Improving Teachers' Understanding of Antisocial Orientation

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By

Salvatore B. Durante,
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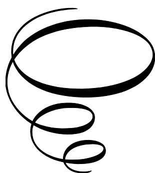
and Jan E. Reddon

Cambridge Scholars Publishing



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This book first published 2021

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

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ISBN (10): 1-5275-6305-7
ISBN (13): 978-1-5275-6305-6

An abridged version of "Improving Teachers' Understanding of Antisocial Orientation" was used to complete the requirements of a Master of Education degree for Salvatore B. Durante.

The views expressed in this book are those of the authors and do not necessarily reflect any endorsement by or extant policies of any institutions with which the authors are affiliated.

We dedicate this book to teachers, hoping that it will facilitate educational environments where cognitive, affective, and social development is possible for all students.

> The first thing that any education ought to give a man is character, and the second thing is education.
> —George Horace Lorimer (1901-1902).[1]

[1] Lorimer, George H. 1901-1902. *Letters from a Self-made Merchant to his Son*. Philadelphia, PA: The Curtis Publishing Company

TRIBUTE

In loving memory of Salvatore Durante's mother, Carmellina Durante (November 14th, 1966 to December 28th, 2020) who devoted her life to her children (Salvatore, Vittorio, Nicole, and Claudio) and husband (Nicola). Carmellina provided her children unconditional love and numerous lessons on overcoming obstacles and ways to be kind, empathic, compassionate, confident, humble, humorous, and humane towards all people. Carmellina was a selfless individual who committed her time to helping and supporting the mental and physical health needs of people in her community. Also, Carmellina was a talented hairstylist and an active volunteer at her children's elementary school. As a volunteer, Carmellina supported the educational and mental and physical health needs of many students. Carmellina valued education and the development of kindness, empathy, compassion, confidence, altruism, humor, and humane treatment of all. On December 28th, 2020, Carmellina Durante passed away suddenly and peacefully at home, surrounded by her children and husband.

TABLE OF CONTENTS

Preface and Acknowledgements ... x

Chapter 1 ... 1
Introduction to the Antisocial Orientation (AO)
1.1: The Purpose and Organization of this Book ... 5
Chapter 1 Summary ... 7

Chapter 2 ... 8
The Classification and Developmental Psychopathology of the Antisocial Orientation (AO)
2.1: Oppositional-Defiant Disorder (ODD) ... 9
2.2: Conduct Disorder (CD) ... 11
2.3: The Antisocial Orientation (AO) in Adulthood ... 13
2.4: Comorbidities ... 16
2.4.1: Anxiety and depressive disorders. ... 16
2.4.2: Bipolar disorder. ... 18
2.4.3: Early onset psychosis. ... 19
2.4.4: Substance abuse. ... 19
2.4.5: Attention-deficit/hyperactivity disorder. ... 20
2.4.6: Lower intelligence in multiple domains of functioning. ... 21
2.4.7: Sleep-wake disorders. ... 22
2.4.8: The development of other personality disorders. ... 23
2.5: A School-Based Coding System for Identification of Youth with an Antisocial Orientation (AO) ... 23
2.5.1: Illustration of special education coding criteria. ... 23
Chapter 2 Summary ... 27

Chapter 3 ... 29
Assessments for Youth with an Antisocial Orientation (AO)
3.1: Intelligence Testing ... 30
3.2: Behavior Testing ... 33
3.3: Issues with Assessments that Evaluate for Psychopathy in Youth Populations ... 35
3.4: Violent Risk Assessment and its Implementation in North American Schools ... 37

3.5: A Need for Vocational Assessments for Youth with an Antisocial Orientation (AO) ... 43
3.6: A Need for Leisure Assessments for Youth with an Antisocial Orientation (AO) ... 46
Chapter 3 Summary ... 48

Chapter 4 ... 50
A Biological Explanation of the Antisocial Orientation (AO)
4.1: A Darwinian Perspective on the Evolution and Function of the Antisocial Orientation (AO) ... 51
4.2: A Physiological Perspective on the Antisocial Orientation (AO) ... 52
4.3: An Ontogenetic Perspective on the Antisocial Orientation (AO) ... 56
Chapter 4 Summary ... 59

Chapter 5 ... 61
A Sociological Explanation of the Antisocial Orientation (AO)
5.1: Attribution Theory ... 62
5.1.1: Correspondent inference theory. ... 62
5.1.2: The covariation model. ... 63
5.2: Ecological Systems Theory and Social Learning Theory ... 64
5.2.1: Adverse childhood experiences. ... 66
5.2.2: Adverse family experiences. ... 68
5.2.3: Peer affiliation. ... 71
5.2.4: Neighborhood disorder. ... 74
5.3: Group Formation and Classroom Composition ... 75
Chapter 5 Summary ... 78

Chapter 6 ... 80
Issues with Pharmacological and Psychotherapeutic Treatments for the Antisocial Orientation (AO)
6.1: Pharmacological Treatments ... 82
6.2: Psychotherapeutic Treatments ... 84
6.2.1: Common factors in psychotherapy. ... 84
6.2.2: Multisystemic therapy and functional family therapy. ... 85
6.2.3: Cognitive behavioral therapy. ... 87
6.2.4: Emotion (affect) regulation training. ... 88
6.2.5: Self-regulation training. ... 88
6.2.6: The incorporation of attachment theory. ... 89

6.2.7: Parent management training. 90
6.2.8: The Stop Now and Plan (SNAP®) model. 93
6.2.9: Trauma-informed therapy. 94
6.2.10: Interventions for youth with an antisocial orientation that have deleterious consequences. 96
Chapter 6 Summary 98

Chapter 7 100
Classroom Strategies, Interventions and Improvements to the School Environment for Youth with an Antisocial Orientation (AO)
7.1: Classroom Strategies and Interventions 102
7.1.1: Creating a trauma-sensitive classroom. 102
7.1.2: Utilization of collaborative problem solving. 104
7.1.3: The Incredible Years® Teacher Classroom Management program. 106
7.1.4: Utilization of emotion regulation, self-regulation, and mindfulness in the classroom. 109
7.1.5: Nonviolent Crisis Intervention® training. 112
7.2: Improvements to the School Environment 115
7.2.1: School climate and authoritative schools. 115
7.2.2: Issues with early school start times. 122
7.2.3: Incorporation of more physical activities in the school schedule. 124
Chapter 7 Summary 126

