DISRUPTIVE BEHAVIOR

Development, Psychopathology, Crime, and Treatment

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OXFORD

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PRAISE FOR DISRUPTIVE BEHAVIOR

Disruptive Behavior, by four Stanford University child and adolescent psychiatrists, is a treasure trove of useful information about these difficult conditions. A real plus is the engaging, first person writing style that holds the reader's interest far more than most texts. As a forensic child and adolescent psychiatrist, I often see how serious disruptive behaviors can bring youth into contact with the juvenile justice system. This volume's in-depth exploration of those behaviors will help the reader immensely in assessing delinquents' needs for treatment, formulating clear treatment plans for youth both in and out of detention, and guiding towards much needed improvements in the systems of care for troubled youth. An extremely valuable resource!

—Peter Ash, MD
Professor and Director
Psychiatry and Law Service
Emory University

One in seven children are diagnosed with a childhood disruptive behavior disorder and we are only now starting to realize the enormous social, financial and legal implications associated with these diagnoses. Professor Hans Steiner is one of the leading experts on childhood disruptive behavior disorders. In this highly readable book, he and his co-authors impressively and definitively cover the field. They provide comprehensive reviews of the historical emergence of the recognition that many individuals with atypically aggressive behavior show these problems because of a psychiatric condition as well as definitive chapters on the taxonomy, epidemiology, etiology, treatment and implications for the justice system. Each chapter is penetrating in its analysis and, critically, provides not only a context for the current problems in the specific area but also clear guidelines as to how these problems can be ameliorated. As such, this definitive work will serve as a pre-eminent guide for graduate students, clinicians and researchers interested in the area alike.

—Dr. R.J.R. Blair
Director, Center of Neurobehavioral Research
Boys Town National Research Hospital
2017 Visiting Professor,
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'Disruptive Behavior: Development, Psychopathology, Crime and Treatment" by Steiner, Daniels, Kelly, and Stadler struck me, after having read so many of these books, apart from its up-to-dateness, by its positive and inspiring tone used while reviewing the literature, and by its stimulating, hope giving tone for practitioners. This textbook addresses therapeutic and services issues on a science based level, but so accessible that every professional will learn from it and will be able to apply it in daily assessment and treatment activities, in clinical settings but in forensic contexts as well. This superb book will certainly be the standard reference for the specialty for years to come! It provides excellent steps in right directions, like speaking of 'DBD-spectrum disorders'. I would stress the importance of this textbook by citing this exemplary sentence: *Fortunately, there is also evidence that early intervention with such high-CU children holds the promise of restoring their developmental progress, when using a multimodal treatment package with a high level of parental involvement, focused on the creation of a warm supportive parent child relationship which facilitates emotional learning.*

—Theo Doreleijers MD PhD
Em. prof. of child and adolescent psychiatry,
VU Univ. medical centre, Amsterdam
Em. prof. of forensic psychiatry, Law Faculty, Leiden University
Honorary president of Europ. Assoc. for forensic ch&adol
psychiatry and psychology EFCAP
Best VU University Teacher Award 2012
Societal Impact Research Award VU University 2010a

—Arne Popma MD PhD, child and adolescent psychiatrist
Head of the dpt. of child and adolescent psychiatry,
VU University medical centre Amsterdam
Prof. of forensic psychiatry, Law Faculty, Leiden University
Chairman of EFCAP Netherlands

In an era of constraining resources for health care, very few health issues have the the potential to improve the lives of the children and families we treat and simultaneously reduce costs for the health, judicial and social welfare systems. This book stands apart from others in the field by laying out a pragmatic framework for addressing childhood aggression and disruptive behaviors. While clinicians and academics will find much insight in this book, many parents might likewise benefit from a nuanced view of the problems they face with their children. Aggression in childhood is normal, but unchecked it results in children with behavioral problems, families with stress, and societies with expensive jails and

health care systems. Read this book and learn the way forward for us to change this trajectory.

—**Niranjan S. Karnik, MD, PhD** | Cynthia Oudejans Harris Professor
Vice Chair for Innovation | Department of Psychiatry
Medical Director | Road Home Program: Center for Veterans & their Families
Director | Section of Population Behavioral Health | Department of Psychiatry

Few constructs, if any, have led to similar plethora of research and debate across policy and practice as youth aggression, antisocial or disruptive behavior. The reasons are related to the high prevalence, complexity, comorbidity, heterogeneity and multi-factorial etiology; in parallel with the resulting impact, impairment, inter-agency involvement, and high service and societal costs. The literature stems for a range of scientific fields, which reflects children and youth's multiple needs, hence appropriate interventions. The wider connotations of criminality and its causes often divide policy in the philosophy underpinning juvenile systems across the world.

