ASPD and Childhood Disorders

DSM Criteria for Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
(*on the following slide*)

B. The individual is at least age 18 years

C. There is evidence of conduct disorder with onset before age 15 years

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode

DSM Criteria for Antisocial Personality Disorder

Three or more of the following:

1. Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
2. Deceitfulness, as indicated by repeated lying, use of aliases, or coning other for personal profit or pleasure
3. Impulsivity or failure to plan ahead
4. Irritability and aggressiveness, as indicate by repeated physical fights or assaults
5. Reckless disregard for safety of self or others
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

ASPD Prevalence

- One of the most common personality disorders
- In community settings:
  - Overall: 4.1%
  - Men > Women: 3:1
- In prison settings:
  - 50-80% among men
  - 20-60% among women

- Some researchers argue that there is no difference in prevalence rates for males and females.
- Others argue that women are more likely to receive at BPD diagnosis and men an ASPD diagnosis when displaying the same types of behaviors.
- While they may share some similarities, these are very different disorders.

ASPD: Comorbidity & Gender Differences

- Substance abuse: 80%
- Increased risk for violent death and suicide (particularly females with ASPD)

Antisocial versus Psychopathy

- Not in the DSM
- ASPD broader than psychopathy
- More behavioral, less affective and interpersonal
- Overlap but not the same thing

Theory

- Genetics play a role – concordance rates are about 50% for MZ
- Genetic deficit s that make them prone to antisocial behavior – poor impulse control
- Impulsiveness and aggression are linked to low levels of serotonin

Theory

- Deficits in verbal skills and executive functioning of the brain
- Linked to deficit in frontal lobe
- These deficits cause poor impulse control

Theory

- Low arousability
  - Low levels of fear
  - Stimulation seeking
- Hostile Attribution Bias
  - Result of harsh or inconsistent parents
- Classical conditioning
  - do not learn to avoid painful stimuli

Theories of Antisocial Personality Disorder

- Genetic predisposition
- Deficits in brain structure and functioning
- Low levels of arousability
- Testosterone
- Harsh and inconsistent parenting
- Physical abuse

Treatment of ASPD

- No psychosocial or medication treatment for ASPD has a strong or even promising evidence-base
- Increase empathy; Develop alternative coping strategies
- Potentially SSRIs – thought not tested

Prognosis

- There is evidence that ASPD is not as persistent as assumed, and that there maybe a process of "mellowing" with age

- Moffit and Caspi's research has supported the existence of two types of ASPD: "adolescent limited" type and a "persistent" type.
  - Persistent type endures into/throughout adulthood

The Ice Man Video:

- **http://www.youtube.com/watch?v=jjTYwZKuyBs**

Prevalence of Mental Disorders in Children

TABLE 10.2 Prevalence of Mental Disorders in Children

Estimated percentages of children who suffer psychological disorders by age 16 years (note that children can be diagnosed with more than one disorder).

Diagnosis	Total	Girls	Boys
Any disorder	36.7%	31.0%	42.3%
Any anxiety disorder	9.9	12.1	7.7
Any depressive disorder	9.5	11.7	7.3
Any behavior disorder	23.0	16.1	29.9
Conduct disorder	9.0	3.8	14.1
Oppositional defiant disorder	11.3	9.1	13.4
ADHD*	4.1	1.1	7.0
Substance use disorder (e.g., alcohol abuse)	12.2	10.1	14.3

Source: Costello, Mustillo, et al., 2003.

*ADHD = attention-deficit/hyperactivity disorder

DSM Criteria for Oppositional Defiant Disorder

- **A.** A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling

  (on the following slide)

- **B.** The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.
- **C.** The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder.