Chapter 8 129
Future Directions

References 132

PREFACE AND ACKNOWLEDGEMENTS

Teaching can be a challenging and demanding profession because teachers must deliver lessons that meet the educational needs of a diverse range of learners. Teachers and school staff must also manage the behaviors of students who may disrupt the lesson and classroom environment. Student misbehavior during class time is expected and therefore, many teacher training programs provide training in classroom management. However, teachers and school staff have expressed concerns about students disregarding classroom management interventions. Furthermore, teachers have indicated a lack of training in how to manage and respond to student aggression and violence. Students who are hostile, aggressive, defiant, and engage in other antisocial behaviors are said to be expressing an antisocial orientation. Teachers are often verbally and physically confronted by students with an antisocial orientation. The stresses of meeting the needs of all students paired with managing students with an antisocial orientation has resulted in many teachers leaving the profession because of feelings of powerlessness and challenges to their mental and physical health. The purpose of this book is to improve teachers' understanding of Antisocial Orientation (AO) through an examination of how antisocial orientation is pathologized, assessed, the biological and sociological factors involved in the expression of an AO, and the pharmacological and psychotherapeutic treatments for youth with AO. The book concludes with classroom strategies and interventions that can ameliorate symptoms associated with AO and potential modifications to the school environment that can foster a prosocial orientation.

We thank Dr. Noorfarah Merali, Dr. George H. Buck, Dr. David M. Gill, Dr. Margaret Iveson, Aryn Ford, Dale Carton, Doug Johnson, Myles Bingham, Réka Serfozo, Charmaine Christiansen, and a number of school staff in the Edmonton Public School system for their input.

CHAPTER 1

INTRODUCTION TO THE ANTISOCIAL ORIENTATION (AO)

Chapter 1 Highlights

- A case study about a student with an Antisocial Orientation (AO).
- Student aggression and violence towards teachers has been a problem since antiquity.
- Pre-service teachers are provided insufficient training in managing student aggression and violence.
- The expression of an AO in youth populations and the many terms for and definitions of an AO.
- Interpersonal theory and the conceptualization of AO.
- The purpose and organization of this book.

April 28, 2014, would be Ann Maguire's final day at Corpus Christi Catholic College, a secondary school in Leeds, United Kingdom (Pidd 2014; Woods 2014). Ann Maguire was known by many of her colleagues and former students as a selfless, passionate, caring, and inspirational Spanish teacher (Woods 2014). On her final day, Ann Maguire was seated at her desk helping students with their Spanish homework, when she was stabbed multiple times in the back and neck by her student, Will Cornick (Pidd 2014; Rayner 2014). After stabbing and chasing after Ann Maguire, Will Cornick went back to his seat in Ann Maguire's classroom and said to his classmates "good times" and described his experience of an "adrenalin rush" (Rayner 2014, para. 26). According to Pidd (2014), Will Cornick had no criminal record, few school misbehavior incidents, and was described by one teacher as a model student. It appears that Will Cornick's motivation to murder Ann Maguire was rooted in early adolescence and informed by a series of environmental factors (Pidd 2014; Rayner 2014). Specifically, around year eight, Will Cornick collapsed during a family holiday and was subsequently, diagnosed with a life-limiting illness (Pidd 2014). Following the collapse and diagnosis, family

members observed changes in Will Cornick's mood and personality (Pidd 2014). In addition, Will Cornick developed an unknown hatred towards Ann Maguire who was a teacher of his since 2009 (Pidd 2014).

In 2013, Will Cornick aspired to be a member of the army, however, due to his medical condition he was unable to join (Pidd 2014). During the late hours of Christmas Eve and early hours of Christmas Day, 2013, Will Cornick expressed to a friend online his dislike of Ann Maguire and wanting to brutally kill her (Pidd 2014). In February of 2014, Will Cornick was placed in internal isolation at school (i.e., an in-school suspension) because of incomplete Spanish homework. Subsequently, Ann Maguire barred him from attending a school bowling trip (Pidd 2014). Court and psychiatric documents reveal that four days prior to the murder, Will Cornick justified his decision to kill Ann Maguire because he could not die by suicide and he felt that college and the army were no longer viable options (Pidd 2014). Furthermore, court and psychiatric records mention that Will Cornick felt proud about the murder and his personality was described by counsel and by psychiatrists as containing psychopathic tendencies (i.e., a severe Antisocial Orientation [AO]; Rayner 2014). At Will Cornick's murder trial, when asked by experts how his actions impacted Ann Maguire's family, Will Cornick remarked "I couldn't give a shit, I know the victim's family will be upset but I don't care; in my eyes, everything I've done is fine and dandy" (Rayner 2014, para. 33).

In a survey of 253,100 American teachers, seven percent indicated that they had been either threatened and/or assaulted by students (Dinkes, Cataldi, Lin-Kelly, and Snyder 2007; Espelage et al. 2013). The issue of student aggression and/or violence towards teachers is rare and not revelatory of the 21st century classroom context because student aggression and/or violence towards teachers has occurred throughout history and cross-culturally (Maeng, Malone, and Cornell 2020). For example, 2000 BC tablets from Mesopotamia, European medieval accounts, and 19th century North American colonial records describe various incidents of student aggression and/or violence towards teachers (Maeng et al. 2020). It is more likely that students will act more aggressively and/or violently towards their peers than teachers (Maeng et al. 2020; Nekvasil and Cornell 2012). For example, students who are involved in risky behaviors (e.g., fighting, drug use, alcohol consumption, etc.) are more likely to be threatened by their peers (Nekvasil and Cornell 2012).

