Antisocial behavior

A pattern of behavior that is verbally or physically harmful to other people, animals, or property, including behavior that severely violates social expectations for a particular environment.

Antisocial behavior can be broken down into two components: the presence of antisocial (i.e., angry, aggressive, or disobedient) behavior and the absence of prosocial (i.e., communicative, affirming, or cooperative) behavior. Most children exhibit some antisocial behavior during their development, and different children demonstrate varying levels of prosocial and antisocial behavior. Some children may exhibit high levels of both antisocial and prosocial behaviors; for example, the popular but rebellious child. Some, however, may exhibit low levels of both types of behaviors; for example, the withdrawn, thoughtful child. High levels of antisocial behavior are considered a clinical disorder. Young children may exhibit **hostility** towards authority, and be diagnosed with **oppositional-defiant disorder**. Older children may lie, steal, or engage in violent behaviors, and be diagnosed with **conduct disorder**. **Mental health** professionals agree, and rising rates of serious school disciplinary problems, delinquency, and violent crime indicate, that antisocial behavior in general is increasing. Thirty to 70% of **childhood** psychiatric admissions are for disruptive behavior disorders, and diagnoses of behavior disorders are increasing overall. A small percentage of antisocial children grow up to become adults with **antisocial personality disorder**, and a greater proportion suffers from the social, academic, and occupational failures resulting from their antisocial behavior.

Causes and characteristics

Factors that contribute to a particular child's antisocial behavior vary, but usually they include some form of **family** problems (e.g., marital discord, harsh or inconsistent disciplinary practices or actual **child abuse**, frequent changes in primary caregiver or in

housing, learning or cognitive disabilities, or health problems). **Attention deficit/hyperactivity disorder** is highly correlated with antisocial behavior. A child may exhibit antisocial behavior in response to a specific stressor (such as the death of a parent or a **divorce**) for a limited period of time, but this is not considered a psychiatric condition. Children and adolescents with antisocial behavior disorders have an increased risk of accidents, school failure, early alcohol and substance use, **suicide**, and criminal behavior. The elements of a moderate to severely antisocial personality are established as early as kindergarten. Antisocial children score high on **traits** of impulsiveness, but low on anxiety and reward-dependence—that is, the degree to which they value, and are motivated by, approval from others. Yet underneath their tough exterior antisocial children have low **self-esteem**.

A salient characteristic of antisocial children and adolescents is that they appear to have no feelings. Besides showing no care for others' feelings or remorse for hurting others, they tend to demonstrate none of their own feelings except **anger** and hostility, and even these are communicated by their aggressive acts and not necessarily expressed through **affect**. One analysis of antisocial behavior is that it is a defense mechanism that helps the child to avoid painful feelings, or else to avoid the anxiety caused by lack of control over the **environment**.

Antisocial behavior may also be a direct attempt to alter the environment. **Social learning theory** suggests that negative behaviors are reinforced during childhood by parents, caregivers, or peers. In one formulation, a child's negative behavior (e.g., whining, hitting) initially serves to stop the parent from behaving in ways that are aversive to the child (the parent may be fighting with a partner, yelling at a sibling, or even crying). The child will apply the learned behavior at school, and a vicious cycle sets in: he or she is rejected, becomes angry and attempts to force his will or assert his pride, and is then further rejected by the very peers from whom he might learn more positive behaviors. As the child matures, "mutual avoidance" sets in with the parent(s), as each party avoids the negative behaviors of the other. Consequently, the child

receives little care or supervision and, especially during **adolescence**, is free to join peers who have similarly learned antisocial means of expression.

Different forms of antisocial behavior will appear in different settings. Antisocial children tend to minimize the frequency of their negative behaviors, and any reliable assessment must involve observation by mental health professionals, parents, teachers, or peers.

Treatment

The most important goals of treating antisocial behavior are to measure and describe the individual child's or adolescent's actual problem behaviors and to effectively teach him or her, positive behaviors that should be adopted instead. In severe cases, medication will be administered to control behavior, but it should not be used as substitute for therapy. Children who experience explosive rage respond well to medication. Ideally, an interdisciplinary team of teachers, social workers, and guidance counselors will work with parents or caregivers to provide universal or "wrap-around" services to help the child in all aspects of his or her life: home, school, work, and social contexts. In many cases, parents themselves need intensive training on **modeling** and reinforcing appropriate behaviors in their child, as well as in providing appropriate discipline to prevent inappropriate behavior.