The authors, with their strong track record and all-encompassing analytic, thoughtful and succinct writing style succeed in integrating the evidence behind such a complex topic. As implications for policy, service, practice and services from different sectors are best understood in their totality, this is the major contribution of this excellent text.

—**Panos Vostanis**
Professor of Child Mental Health, University of Leicester
Visiting Professor, University College London
8th December 2016

The authors would like to dedicate this volume to the Chicago Reformers and August Aichhorn. They started us out in the right direction.

Palo Alto, California, and Bern, Switzerland, December 2016

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I also would like to thank all my previous students who have helped me bring a substantial body of knowledge to this domain of research and teaching: Elizabeth Cauffman, PhD; Marina Zelenko, MD; Jeff Wilson, MD; Maya Petersen, MPH; Amy Campanaro, PhD; Belinda Plattner, MD; Sabine Voelkl-Kernstock, PhD; Melissa Silvermann, MD; Allison Redlich, PhD; Stephanie Hawkins, PhD; Laura Delizonna, PhD; Kirti Saxena, MD; Leena Khanzode, MD; Ranjit Padhy, MD; Marie Soller, MD; Arne Popma, MD; Niranjan Karnik, MD, PhD; Martin Fuchs, MD; Julia Huemer, MD.

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Contents

1

Introduction to Disruptive Behavior Disorders

1.1 What Is the Problem?

Disruptive behavior disorders (DBDs) are among the most common diagnoses in mental health clinics. They constitute about 40% to 60% of referrals in clinics and practices helping children and adolescents with psychiatric problems. They are also commonly referred to under their subset labels: oppositional defiant disorder (ODD), conduct disorder (CD), and other specified and unspecified disruptive and impulse-control disorders. There have been some recent changes in the taxonomy of the American *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5) and the International Classification of Diseases, which have implications for diagnosis and treatment that we discuss extensively.

DBDs are complex conditions that frequently co-occur with other diagnoses and/or are misdiagnosed all together. Youth with DBDs and their families often present to clinicians with maximal levels of dysfunction at home, school, work, and/or social environments. Very often, there is involvement with the law, especially in the adolescent age range. We believe that a developmental approach grounded in an understanding of behaviors suggestive of typical development and cognizant of symptoms indicating abnormal or atypical development is essential in accurately diagnosing and treating DBDs (Steiner, 2015). A developmental perspective is mindful of the context in which DBD symptoms arise (e.g., family structure, peer group, neighborhood, educational system) and their potential impact on the behavior of children. The developmental perspective presented in this text began its evolution during the nineteenth century, has matured over the years, and now rests on solid empirical data and practice-based evidence.

The birth of the child-saving movement during the nineteenth century, which occurred as a result of troubling events of the time and rapid increases in juvenile

delinquency, was an early sign of a growing developmental perspective revolving around altruism and humanism. The Child Savers, especially Jane Addams, made their mark in the nineteenth century by petitioning for the development of a juvenile justice system—a system based primarily on young offenders' developmental status, not simply the types of crimes they committed and usual consequences. The Child Savers believed that focusing on youths' developmental status was essential for early identification and prevention. Such efforts consisted of educating and providing appropriate guidance to parents, other caregivers, and custodial and criminological personnel on normal and abnormal child development (Platt, 1977).

This Child Saving reform helped to establish the first juvenile court, located in Cook County, Illinois, in 1899, as a means of providing age-appropriate accountability, remediation, and rehabilitation. The process of establishing the first juvenile court was not without its growing pains. Among these challenges were unfair sentencing and arrests, which rose significantly despite the efforts of the reform. Additional backlash presented by way of overabundance of adult supervision. In another example, Addams spearheaded the creation of the Hull House, a settlement house located in Chicago, and later the Juvenile Protective Association whose mission was to curb juvenile delinquency throughout Chicago. Overall, the Child Savers movement generated a great deal of overdue attention to the topic of juvenile delinquency and led to new interventions for disenfranchised and at-risk youth.

A similar movement to that of the Chicago-based Child Savers emerged a few years later in Europe, under the direction of the director of the Vienna Juvenile Reform Schools in the 1920s and 1930s, August Aichhorn. Aichhorn sought to address the same concerns as the Child Savers with an educational/developmental approach. His theories and conceptualizations added a potentially valid treatment perspective to the forensic innovations of the Chicago reformers. Aichhorn was well acquainted with Sigmund Freud's writings and in close contact with the psychoanalytic community. He was first and foremost a teacher, who, with Anna Freud's encouragement, later became a psychoanalyst himself. Aichhorn (1935/1984) also published the seminal text *Verwahrloste Jugend* [*Wayward Youth*]. He was the first to approach juvenile delinquency from a developmental, psychiatric, psychological, and pedagogical perspective. Aichhorn's perspective strongly acknowledged the social context in which juvenile delinquency arose. According to Aichhorn, aggressive and antisocial behavior in youth was indicative of developmental trajectories gone awry. In Aichhorn's view, children start out in life as "asocial" beings whose world view does not extend beyond their own desires. As children grow, society demands that they develop a capacity to see beyond themselves, cope with frustration, and fulfill their needs while navigating the demands of others. According to Aichhorn, "The child needs to be