Espelage and colleagues (2013) suggest that teacher training programs provide insufficient training in prevention and behavioral management of student aggression and/or violence. Therefore, it is crucial that teacher training programs provide more education on classroom management

because student misbehavior, disruptive talking, aggression and/or violence can increase teacher stress, compromise classroom and school safety, and reduce the academic performance of other students (Alvarez 2007; Maeng et al. 2020). Student misbehavior, aggression and/or violence creates a hostile and disruptive learning environment for other students and decreases the effectiveness and cohesion of a teacher's lesson plan (Maeng et al. 2020). Teachers who are unable to manage student misbehavior, aggression and violence, and have been victimized by students will often leave the profession for reasons such as poor administrative support, feelings of powerlessness, and reductions to their work performance, interpersonal relationships, and mental (e.g., increased experiences of fear and symptoms of depression), and physical health (Espelage et al. 2013; Maeng et al. 2020).

Not surprisingly, all students will have some animosity towards school because schooling is not optional (i.e., students cannot dropout of school until a certain age), requires that students be rule abiding and takes students away from their leisure activities (Labaree 2000). Therefore, student misbehavior, aggression and/or violence could be related to frustrations towards the school context which restricts their abilities to do what they desire (Bronfenbrenner 1979a; Goffman 1961). In addition, various psychological, physiological, and interpersonal (e.g., intimate relationships, friendships, family dynamics) changes that occur during childhood and adolescence may result in inevitable conduct issues in schools and other settings (Brechwald and Prinstein 2011; Caballero, Granberg, and Tseng 2016; Moffitt 1993). However, youth who frequently violate people's rights through manipulation, intimidation, and/or violence to attain resources and personal needs (e.g., power) in various contexts are adopting a severe AO (Blackburn 2003; Hashmani and Jonason 2018; Kiesler 1996; Reddon and Durante 2019).

Many terms and hypotheses have been presented throughout the centuries to describe individuals with a severe AO (Cleckley 1955; Cooke 2003; Crego and Widiger 2018; Goodwin and Guze 1996; Lykken 2018; Millon, Simonsen, and Birket-Smith 2003; Pietrini, Rota, and Pellegrini 2017). For example, Inuit in northwest Alaska use the term kunlangeta to describe individuals (particularly men) who lie, cheat, steal, take sexual advantage of other villagers' women and do not partake in hunting (Cooke 2003; Lykken 2018). Also, Plato hypothesized that "no one is willingly evil, but one can become evil for a bad disposition in his body and for a training without a true education" (Plato, as cited by Pietrini et al. 2017, 192). Moreover, the psychopath label has been popular since the mid-1950s when Hervey Cleckley used the term in his book, *The Mask of*

Sanity (1955) to pathologize individuals who engage in criminal and deviant acts. Critics such as Gunn (2003) and Toch (2003) have argued that the psychopath term is pejorative and antiquated despite its ubiquitous use in the public and scientific community. For example, in educational settings, psychological and behavioral reports that describe a youth's personality and behavior as featuring psychopathic characteristics can negatively impact how a teacher works with the youth because there is a communication that the student is difficult to work with and unlikeable (Gunn 2003; Reddon and Durante 2019; Toch 2003).

Conceptualization of antisocial behaviors and antisocial personality traits as representative of an orientation (i.e., the AO) avoids placing individuals in a fixed and categorical classification system that may have counterproductive effects on how individuals are treated in educational, mental health, and other settings (Szasz 1961; Toch 1970). The AO is informed by interpersonal theory which proposes that people's personalities and behaviors can be plotted along two interconnected dimensions (i.e., hostility versus friendliness and dominance versus submissiveness) known as the interpersonal circumplex (see Figure 1.; Kiesler 1996; Reddon and Durante 2019; Roberton, Daffern, Thomas, and Martin 2012). Individuals with an AO are inherently hostile and this hostility can vary in intensity based on biological and environmental factors. Generally, individuals who exhibit an AO are often hostile and dominant because the hostile and dominant interpersonal approach maintains their safety and ability to have power over people in various contexts (Reddon and Durante 2019). However, some people can elicit an AO that is hostile but more submissive (e.g., passive-aggressiveness).

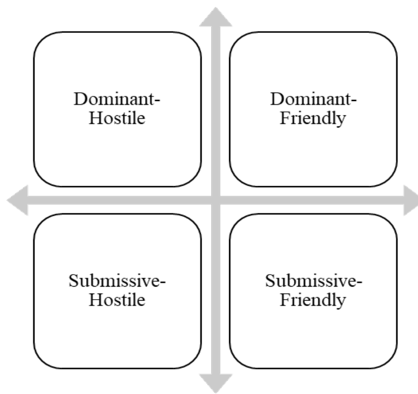

Figure 1. The core dimensions of the interpersonal circumplex.

The expression of hostility is not a choice made by individuals with an AO and is mainly an automatic response that the individual acquired over time (Kiesler 1996). The rigidity in response by individuals with an AO is also known as the "dynamism of difficulty" (Kiesler 1996, 130). Dynamism of difficulty refers to the limited behaviors that individuals develop as a result of biological and environmental factors. Consequently, individuals with an AO are unable to be flexible or spontaneous and have only one approach for interpersonal exchanges (Kiesler 1996). For example, youth with a severe AO have difficulties with adapting their cognitions, emotions, and behaviors because their extreme AO has become habitual (Kiesler 1996). Therefore, for students with an AO this means that their hostility will draw hostility.

Teachers and school staff will need to overcome a rigid interpersonal approach and support students towards a more prosocial orientation.[1] This means that teachers and school staff need to respond to students with an AO with friendliness and other de-escalation strategies (Roberton et al. 2012). Regardless of the difficulties with using friendliness and de-escalation, teachers and school staff must use a complementary interpersonal approach over anticomplementary interpersonal (i.e., responding to hostility with hostility) or acomplementary interpersonal (i.e., using friendliness and hostility inconsistently when responding to hostility) exchanges (Kiesler 1996). Complementary interactions allow for individuals to move toward one another despite differing interpersonal orientations. In contrast, anticomplementary interactions facilitate approach or avoidance and acomplementary interactions can cause mixed and confused response by both individuals (Kiesler 1996). If teachers are consistent with using friendliness or a complementary approach, gradually students with an AO can learn to approach their teachers with less hostility and begin to develop prosocial exchanges with their teacher, school staff, and other students.

