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Review article

# Psychiatric evaluation of youths with Disruptive Behavior Disorders and psychopathic traits: A critical review of assessment measures

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ABSTRACT

Disruptive Behavior Disorders (DBDs) are stable and impairing disorders, heterogeneous in presentation, developmental pathways, and treatment needs. Disentangling subtypes according to psychopathological dimensions is helpful for timely diagnoses, precise prognoses and tailored interventions. Psychopathic traits are relevant in subtyping DBDs with severe antisocial and aggressive behaviors. Three psychopathy dimensions have been found: 1) an affective dimension, the callous-unemotional (CU) trait, with lack of empathy and remorse, and with short-lived emotions; 2) an interpersonal dimension, the narcissistic domain, with manipulative abilities, superficial charm, egocentricity and grandiosity; 3) a behavioral dimension, the impulsivity or impulsive-irresponsibility, with irresponsibility, proneness to boredom, and novelty seeking. Recently, research suggests that youth with CU traits, similarly to adults with psychopathy, can present a low-anxious "primary" and high-anxious "secondary" variants. Our aim is to critically review the main measures of psychopathic traits, including the three main dimensions (with specific emphasis on CU traits), and the "primary/secondary" distinction, focusing on the assessment in clinical settings. An assessment procedure is proposed, based on previous literature and personal clinical experience.

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## 1. Introduction

Disruptive Behavior Disorders (DBDs), including Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD), are among the

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most frequent clinical conditions in child and adolescent mental health settings (Steiner and Remsing, 2007). They are associated with a host of social, emotional, and behavioral problems with high costs for the community (Kolko and Pardini, 2010; Odgers et al., 2008). In the DSM-5 (American Psychiatric Association, 2013), ODD and CD are part of a new, wider category named Disruptive, Impulse–Control and Conduct Disorders, which also includes other behavioral problems, such as Intermittent Explosive Disorders, Kleptomania, Pyromania, Antisocial Personality Disorder, and Unspecified Disruptive, Impulse-Control and Conduct Disorders. This category, although necessary for a diagnosis, cannot capture the complexity of the clinical manifestations of DBDs, which are highly heterogeneous in terms of clinical presentation, outcome, and response to treatments (Frick and Viding, 2009). Recent research has been focused on reducing this heterogeneity, to improve the clinician's diagnostic and prognostic abilities.

Psychopathic traits, previously considered as a meaningful (negative) specifier for severe antisocial and aggressive behaviors in adult psychopathology, have been re-discovered as a relevant factor in subtyping conduct problems in youth (Frick et al., 2000a). The multidimensional structure of adult psychopathy has been confirmed in adolescents (Frick et al., 2000b; Kotler and McMahon, 2005), and three main psychopathy dimensions have been found: 1) an affective dimension, callous-unemotional (CU) trait, characterized by lack of empathy and remorse together with short-lived emotions; 2) an interpersonal dimension, narcissism or grandiose manipulation, characterized by verbal and manipulative abilities, superficial charm, egocentricity and glibness; 3) a behavioral dimension, impulsivity or disinhibition or impulsive-irresponsibility, whose main features are irresponsibility, proneness to boredom, novelty seeking and antisocial behaviors. Some variations of these features depend on the diagnostic measures used.

Callous-Unemotional traits have been more extensively explored in youth with DBDs, providing additional diagnostic and prognostic value to the DBD diagnosis in youth, with respect to a variety of cognitive, affective, personality, social and neurobiological features, as extensively described by Frick et al. (2014). These findings suggest that the causal mechanisms underlying behavioral problems may be different in DBD children and adolescents with or without CU traits. Previous studies have shown that CU traits in childhood with DBDs are concurrently and prospectively associated with more severe behavioral problems (Lopez-Romero et al., 2012; Lynam et al., 2009; McMahon et al., 2010), lower levels of pro-social behavior, social competence skills and emotional regulation (Masi et al., 2011; Viding et al., 2005), increased risk of maintaining disruptive behavior and of poorer treatment response (Fontaine et al., 2011; Masi et al., 2013; Pardini and Loeber, 2008). Processing emotions is disrupted as well, being patients impaired in their responsiveness to and recognition of cues to others' fear and sadness (Frick et al., 2014). More specifically, CD youths with CU traits, compared to those with CD without CU, engage in more severe and persistent patterns of antisocial behavior, even controlling for the severity or the age of onset of their CD, and for comorbidities (Frick and White, 2008; Muratori et al., 2016a). Intriguingly, youths with CU traits without conduct problems exist, present lower levels of impulsivity and higher levels of executive control and self-regulation, and more school integration than those with high CU traits and conduct problems (Wall et al., 2016).