educated into a state of prosocial adjustment, a task which only can be fulfilled if the child's emotional development proceeds normally." A major turning point in how we view the young people described in this text is credited to Aichhorn, who was the first to separate criminal labels from clinical ones. This change in perspective paved the way for studies of delinquents, aggression, and antisocial acts as forms of psychiatric syndromes, independent of court proceedings and adjudication. Aichhorn essentially founded the discipline of psychoeducation and child guidance. His philosophies have collectively influenced our field, ultimately laying the groundwork for the development of effective interventions informed by psychological and developmental principles.

Aichhorn's masterful depictions of youth in the early twentieth century mirror the harsh realities and associated emotional problems faced by many young people in modern society. His work has helped us understand much of what children in impoverished neighborhoods in the United States today are still experiencing. If we assume that the United States is historically rooted in violence, gun ownership, gang organizations, and a lack of social supports and structures, we can see how raising children under such circumstances is a formidable task. In his famous third chapter of *Wayward Youth*, Aichhorn presents an impressive array of case studies that link antisocial behaviors such as stealing, lying, aggression, and even violence to growing up in poverty. The children Aichhorn depicted lived in communities with inadequate schools, impoverished infrastructures, and regular exposure to potentially traumatic events, such as industrial and other accidents. Today, Aichhorn's Vienna of the 1920s is alive and well in places like East Los Angeles, New Orleans, Oakland, San Jose, and Washington, DC, to name a few. While the approaches to addressing aggression and antisocial behavior in youth have evolved over time, we value and share the developmental perspective pioneered by the Child Savers and August Aichhorn nearly a century ago. Aichhorn's work spawned a growing stream of clinical, epidemiological, basic scientific, and, most recently, neuroscientific studies that are the backbone of this volume.

1.2 Why Have We Been So Slow in Moving the Field?

An explanatory note is called for at this point. As mentioned, the majority of youth treated in child and adolescent psychiatry clinics throughout North America will have problems related to some form of aggression. We still struggle, however, with diagnosis and specific treatment for these youths. We have had the developmental and pedagogic perspective on these problems for many years without the rapid progress in identification, prevention, and treatment

we should hope for. The study of aggression and mental disorders, in which aggression is a hallmark feature (e.g., CD, ODD), lags behind that of other areas of child and adolescent psychiatry (e.g., attention deficit hyperactivity disorder [ADHD], anxiety, depression). To what can this delay and slowed progress be attributed? In our view, the reasons for the relatively slow progress in the study of aggression and its associated conditions are complex historical, political, and methodological. Antisocial acts and aggression, which constitute the main cluster of symptoms in this grouping of disorders, are very common, especially in the adolescent age range and in toddlerhood. This can be confusing in attempting to delineate normal from pathological development. Also contributing to the difficulty with diagnosing these disorders is the fact, that by definition, most of these acts involve other people—one person's aggression is another's standing up for oneself in self-defense—and societal norms. The latter certainly vary widely, especially with large countries, like the United States; countries that are diverse in their population characteristics; or countries that are in chaos, such as during wartime. All of these factors contribute to problems with accurate identification and measurement of response to intervention. Unlike almost exclusively based internalizing syndromes, such as depression, we have to struggle as clinicians to do the best we can do under very complicated circumstances.

Another reason that is more of a political nature probably also contributed to the current state of affairs. In 1988, Vice President George H. W. Bush appointed Dr. Fredrick Goodwin to head the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). Goodwin was a proponent of the Violence Initiative, a federal proposal by the department of Health and Human Services that sought to reduce violent crime in America's inner cities by identifying individuals, primarily inner-city youths, whose background and genetic makeup placed them at risk for committing unlawful acts of aggression. The hope of those involved in creating the Violence Initiative was that identifying at-risk youth would lead to effective early intervention and ultimately reduce inner-city violence. During a 1992 press conference, Goodwin likened the "loss of social structure" within "high impact inner-city areas" prone to violence to the behavior of monkeys in the wild. Goodwin's comments sparked a firestorm of controversy and fears by some that the government would use the Violence Initiative as a means of controlling disenfranchised youth deemed at risk for violence through psychotropic medications. Goodwin resigned from his position as head of the ADAMHA shortly after making these remarks, the Violence Initiative faded from public view, and federally funded studies of aggression became politically risky. This discouraged young researchers from pursuing the topic, national agencies such as the National Institute of Mental Health (NIMH) from funding studies, and industry from investment in developing and researching

medications that could contribute to successful treatment. The end result was a hiatus of several decades, during which this important area of clinical child and adolescent psychiatry languished.