1.1: The Purpose and Organization of this Book

The purpose of this book is to improve teachers' understanding of AO. Improvements to teachers' understanding of AO can address the limited pre-service training in appropriate responses to student aggression and violence. Also, teachers who understand the AO and other mental, physical, and social concerns can develop classroom environments that

[1] An individual's orientation towards others can move along the interpersonal circumplex axes and thus, an individual's orientation is not fixed in place.

can minimize the expression of the AO and bolster a prosocial orientation for all students.

The first topic covered is the classification and the developmental psychopathology of the AO. The first topic will provide an overview of diagnoses for children and adolescents with an AO in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA] 2013) and the *International Statistical Classification of Diseases and Related Health Problems* (11th revision; ICD-11; World Health Organization [WHO] 2018). In addition, the first topic has a section on a school-based coding system (e.g., the Alberta special education coding criteria; Alberta Education 2019) for identification of youth with an AO.

The second topic covers assessments for youth with an AO. Teachers and school staff should be knowledgeable of intelligence and behavior testing because both impact how teachers work with students, develop lesson plans, and communicate a student's progress over the school year. Also, teachers should gain an understanding of the issues with assessing an AO and violent risk assessment. The second topic concludes with an examination of the need for vocational and leisure assessments and the ways that these assessments can be used for students with an AO.

The third topic covers a biological explanation of the AO. A biological explanation of the AO, uses the following three perspectives: Darwinian, physiological, and ontogenetic. A Darwinian perspective explores the evolution and functionality of an AO. A physiological perspective evaluates the neurological, physiological and endocrinological systems that can cause an AO. An ontogenetic perspective examines the genetic and environmental factors causing an AO.

The fourth topic evaluates the sociological explanation of the AO. The social explanation uses attribution theory, ecological systems theory, and social learning theory. Each theoretical approach explores the environmental and social factors facilitating the expression of an AO in youth populations. The fourth topic concludes with an evaluation of group formation and issues with classroom composition in the expression of the AO in various social and educational contexts.

The fifth topic explores issues with pharmacological and psychotherapeutic treatments for the AO. The fifth topic evaluates the ethics and effectiveness of medications for youth with an AO. Discussion of psychotherapeutic treatment covers issues with determining the best kind of treatment plan for alleviating symptoms associated with the AO. Also, the psychotherapeutic treatment section provides information about individual, group, and family psychotherapy approaches in the management

and alleviation of the mental, physical, and social concerns of youth with an AO.

The sixth topic provides teachers with classroom strategies and interventions and improvements to the school environment for youth with an AO. The classroom strategies and intervention section includes information about various approaches for creating a prosocial classroom environment and appropriate interventions to prevent and respond to student aggression and/or violence. The improvements to the school environment section explores how schools can create a prosocial environment, issues with punitive responses (e.g., seclusion and restraining youth with an AO), incorporation of nature and other architectural modifications to support a prosocial environment. In addition, the improvements to the school environment section considers how school scheduling can be changed and ways to incorporate physical activity in schools.

Finally, the book concludes with a discussion of future directions for improving teachers' understanding of AO.

Chapter 1 Summary

The death of Ann Maguire is an extreme example of what can occur in schools and the impact of a student who exhibits a severe AO. Aggression and violence towards teachers have persisted in schools throughout the centuries. Teachers entering the profession need more training in responding to and ameliorating student aggression and violence. Also, improvements to pre-service teacher training in student aggression and violence may decrease the number of teachers leaving the profession early in their careers.

Throughout history, many terms have been presented to describe antisocial behaviors, and individuals who exhibit aggressive and violent traits. We are advocating for the conceptualization of student aggression and violence as an Antisocial Orientation (AO). The AO is informed by interpersonal theory which proposes that people's personalities and behaviors can be plotted along the interpersonal circumplex. Conceptualization of student aggression and violence as an orientation avoids limiting students to pejorative labels and assumptions about their lack of capacity to change their cognitions, emotions, and behaviors. The importance of the AO concept is that teachers and school staff can learn to respond to students with prosocial approaches to improve their wellbeing and educational experience.

CHAPTER 2

THE CLASSIFICATION AND DEVELOPMENTAL PSYCHOPATHOLOGY OF THE ANTISOCIAL ORIENTATION (AO)

Chapter 2 Highlights

- How individuals externalize and internalize problems.
- The diagnosis and history of Oppositional-Defiant Disorder (ODD), Conduct Disorder (CD), and the Antisocial Orientation (AO) in adulthood.
- The co-occurrence of other mental and/or physical health concerns (i.e., comorbidities) for individuals with an Antisocial Orientation (AO).
- How psychiatric and medical diagnoses can be translated in a school-based coding system.

The study of psychopathology involves an understanding of externalizing versus internalizing problems because the dichotomy provides insight into an individual's intrapersonal and interpersonal processes (Achenbach, Ivanova, Rescorla, Turner, and Althoff 2016; APA 2013; Caspi et al. 2002). Individuals with AO experience symptoms that are predominately found in the externalizing problem group of disorders (APA 2013). For example, youth with an AO may resolve concerns with others through physical and/or verbal aggression and/or have difficulties with impulsivity. However, individuals with an AO can also internalize their problems. For example, youth with an AO may experience anxiety and depressive symptomatology and engage in acts of self-harm (APA 2013; Fanti et al. 2019; Vaughn, Salas-Wright, DeLisi, and Larson 2015). Regardless, analysis of how the AO is pathologized in youth populations, reveals that most often children and adolescents with a severe AO are placed under the "disruptive, impulse-control and conduct disorders" (APA 2013, 461) group in the DSM-5 and are frequently diagnosed with oppositional-defiant disorder (ODD) and/or conduct disorder (CD; Capaldi and Eddy

2015; Vanzin and Mauri 2019). Similarly, the ICD-11 classifies youth with a severe AO under the disruptive behavior or dissocial disorders group which includes ODD and conduct-dissocial disorder (WHO 2018).