DSM Criteria for Oppositional Defiant Disorder

Four or more of the following:

Angry/Irritable Mood

1. Often loses temper
2. Is often touchy or easily annoyed
3. Is often angry and resentful

Argumentative/Defiant Behavior

4. Often argues with authority figures or, for children and adolescents, with adults
5. Often actively defies or refuses to comply with requests from authority figures or with rules
6. Often deliberately annoys others
7. Often blames others for his or her mistakes or misbehavior

Vindictiveness

8. Has been spiteful or vindictive at least twice within the past 6 months

DSM Criteria for Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violates, with the presence of three (or more) of the following in the past 12 months, with a least one in the past 6 months:

(on the following slide)

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning

C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder

DSM Criteria for Conduct Disorder

Three or more of the following:

- Aggression to people and/or animals
  1. Often bullies, threatens or intimidates others
  2. Often initiates physical fights
  3. Has used a weapon that can cause serious physical harm to others
  4. Has been physically cruel to people
  5. Has been physically cruel to animals
  6. Has stolen while confronting a victim
  7. Has forced someone into sexual activity
- Destruction of property
  1. Has deliberately engaged in fire setting with the intention of causing serious damage
  2. Has deliberately destroyed others' property (other than by fire setting)
- Deceitfulness or theft
  1. Has broken into someone else's house, building, or car
  2. Often lies to obtain goods or favors or to avoid obligations (i.e., cons others)
  3. Has stolen items of nontrivial value without confronting the victim (e.g., shoplifting, but without breaking and entering: forgery)
- Serious violations of rules
  1. Often stays out at night despite parental prohibitions, beginning before age 13 years
  2. Has run away from home overnight at least twice while living in a parental or parental surrogate home (or once without returning for a lengthy period)

Treatment for Conduct and Oppositional Defiant Disorders

- Psychological and Social Therapies
  - Cognitive-Behavioral Therapy: teach problem-solving skills, teach "self-talk," discuss real and hypothetical situations, and practice appropriate responses.
  - Family Therapy

- Drug Therapies

DSM Criteria for Attention-Deficit/Hyperactivity Disorder

Either A or B: Six or more for at least 6 months that is disruptive and developmentally inappropriate

Inattention

- Not give close attention to details or makes careless mistakes in schoolwork, work or other activities
- Trouble keeping attention on tasks or play activities
- Not seem to listen when spoken to directly
- Not follow instruction and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- Has trouble organizing activities
- Avoids, dislikes, or doesn't want to do tasks involving prolonged mental effort (such as schoolwork or homework)
- Loses things needed for tasks and activities (e.g. toys, school assignments)
- Easily distracted
- Forgetful in daily activities

A. Inattention

Hyperactivity

- Fidgets with hands or feet or squirms in seat
- Gets up from seat when remaining in seat is expected
- Runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless)
- Has trouble playing or enjoying leisure activities quietly
- Often "on the go" or often acts as if "driven by a motor"
- Talks excessively

Impulsivity

- Blurts out answers before questions have been finished
- Has trouble waiting one's turn
- Interrupts or intrudes on others (e.g. butts into conversations or games)

B. Hyperactivity- Impulsivity

DSM-IV TR Criteria for Attention-Deficit/Hyperactivity Disorder

Criteria continued….

- C. Some symptoms that cause impairment were present before age 7*
- D. Some impairment from the symptoms is present in two or more settings (e.g., at school/work and home)
- E. Clear evidence of significant impairment in social, school, or work functioning.

- *changed in DSM V to age 12

Treatments for ADHD

- Stimulants
  - Most children with ADHD are treated with stimulant drugs, such as Ritalin, Dexedrine, and Adderall
  - May work by increasing levels of dopamine
- Other drugs (e.g., atomoxetine, clonidine, and guanfacine)
  - Not stimulants but affect levels of norepinephrine
- Behavioral therapies
  - Focus on reinforcing attentive, goal-directed, and prosocial behaviors and extinguishing impulsive and hyperactive behaviors
- Combination of stimulant therapy and psychosocial therapy is best

DSM-IV-TR Criteria for Separation Anxiety Disorder

- **A.** Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by 3 or more of the following:
  - Recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
  - Persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
  - Persistent and excessive worry that an event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
  - Persistent reluctance or refusal to go to school or else where because of fear of separation
  - Persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
  - Persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
  - Repeated complaints of physical symptoms (headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated
- **B.** The duration of the disturbance is at least 4 weeks.
- **C.** The onset is before age 18 years.
- **D.** The disturbance causes clinically significant distress or impairment in social, academic or other important areas of functioning.