In recent years, the study of antisocial acts, aggression, and its antecedents has been resurrected in the United States due to exciting emerging evidence from neuroscience, epidemiology, and clinical trials. For instance, the pioneering work of James Blair at the NIMH has elucidated the neurobiological underpinnings of psychopathy and aggression leading to initiatives like the NIMH proposed Research Domain Criteria (RDoC) approach (Blair, Karnik, Coccaro, & Steiner, 2009). The RDoC provides a dimensional perspective, steering the field away from the current categorical perspective espoused by the DSM. In addition, research over the past 20 years has identified distinct subtypes of aggression (e.g., predatory vs. reactive) based on neurocognitive underpinnings of disruptive behavior that have major implications on the effectiveness of psychotherapeutic and medication interventions (Blair et al., 2009; Padhy et al., 2011; Steiner, 1999; Steiner & Karnik, 2004; Vitiello, Behar, Hunt, Stoff, & Ricciuti, 1990; Vitiello & Stoff, 1997).

The work of Hans Eysenk, Adrian Raine, James Blair, Paul Frick, Robert Hare, and members of their laboratories and clinics over the past 20 years has significantly advanced our understanding of aggression and antisocial behavior. However, our current diagnostic scheme, the DSM-5, has not thoroughly integrated the remarkable insights of August Aichhorn's developmental perspective, innovative approaches such as the RDoC dimensional based approach, or accumulating data on the neurobiology of aggression with its conceptualization of youth aggression and antisocial behavior. The DSM-5 lists a variety of symptoms for disorders associated with pathological aggression, most notably CD and ODD. By contrast, a truly developmental psychiatry perspective on dissocial behavior and the latest research findings suggests that whether these behaviors are truly "symptoms" of an internally based disorder are best understood when the context (e.g., social environment, past experiences, temperament) in which they occur has been taken into account and ruled out as the major driver of the problem. From a developmental psychiatry perspective, DBDs are not always intrinsically determined, as the criteria set forth by the DSM-5 implies. For instance, socioeconomic and ethnic bias is a flaw within our current classification system for DBDs.

This is relevant, because, for instance, our juvenile justice system has disproportionate numbers of youth who come from poor backgrounds and ethnic minorities. Most of the youth involved in the American juvenile justice system, a population of high ecological validity, meet criteria for some form of DBD. The lopsided nature of the population within our juvenile justice system is testament to the fact that, in general, DBD diagnoses are not fixed innate genetically predetermined conditions. Instead, the development of DBDs is influenced by a

wide variety of psychosocial risk factors (e.g., peer group, family system, socioeconomic status, temperament, genetic background).

As illustrative examples, let us consider a scenario where a youth lives in an active warzone or is a refugee fighting for survival. Acts of stealing, deception, lying, robbery, and even aggression assume a very different meaning when we find ourselves in such circumstances. To diagnose a youth with CD while he is fighting for survival would indeed be adding insult to injury. We contend that by focusing on the environmental, biological, and underlying neurocognitive factors that influence aggression we can better delineate the syndromes that truly are predominantly internally driven. That is, we can begin to describe the aspects of youth's presentation that operate somewhat independently of social context (e.g., temperament, biologic reactivity) and implement individualized treatment approaches that are consistent with current theories on child development and the latest research (Padhy et al., 2011).

Starting with the third edition of the DSM in 1980, classifying aggression and antisocial acts according to diagnostic criteria was a significant step forward in helping clinicians identify patients and their needs, independent of the juvenile justice system. We discuss the exact criteria for classification of DBDs in the DSM and the International Classification of Diseases in chapter 2. In the meantime, we offer another important critique of the current diagnostic practices. Additionally, we propose an alternate clinical template that is based on the integration of findings from clinical and preclinical studies and takes into account the problems that arise when we ignore social context. Our current classification system includes few important distinctions of the type of aggression and antisocial acts that have shown promise in developing a more refined diagnostic approach and allow for more precisely tailored interventions.

Before we discuss the state of diagnosis (chapter 2), epidemiology (chapter 3), etiology (chapter 4), and treatment (chapter 5), as well as the implications of our knowledge for forensic populations (chapter 6), we offer a carefully considered list of criticisms of the way we diagnose DBDs at the present time. This will help us stay abreast of the field and will instill us with appropriate caution as we approach this difficult set of problems.

1.3 Persistent Problems with Current Psychiatric Approaches to Antisocial and Aggressive Acts and Possible Solutions

The current diagnostic criteria in the DSM-5 do not differentiate youth based on their profile of aggression. We have come to appreciate that aggression and antisocial behavior can either be carefully planned or can be highly reactive to triggers