2.1: Oppositional-Defiant Disorder (ODD)

The age of onset for Oppositional-Defiant Disorder (ODD) is during the preschool years with rare occurrences post-early adolescence (i.e., ages 10 to 14 years old) and ODD is more prevalent in males than in females (APA 2013; Burke and Romano-Verthelyi 2018; Klyce 2018; WHO 2018). In a meta-analysis of worldwide mental health concerns in youth populations, the worldwide prevalence rate of ODD was 3.6% (Polanczyk, Salum, Sugaya, Caye, and Rohde 2015). The DSM-5 (APA 2013, 462) describes the following fundamental criteria for a diagnosis of ODD.

> Criterion A involves 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.
>
> 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.

The DSM-5 diagnostic criteria for ODD also includes criterion B which describes that the behaviors be distressing to the individual and/or others or that behaviors negatively impact various modes of functioning (e.g., educational, social, and vocational). Furthermore, Criterion C explains that behaviors cannot occur "during the course of a psychotic, substance use, depressive, or bipolar disorder" (APA 2013, 462) and "criteria not met for disruptive mood dysregulation disorder" (APA 2013, 462). The presentation of ODD can be mild, moderate or severe depending on if the individual expresses symptoms in one or more settings (APA

2013). The ICD-11 diagnostic criteria for ODD is similar to the DSM-5 conceptualization. Specifically, the ICD-11 (WHO 2018) describes ODD as six months or more of childhood or adolescent behavior that is defiant, disobedient, provocative or spiteful, and occurring when the individual is interacting with others who are not their siblings.

An historical overview of ODD shows that it first appeared in the DSM-III (APA 1980) and was influenced by the 1960s concept of the oppositional personality which was mainly a description of passive-aggressiveness (Burke and Romano-Verthelyi 2018). The DSM-III presented five symptoms (i.e., violation of minor rules, temper tantrums, argumentativeness, provocative behavior, and stubbornness) and required that symptoms occur over a period of six months for a diagnosis of oppositional disorder (later renamed ODD in the DSM-III-R [APA 1987]). The current version of ODD is very similar to the eight symptoms presented in the DSM-III-R (APA 1987). However, the DSM-IV (APA 1994) removed swearing/obscene language from the DSM-III-R's diagnostic criteria and incorporated frequency for each of the symptoms/behaviors (Burke and Romano-Verthelyi 2018).

Convoluting the ODD construct is the historical belief that it is a mild form of CD which is a severe AO in childhood or adolescence (Burke and Romano-Verthelyi 2018). Also, some researchers have raised concerns about the classification of ODD as a disruptive behavior concern (Cavanagh, Quinn, Duncan, Graham, and Balbuena 2017). For example, Cavanagh and colleagues conducted a parallel analysis of the eight ODD diagnostic items and utilized the SNAP parent and teacher rating scales (i.e., the SNAP assesses attention-deficit/hyperactivity disorder [ADHD], ODD, anxiety disorders, conduct disorders, and mood disorders; Swanson, n.d.) with a sample of 4,380 children. The authors found that ODD was more likely an issue with emotion regulation than a disruptive behavior concern (Cavanagh et al. 2017). In other words, antisocial behaviors associated with the diagnosis of ODD are mainly a result of a child's or adolescent's difficulties with monitoring and controlling their emotional responses (i.e., emotion regulation) and not necessarily caused by issues with authority figures and compliance (i.e., disruptive behavior concerns). Cavanagh and colleagues also suggest that ODD and CD are distinct disorders, however, both are highly correlated with one another. In the AO conceptualization, ODD and CD share hostility as a core interpersonal feature, however, CD is a more severe version of AO in youth populations (Kiesler 1996).

2.2: Conduct Disorder (CD)

The age of onset for Conduct Disorder (CD) can occur in either childhood or adolescence and is often more frequently diagnosed in males than females (APA 2013; Clanton, Baker, Rogers, and De Brito 2017; Fairchild, Hawes et al. 2019; McDonough-Caplan and Beauchaine 2018). The worldwide prevalence rate of CD is 2.1% in child and adolescent populations (Polanczyk et al. 2015). To be diagnosed with CD, the DSM-5 (APA 2013, 469-470) describes the following criteria (i.e., Criterion A):

> A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:
>
> Aggression to People and 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 (e.g., a bat, brick, broken bottle, knife, gun).
> 4. Has been physically cruel to people.
> 5. Has been physically cruel to animals.
> 6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
> 7. Has forced someone into sexual activity.
>
> Destruction of Property
>
> 8. Has deliberately engaged in fire setting with intention of causing serious damage.
> 9. Has deliberately destroyed others' property (other than by fire setting).
>
> Deceitfulness or Theft
>
> 10. Has broken into someone else's house, building, or car.
> 11. Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
> 12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).
>
> Serious Violation of Rules
>
> 13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
> 14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
> 15. Is often truant from school, beginning before age 13 years.

Criterion B in the CD diagnostic criteria requires that the "disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning" (APA 2013, 470). In addition, Criterion C describes individuals who are 18 years or older but do not meet the diagnostic criteria for Antisocial Personality Disorder (APA 2013). The DSM-5 criteria for CD outlines several specifiers that indicate subtypes based on age of onset and other specifiers provide information about the individual's capacity for prosocial emotions (APA 2013). Specifically, the "limited prosocial emotion" (APA 2013, 470) specifier identifies personality and behavioral characteristics such as "lack of remorse or guilt," "callous-lack of empathy," "unconcerned about performance," and "shallow or deficient affect" (APA 2013, 470-471). In psychological research, an equivalent term for the limited prosocial emotions specifier is callous and unemotional traits (APA 2013; Clanton et al. 2017; Fairchild, Hawes et al. 2019; Kimonis and Fleming 2019; Marcus 2017; McDonough-Caplan and Beauchaine 2018; Salekin, Andershed, and Clark 2018; Trentacosta et al. 2019). Furthermore, the DSM-5 diagnostic criteria for CD indicates mild, moderate and severe levels of severity based on the number of conduct problems and the intensity of harm to others (APA 2013). For example, lying to others would be classified as mild while theft without confrontation would be considered moderate. The ICD-11 (WHO 2018) and the DSM-5 diagnostic criteria for CD are almost interchangeable with the caveat that the ICD-11 labels CD as conduct-dissocial disorder. Also, the ICD-11 (WHO 2018) indicates that isolated dissocial or criminal acts cannot be used as justification for conduct-dissocial disorder diagnosis.