Proposed Etiologies for Separation Anxiety Disorder

Biological: may be genetic predisposition to anxiety disorders, including separation anxiety and panic attacks.

Behavioral inhibition: children are born with an inhibited, fearful temperament.

Traumatic and uncontrollable events: traumatic events can cause chronic uncontrollability; parents may encourage fearful behavior or not encourage independence.

Treatments for Separation Anxiety

- Cognitive-Behavioral Therapies
  - New skills for coping and for challenging cognitions that feed anxiety
  - Relaxation exercises
  - Challenge fears about separation
  - Learn to use “self-talk” to calm themselves
  - Increased periods of separation from the parents
  - Parents may be taught to model nonanxious reactions to separations and to reinforce nonanxious behavior in their children.
- Medication

Elimination Disorders

- Enuresis
  - Unintended urination at least 2x/week for 3 months
  - Child over 5 years of age
  - Causes may be genetic, or anxiety/conflicts, or inapproriate toilet training
  - Treated with medications, bell and pad method
- Encopresis
  - Unintended defecation at least 1x/month for 3 months
  - Child over 4 years of age
  - Usually begins after episodes of severe constipation
  - Treated with medication and behavioral contracting

Disorders of Cognitive, Motor, and Communication Skills

Learning disorders	▪ Reading disorder ▪ Mathematics disorder ▪ Disorder of written expression	▪ Deficits in ability to read ▪ Deficits in mathematics skills ▪ Deficits in the ability to write
Motor skills disorders	▪ Developmental coordination disorder	▪ Deficits in the ability to walk, run, hold on to objects
Communication disorders	▪ Expressive language disorder ▪ Mixed receptive-expressive language disorder ▪ Phonological disorder ▪ Stuttering	▪ Deficits in the ability to express oneself through language ▪ Deficits in the ability both to express oneself through language and to understand the language of others ▪ Use of speech sounds inappropriate for age or dialect ▪ Severe problems in word fluency

Causes and Treatment of Disorders of Cognitive, Motor, and Communication Skills

- Genetic factors
- Abnormalities in brain structure and functioning
- Environmental factors
  - lead poisoning
  - birth defects
  - sensory deprivation
  - low socioeconomic status

- Treatment of these disorders usually involves therapies designed to build missing skills

Criteria for Intellectual Disability (Intellectual Developmental Disorder)

- The diagnosis of mental retardation requires that a child show both poor intellectual functioning and significant deficits in everyday skills
- A. Significantly sub average intellectual functioning, indicated by an IQ of approximately 70 or below.
- B. Significant deficits relative to others of the same age in at least two of the following areas:
  - Communication
  - Self Care
  - Home Living
  - Social or interpersonal skills
  - Use of community resources
  - Self direction
  - Academic skills
  - Work
  - Leisure
  - Health
  - Personal safety
  - Onset before age 18

Biological Causes of Intellectual Disability

- Genetic contributions
- Brain damage during gestation and early life
- Prenatal environment
  - Drugs and alcohol (e.g., fetal alcohol syndrome)
  - Infectious diseases (e.g., rubella, syphilis)
- Severe head trauma
- Social factors
  - Low SES

Treatments for Intellectual Disability

▪ Behavioral Strategies	▪ Involvement of parents and caregivers, behavioral modeling, integrated approach
▪ Drug Therapy	▪ Neuroleptic medications, atypical antipsychotics to reduce aggression, antidepressants to reduce depression
▪ Social Programs	▪ Early intervention, mainstreaming, institutionalization when necessary, group homes that provide comprehensive care

