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- It operates at a high cost to society because of the reduced quality of life for the victims of the antisocial acts and the financial costs to the legal system that must respond to the acts that violate laws.[3]
- It predicts a host of problems in adjustment for the person with the disorder throughout their lifespan, including mental health problems (eg, substance abuse), legal problems (eg, risk for arrest), educational problems (eg, school dropout), social problems (eg, poor marital adjustment), occupational problems (eg, poor job performance), and physical health problems (eg, poor respiratory function).[4]

Given the prevalence, cost, and impairment associated with CD, it is not surprising that a substantial amount of research has been conducted to understand the causes of this disorder and to use this knowledge to develop effective methods to prevent or treat it. One of the most consistent findings from this work is that interventions that seek to target a reduction in antisocial behavior are least costly and most effective if they are implemented early in childhood.[5] As a result, a substantial amount of research on CD has focused on identifying early markers that predict either who will develop the disorder or who is at risk for showing the most severe and persistent forms of antisocial behavior once it develops.

BEHAVIORAL APPROACHES TO EARLY IDENTIFICATION

Types of Behavior Associated with Poor Outcomes

Early research attempting to identify early indicators of risk for persistent antisocial behavior focused on the frequency and severity of the behavior displayed, with severity being defined as the number and variety of different behaviors displayed by the child and the number of settings in which the child displays the behaviors.[6] For example, Robins reported on a classic longitudinal study of 314 children referred to a child mental health clinic for CD symptoms and reported that the risk for showing an antisocial disorder as an adult was a linear function of the number of symptoms exhibited in childhood.[7] Specifically, 15% of children with 3 to 5 symptoms in childhood were diagnosed with an antisocial disorder as an adult, in comparison to 25% of children with 6 or 7 symptoms, 29% of children with 8 or 9 symptoms, and 43% of children with greater than 10 symptoms.

Another early marker of severity for children and adolescents with CD has been the presence of aggression. That is, when antisocial behavior is separated into those behaviors that can be considered aggressive (eg, bullies others, initiates physical fights) and those that are nonaggressive (eg, vandalism, lies, truant), the aggressive behaviors seem to be more stable and stronger predictors of problems continuing into adulthood.[8] In addition to simply documenting the presence of aggression, there has been research suggesting that the form that the aggression takes could be important. For example, research has distinguished between reactive aggression, which occurs as an angry response to provocation or threat, and proactive aggression, which is typically unprovoked and often used for instrumental gain or dominance over others.[9] Research suggests that some children with severe conduct problems only show reactive forms of aggression, whereas others show a combination of both reactive and proactive forms of aggression.[10] Children showing combined forms of aggression often have more problems across development.[9]

Thus, research suggests that the number, severity, and degree of harm that a child's antisocial behavior causes to others are important factors to consider as markers of risk for poor outcome. To reflect this, the diagnostic criteria for CD in the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM)[1,11] have