The history of how CD became included in the DSM parallels the historical interest in explaining the developmental roots of criminality and other antisocial behaviors (McDonough-Caplan and Beauchaine 2018). For example, Robins and O'Neal (1958) conducted a longitudinal study that evaluated the mortality, mobility, and criminality of individuals with severe childhood antisocial behavioral concerns. Robins and O'Neal found that individuals with a childhood history of severe antisocial behaviors had a poor prognosis, specifically, individuals were more likely to die violently (e.g., homicide), and be involved in crime. Also, individuals with severe antisocial behaviors throughout the lifespan were more likely to die in early adulthood (Goodwin and Guze 1996; Robins and O'Neal 1958). CD in the DSM (APA 1952) was first described as conduct disturbance and as a label for a certain type of childhood adjustment reactance (McDonough-Caplan and Beauchaine 2018). Next, the DSM-II (APA 1968) included two forms of conduct problems, specifically, group delinquent reaction and unsocialized aggressive reaction. The DSM-III (APA 1980) would be

the first introduction of CD as a diagnostic term. CD in the DSM-III was based on a similar continuum as the interpersonal circumplex. Specifically, the DSM-III (APA 1980) defined four subtypes of CD that could be plotted along two of the following intersecting dimensions: socialization (i.e., socialized versus unsocialized) and aggression (i.e., aggressive versus nonaggressive). The DSM-IV (APA 1994) first distinguished between life-course persistent and adolescent-onset CD based on the findings of Moffitt (1993). Presently, CD in the DSM-5 (APA 2013) has maintained the life-course persistent and adolescent-onset distinction through its inclusion of the age of onset specifier. CD in the AO model would place individuals at the extreme levels of hostility and dominance given the DSM-5 and ICD-11 diagnostic criteria.

2.3: The Antisocial Orientation (AO) in Adulthood

Youth who are diagnosed with CD unlike youth diagnosed with ODD may continue an AO into adulthood (Moffitt 1993). The maintenance of an AO in adulthood may transform into a DSM-5 (APA 2013) diagnosis of Antisocial Personality Disorder (ASPD). The DSM-5 (APA 2013, 645) defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture" and often individuals with personality disorders may experience intrapersonal and interpersonal distress as a result of their personality traits. Furthermore, the DSM-5 (APA 2013) clusters personality disorders into the following categories: Cluster A (i.e., odd or eccentric), Cluster B (i.e., dramatic, emotional, or erratic) and Cluster C (i.e., anxious or fearful). ASPD is a Cluster B personality disorder and the DSM-5 (APA 2013, 659) describes the following diagnostic criteria for ASPD (i.e., Criteria A to D):

> A. 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:
>
> 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 repeatedly lying, use of aliases, or conning others for personal profit or pleasure.
> 3. Impulsivity or failure to plan ahead.
> 4. Irritability and aggressiveness, as indicated 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.

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 bipolar disorder.

The prevalence rate of ASPD is approximately, 0.2% and 3.3% and is often diagnosed more in males than in females and especially in prison populations (APA 2013).

The ICD-11 (WHO 2018) has taken a dimensional approach for diagnosis of personality disorder and has removed a type-specific categorization of personality disorders (Bach and First 2018; Ekselius 2018). In the ICD-11, the presence of a personality disorder is diagnosed and prefaced by a description of the personality disorder trait characteristics (Ekselius 2018). The personality disorder trait characteristics are based on six personality domains (i.e., negative affectivity, detachment, dissociality, disinhibition, anankastia [e.g., feelings of doubt, perfectionism, rigidity, etc.], and borderline pattern; WHO 2018). For example, individuals with ASPD would be classified as dissociality in personality disorder in the ICD-11 (WHO 2018). In addition, the ICD-11 (WHO 2018) specifies the severity of the personality disorder by identifying the personality disorder as either mild, moderate or severe. A novel element to the ICD-11 is the inclusion of personality difficulty for individuals who have mental health concerns but do not meet the requirements for personality disorder diagnosis (Bach and First 2018; Ekselius 2018; WHO 2018). With this in mind, individuals with an AO who are distressed by their personality traits and behaviors can be diagnosed with dissociality in personality difficulty in the ICD-11 classification system (WHO 2018).

An issue facing both the DSM-5 (APA 2013) and the ICD-11 (WHO 2018) conceptualization of the AO in adulthood is the scientific community's usage of the terms psychopath and sociopath (Cleckley 1955; Crego and Widiger 2018; Goodwin and Guze 1996; Gunn 2003; Lykken 2018; Toch 2003). Psychopathy is conceptualized as a severe AO that is more biologically based while sociopathy is a severe AO that is formed by environmental factors (Lykken 2018). In the early stages of formulating the DSM-5, the working group on personality disorders debated changing ASPD to antisocial/psychopathic personality disorder, however, presently, neither psychopathy nor sociopathy can be used diagnostically (Crego and Widiger 2018).

Hervey Cleckley (1955, 380-381) was one of the first scholars to attempt a diagnostic description of psychopathy and proposed the following 16 characteristics as distinct traits of an individual with psychopathy:

1. Superficial charm and good 'intelligence.'
2. Absence of delusions and other signs of irrational 'thinking.'
3. Absence of 'nervousness' or psychoneurotic manifestations.
4. Unreliability.
5. Untruthfulness and insincerity.
6. Lack of remorse or shame.
7. Inadequately motivated antisocial behavior.
8. Poor judgment and failure to learn by experience.
9. Pathologic egocentricity and incapacity for love.
10. General poverty in major affective reactions.
11. Specific loss of insight.
12. Unresponsiveness in general interpersonal relations.
13. Fantastic and uninviting behavior, with drink and sometimes without.
14. Suicide rarely carried out.
15. Sex life impersonal, trivial, and poorly integrated.
16. Failure to follow any life plan.