Pervasive Developmental Disorders

- Autism
- Asperger's disorder
- Rett's disorder
- Childhood disintegrative disorder

Autism Spectrum Disorder

- 1) deficits in social communication and social interaction and
- 2) restricted repetitive behaviors, interests, and activities (RRBs)
- Because both components are required for diagnosis of ASD, social communication disorder is diagnosed if no RRBs are present

Autism Spectrum Disorder

I. Total of 6 (or more) items from A, B, and C, with at least 2 from A and 1 from B and C

A. Qualitative impairment in social interaction as manifested by at least two of the following:

1. Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body posture, and gestures to regulate social interaction
2. Failure to develop peer relationships appropriate to developmental level
3. A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people
4. Lack of social or emotional reciprocity

B. Qualitative impairments in communication as manifested by at least one of the following:

1. Delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
2. In individuals with adequate speech, marked impairment in initiating or sustaining conversation with others
3. Stereotypes and repetitive use of language or idiosyncratic language
4. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

C. Restricted repetitive and stereotyped patterns of behavior, interest and activities, as manifested by at least two of the following:

1. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
2. Apparently inflexible adherence to specific, nonfunctional routines or rituals
3. Stereotyped and repetitive motor mannerisms (e.g. hand or finger flapping or twisting, or complex whole-body movements)
4. Persistent preoccupation with parts of objects

II. Delays or abnormal functioning in at least one of the following areas, onset prior to age 3 years: (A) social interaction, (B) language as used in social communication, (C) symbolic or imaginative play.

TABLE 10.9 Other Pervasive Developmental Disorders

The *DSM-IV-TR* recognizes two pervasive developmental disorders in addition to autism and Asperger's disorder.

Disorder	Description
Rett's disorder	Apparently normal development through the first 5 months of life and normal head circumference at birth, but then deceleration of head growth between 5 and 48 months, loss of motor and social skills already learned, and poor development of motor skills and language
Childhood disintegrative disorder	Apparently normal development for the first 2 years, followed by significant loss by age 10 in at least two of the following: expressive or receptive language, social skills or adaptive behavior, bowel or bladder control, play, motor skills; also, abnormalities of functioning in at least two of the following areas: social interaction, communication, or restricted, repetitive, and stereotyped patterns of behavior, interests, and activities

Diagnostic Controversy and DSM-5

- Distinctions between pervasive developmental disorders, particularly between autism and Asperger's disorder, have been controversial
- These disorders co-occur in the same families and there is no clear evidence that they have different causes.
- Childhood disintegrative disorder and Rett's disorder are very rare, and the validity of these diagnoses has been questioned.
- In the DSM-5, all the pervasive developmental disorders are likely to be subsumed under the new category of *autism spectrum disorder.*

Contributors to Autism

- Biological factors
  - Genetics
  - Neurological factors

Treatments for Autism

- **Medications** have been shown to improve some of the symptoms of autism (e.g., overactivity, stereotyped behaviors, sleep disturbances)
- Psychosocial therapies (combination of behavioral techniques and structured educational services)
- http://www.metacafe.com/watch/cb-oM5ko7LyCsV3/autism_and_cooking_a_sensory_experience/

Response Papers (choose one)

- Discuss whether there are different learning styles among students, too such as visual, auditory or kinesthetic. How do you usually learn material best? What type of learning style is encouraged in college and are those ways the best for learning?
- Research has shown some links between violent video games and aggressive thoughts, feelings and behaviors? Why might this be and do you think it means we should intervene/make more policy regarding gaming?

Movies…

- Bill (1981)/ Bill: On his own (1983)
- Forrest Gump (1994)
- Rain Man (1988)
- The Other Sister (1999)
- What's Eating Gilbert Grape? (1993)