All these features are associated with putative markers of Central Nervous System (CNS) functioning, namely a reduction in amygdala activity and a dysfunction of the caudate, nucleus accumbens, and ventro-medial prefrontal cortex (for a review see Blair, 2013). As a consequence of this extensive body of research, the DSM-5 has included the specifier "with Limited Prosocial Emotions" (LPE) within the diagnostic category of CD (American Psychiatric Association, 2013). To fit the criteria for this CD specifier, patients must meet a full diagnosis of CD and present at least two features among the following: lack of remorse or guilt, callous-lack of empathy, unconcern about performances, shallow or deficient affect. These features must be present for at least 12 months and in more than one relationship and setting, as ascertained possibly according to multiple sources of information.

Parallel to the analysis of psychopathic traits, and not alternatively to this approach, another line of evidence has focused on the distinction between "primary" and "secondary" psychopathy variants (Karpman, 1941, 1948). According to this taxonomy, the two variants are phenotypically indistinguishable, but they differ with respect to the presence of anxiety and the motivational and etiological origins of antisocial and aggressive behavior. Research focused on subtyping children and adolescents with psychopathic traits and high on CU traits indicates that excessively low ("primary") and high ("secondary") anxiety levels may represent a meaningful disentangling element (Kimonis et al., 2011). High-anxious CU variants are characterized by lower self-esteem, greater psychosocial immaturity (e.g., irritability, withdrawal, poor assertiveness), greater susceptibility to peer pressure, higher impulsivity and reactive aggression scores (Fanti et al., 2013). These findings also suggest distinct risk factors associated with the two variants of psychopathy, with the secondary variant being more related to histories of abuse (Kimonis et al., 2012). To date, the interrelation among CU traits, anxiety symptoms, and the severity of behavioral problems in CD patients is intriguing, even if complex and incompletely understood.

The aim of this review is to critically analyze the available measures for the diagnosis of youth with DBDs and psychopathic traits, with a specific focus on the evaluation in clinical settings, for further tailoring clinical assessment and treatment options, thus impacting prognosis. Although the all the three psychopathic dimensions (CU, narcissism, impulsivity) will be addressed, the first and principal focus of the analysis will be the affective dimension, that is the CU traits, including possible developmental caveats in its evaluation. Based on the line of evidence supporting the distinction between primary and secondary psychopathy, the diagnostic implications of this conceptualization and taxonomy will be also explored (Table 1).

## 2. Methodological caveats in the assessment of callous unemotional traits

The clinical assessment of CU traits in patients with CD and other DBDs may present specific caveats. The first issue regards the stability of CU traits in time. Although CU traits are usually considered stable during development, not all youths presenting these features at the first evaluation continue to show them across childhood, and from childhood to early adolescence, both in the natural course, and as a consequence of specific interventions (Frick et al., 2003a; Dadds et al., 2005; Obradivic et al., 2007; Fontaine et al., 2010, 2011). For instance, some longitudinal studies with typical developing youths suggest that CU traits more commonly decrease rather than increase in time (Frick et al., 2003b; Lynam et al., 2007; Pardini and Loeber, 2008). Other studies exploring CU traits in children with behavioral problems have shown that CU scores may decrease after treatment for a subset of patients, and those with the most stable and high CU traits show the poorest outcomes at follow-up (Hawes and Dadds, 2005; Kolko et al., 2009). Fontaine et al. (2010) found that a small proportion of children have unstable levels of CU traits over time, although elevated levels of CU traits (even if unstable) represent a relevant marker for risk of adjustment problems in early adolescence. Callous Unemotional traits can be

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