Cleckley's 16 characteristics of an individual with psychopathy would heavily influence the psychological community and especially, Robert Hare who further popularized the term and advocated for its incorporation in the DSM (Hare 1993, 1996). Despite not being a diagnostic term, some psychologists and researchers have utilized and preferred Hare's psychopathy construct and assessment (i.e., the *Psychopathy Checklist-Revised* [PCL-R]; Hare 1991, 2003) to the DSM and ICD versions of adults with a severe AO (Crego and Widiger 2018). Hare's presentation of psychopathy is very much influenced by Cleckley's initial conception of the disorder (Hare 1993). In Hare's (1993, 34) book, *Without Conscience*, he presents the following as the main symptoms of psychopathy:

Emotional/Interpersonal:
- Glib and superficial.
- Egocentric and grandiose.
- Lack of remorse or guilt.
- Lack of empathy.
- Deceitful and manipulative.
- Shallow emotions.

Social Deviance:
- Impulsive.
- Poor behavior controls.

Need for excitement.
Lack of responsibility.
Early behavior problems.
Adult antisocial behavior.

Clearly, the symptoms presented by Hare share qualities with and build upon Cleckley's psychopathy construct. Hare's main contribution to psychopathy assessment is the PCL-R (Hare 2003) which provides psychologists, psychiatrists, and other mental health professionals information about the intensity of an individual's psychopathic traits and behaviors through an evaluation of an individual's potential difficulties with affect and interpersonal relationships (i.e., Factor I) and a deviant lifestyle/antisocial behaviors (i.e., Factor II). In relation to youth diagnosis, the psychopathy concept has been somewhat incorporated into the DSM-5 and ICD-11 with the inclusion of callous and unemotional traits (Kimonis and Fleming 2019). Furthermore, some mental health professionals and researchers have developed assessments that evaluate psychopathy in childhood and adolescence (Salekin et al. 2018). Regardless, a severe AO in childhood and adolescence can continue into adulthood and may become a personality disorder that is mainly antisocial/dissocial (APA 2013; Moffitt 1993; WHO 2018).

2.4: Comorbidities

Comorbidity is the presence and co-occurrence of other mental and/or physical health concerns (Valderas, Starfield, Sibbald, Salisbury, and Roland 2009). Youth with an AO may also experience anxiety and/or depressive disorders, bipolar disorder, early onset psychosis, substance abuse concerns, ADHD, lower intelligence in multiple domains of functioning, and sleep-wake disorders (APA 2013; WHO 2018). In addition, misbehavior, aggression and/or violence in childhood and adolescence could indicate the development of other personality disorders that are not mainly ASPD/dissociality in personality disorder or difficulty (APA 2013; WHO 2018).

2.4.1: Anxiety and depressive disorders

In 2015, an estimated 3.6% of individuals worldwide were impacted by anxiety disorders (WHO 2017). Anxiety disorders are commonly diagnosed and individuals may experience symptoms such as intense worry or fear towards real and/or imagined threats (APA 2013; Miloyan, Bulley, Bandeen-Roche, Eaton, and Gonçalves-Bradley 2016; WHO 2017,

2018). Examples of anxiety disorders that are commonly diagnosed are agoraphobia, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, posttraumatic stress disorder (PTSD), social anxiety disorder, and specific phobias (APA 2013; WHO 2017, 2018). Anxiety disorders frequently co-occur with depressive disorders (APA 2013, Miloyan et al. 2016; WHO 2017, 2018). In 2015, approximately 4.4% of the world's population was diagnosed with depressive disorders (WHO 2017). Individuals with depressive disorders may experience symptoms such as intense sadness, hopelessness, suicidal ideation, and decreases in pleasure over a period of weeks, months or years (APA 2013; WHO 2017, 2018). Examples of depressive disorders are major depressive disorder, depressive episode and persistent depressive disorder (formerly known as dysthymia; APA 2013; WHO 2017, 2018). Studies on youth with an AO have shown an association with anxiety and depressive disorders and the expression of aggression, conduct problems, and other antisocial behaviors (Fanti et al. 2019; Ghandour et al. 2019). For example, Ghandour and colleagues analyzed a 2016 American survey of children's health to generate a prevalence estimate of childhood and adolescent depression, anxiety, and conduct problems. Results showed that amongst children age three to 17 years, approximately 3.2% were diagnosed with depression, 7.1% with anxiety concerns and 7.4% with a conduct problem. Ghandour and colleagues' findings suggest that youth with conduct problems may have difficulties with regulating their emotions. Consequently, antisocial behaviors may arise because of an inability to self-regulate and/or express emotions in a non-aggressive manner.

Further support for the association amongst anxiety, depression and youth antisocial behavior is a study conducted by Fanti and colleagues (2019). The authors hypothesized that anxiety would inhibit misbehavior (i.e., conduct problems). Also, Fanti and colleagues explain that youth who engage in behaviors or activities that result in conduct problems will more likely experience depressive feelings. To support their hypothesis, Fanti and colleagues conducted a path analysis of a Swedish prospective longitudinal data set of approximately 2,000 children who were assessed for depression, anxiety, and conduct/behavioral concerns. Results showed that conduct problems increased levels of depression; however, there was insufficient evidence for anxiety as an inhibitor for future involvement in misbehavior. In addition, the analysis showed that anxiety symptoms predicted development of depressive symptoms. Alternatively, conduct problems predicted the development of anxiety symptoms in middle childhood (Fanti et al. 2019). Fanti and colleagues' results were consistent for both males and females. However, preschool conduct problems and

subsequent childhood depressive symptoms were only significant for female children.

2.4.2: Bipolar disorder

Bipolar disorder is an affective (mood) disorder in the DSM-5 and ICD-11 and causes people to experience mania (e.g., euphoria, increased energy, rapid speech, etc.) and major depressive disorder (APA 2013; WHO 2018). There are two types of bipolar disorder (i.e., I and II) with the period and the severity of mania being the distinguishing symptom of the two types (e.g., a person with bipolar I disorder experiences mania for one week or longer while a person with bipolar II disorder experiences less severe manic episodes; APA 2013; WHO 2018). The prevalence of bipolar disorder in child and adolescent populations is difficult to approximate because of misdiagnosis or overestimation (Kessing, Vradi and Andersen 2014; Lake 2012). For example, manic symptoms share similarities with symptoms of psychosis, therefore, psychologists, psychiatrists and other mental health professionals may have difficulties distinguishing between mania and psychotic disorders (Lake 2012).

Frías, Palma, and Farriols (2015) conducted a database search analysis and found that the prevalence rate for a diagnosis of bipolar disorder and a comorbid disruptive behavior disorder was approximately 31%. Frías and colleagues suggest that disruptive behavior disorders could be a prodromal sign of youth bipolar disorder. Moreover, Weintraub, Axelson, Kowatch, Schneck, and Miklowitz (2019) in their study of 145 adolescents with bipolar I and II disorder (APA 2013) who received either family-focused therapy or brief psychoeducational therapy over a course of two years discovered that comorbid disruptive behavior disorders were associated with increased family conflict and more severe symptoms of depression. The DSM-5 (2013) and ICD-11 (WHO 2018) indicate that for disorders such as ODD and CD/conduct-dissocial disorder, diagnosis cannot be given if conduct problems and/or antisocial behaviors occur during a mood episode. Nevertheless, if criteria are met for a diagnosis of CD and mood disorder, the DSM-5 advises that both diagnoses be given (APA 2013, 475). With this in mind, Biederman and colleagues (2018) examined four longitudinal datasets that include youth with bipolar disorder and CD to ascertain how pediatric bipolar disorder impacts the development of CD and ASPD. Biederman and colleagues (2018) suggest that bipolar I disorder and CD highly overlap with each other and that youth with bipolar I disorder and CD were more aggressive than youth with CD without a comorbid bipolar I disorder. In their analysis of the four

longitudinal studies, Biederman and colleagues found that if manic symptoms went into remission then it was less likely that youth would develop CD and ASPD. Therefore, Biederman and colleagues argue that it is necessary to treat manic symptoms early to minimize the risk and severity of a severe AO in adulthood.

2.4.3: Early onset psychosis

Schizophrenia is a rare mental health concern that is classified as a psychotic disorder in both the DSM-5 (APA 2013) and ICD-11 (WHO 2018). Individuals with schizophrenia experience "delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior and/or negative symptoms (i.e., diminished emotional expression or avolition" [APA 2013, 99]). The literature on the development of schizophrenia has frequently shown that individuals were diagnosed with CD prior to age 15 (Hodgins 2017; Hodgins and Klein 2017; Hodgins Piatosa and Schiffer 2014). In addition, Malcolm and colleagues (2011) interviewed 102 patients who experienced a psychotic episode and found that CD symptoms paired with cannabis use were associated with first episode of psychosis. Malcolm and colleagues suggest that CD symptoms may increase the risk for youth consuming or inhaling intoxicating substances and therefore, increasing the likelihood for psychosis. Seemingly, the violent and aggressive behaviors and conduct problems associated with CD may reflect a prodromal phase for future psychosis (Hodgins 2017; Hodgins and Klein 2017; Hodgins et al. 2014). Consequently, if early symptoms of psychosis and antisocial behaviors (e.g., violence, aggression, misbehavior, etc.) are left untreated then it is more likely that individuals will develop schizophrenia and continue to behave towards others aggressively and in some cases violently (Látalová 2014).

2.4.4: Substance abuse

Swendsen and colleagues (2012) explain that alcohol consumption and drug abuse during adolescence may determine future concerns with and diagnosis of substance-related and addictive disorders (APA 2013; WHO 2018). Approximately, 59% to 71% of adolescents will consume alcohol by age 17 and 31% to 44% of adolescents will try cannabis by age 17 (Swendsen et al. 2012). Given that alcohol consumption and drug use appear to be common in adolescence, Swendsen and colleagues utilized the National Comorbidity Survey-Adolescent Supplement which is an American survey that informs diagnostic interviews for youth age 13 to 18

years (i.e., a total sample size of 10,123 adolescents). Swendsen et al. describe four lifetime stages of alcohol abuse (i.e., use, regular use, abuse without dependence, and abuse with dependence) and four lifetime stages of illicit drug use (i.e., opportunity to use, first drug use, drug abuse without dependence, and drug abuse with dependence). Also, the study was concerned with prevalence amongst various demographic variables (e.g., age, sex, race) and the association between demographic variables and transition among stages. Results showed that 78% of adolescents age 17 to 18 years used alcohol at some point in their life and approximately 10% of participants consumed alcohol by age 13 to 14 years. Similarly, 60.2% of American adolescents had the opportunity to use drugs and 81.4% of adolescents were exposed to drugs by age 17 to 18 years. Generally, males were more likely to use alcohol and drugs. Furthermore, black adolescents had lower rates of alcohol and drug abuse than white or Hispanic adolescents. Also, the authors found that the median age of onset for alcohol abuse with or without dependence was age 14. The median age of onset for drug abuse with dependence was age 14 and age 15 for drug abuse without dependence.

Often youth with an AO will have a comorbid substance related disorder which may exacerbate their mental (e.g., heightened aggression, risk-taking, and impulsivity) and physical health (Brechwald and Prinstein 2011; Malcolm et al. 2011; Soe-Agnie, Paap, VanDerNagel, Nijman, and de Jong 2018; Vanzin and Mauri 2019). For example, Soe-Agnie and colleagues (2018) in a systematic review of substance abuse and antisocial syndromes found that individuals often abuse a variety of intoxicating substances (e.g., cannabis, cocaine, hallucinogenic drugs, and opioids) to manage life concerns. Therefore, it is crucial that mental health professionals and school staff address substance abuse concerns early on to minimize the adverse consequences of alcohol and drug abuse.

2.4.5: Attention-deficit/hyperactivity disorder

Sixty percent of youth with ADHD are diagnosed with either ODD and/or CD (Nosratmirshekarlou, Andrade, Jette, Lawson, and Pringsheim 2018). ADHD is a common mental health concern in schools (Nosratmirshekarlou et al. 2018) and individuals with ADHD may experience symptoms such as difficulties with focusing, poor impulse control, and need for stimulation (APA 2013; WHO 2018). Symptoms associated with ADHD appear to reduce cognitive functioning and a youth’s ability to self-regulate (Liu, Huang, Kao, and Gau 2017; Nosratmirshekarlou et al. 2018). Unfortunately, youth with ADHD and