A variety of methods may be employed to deliver social skills training, but especially with diagnosed antisocial disorders, the most effective methods are systemic therapies which address communication skills among the whole family or within a peer group of other antisocial children or adolescents. These probably work best because they entail actually developing (or redeveloping) positive relationships between the child or adolescent and other people. Methods used in social skills training include modeling, role playing, corrective feedback, and token **reinforcement** systems. Regardless of the method used, the child's level of cognitive and **emotional development** often determines the success of treatment. Adolescents capable of learning communication and problem-solving skills are more likely to improve their relations with others.

Anxiety/Anxiety disorders

An unpleasant emotion triggered by anticipation of future events, memories of past events, or ruminations about the self.

Stimulated by real or imagined dangers, anxiety afflicts people of all ages and social backgrounds. When the anxiety results from irrational fears, it can disrupt or disable normal life. Some researchers believe anxiety is synonymous with fear, occurring in varying degrees and in situations where people feel threatened by some danger. Others describe anxiety as an unpleasant emotion caused by unidentifiable dangers or dangers that, in reality, pose no threat. Unlike fear, which is caused by realistic, known dangers, anxiety can be more difficult to identify and to alleviate.

Rather than attempting to formulate a strict definition of anxiety, most psychologists simply make the distinction between normal anxiety and neurotic anxiety, or anxiety disorders. Normal (sometimes called objective) anxiety occurs when people react appropriately to the situation causing the anxiety. For example, most people feel anxious on the first day at a new job for any number of reasons. They are uncertain how they will be received by co-workers, they may be unfamiliar with their duties, or they may be unsure they made the correct decision in taking the job. Despite these feelings and any accompanying physiological responses, they carry on and eventually adapt. In contrast, anxiety that is characteristic of anxiety disorders is disproportionately intense. Anxious feelings interfere with a person's ability to carry out normal or desired activities. Many people experience stage fright—the fear of speaking in public in front of large groups of people. There is little, if any, real danger posed by either situation, yet each can stimulate intense feelings of anxiety that can affect or derail a person's desires or obligations. Sigmund Freud described neurotic anxiety as a danger signal. In his id-ego-superego scheme of human behavior, anxiety occurs when unconscious sexual or aggressive tendencies conflict with physical or moral limitations.

Anxiety disorders afflict millions of people. Symptoms of these disorders include physiological responses: a change in heart rate, trembling, dizziness, and tension, which may range widely in severity and origin. People who experience generalized anxiety disorder and panic disorders usually do not recognize a specific reason for their anxiety. **Phobias** and **obsessive-compulsive disorders** occur as people react to specific situations or stimuli. Generalized anxiety disorder is characterized by pervasive feelings of worry and tension, often coupled with fatigue, rapid heart rate, impaired **sleep**, and other physiological symptoms. Any kind of **stress** can trigger inappropriate, intense responses, and panic attacks can result. People suffering from generalized anxiety experience "free-floating" fears, that is, no specific event or situation triggers the response. People keep themselves on guard to ward against unknown dangers.

It is believed that generalized anxiety disorder is, at least to some extent, inherited, or is caused by chemical imbalances in the body. Depending on the severity of the symptoms and the responsiveness of the patient, treatment may vary. Often, drugs in the benzodiazepine family (Valium, Librium, and Xanax) are prescribed. These drugs combat generalized anxiety by relaxing the **central nervous system**, thus reducing tension and relaxing muscles. They can cause drowsiness, making them an appropriate treatment for insomnia. In proper dosages, they can relieve anxiety without negatively affecting thought processes or alertness. Medication is most effective when combined with psychological therapies to reduce the risk of recurrence. **Behavior therapy** is designed to help modify and gain control over unwanted behaviors by learning to cope with difficult situations, often through controlled exposures to those situations. **Cognitive therapy** is designed to change unproductive thought patterns by learning to examine feelings and distinguish between rational and irrational thoughts. Relaxation techniques focus on breathing retraining to relax and resolve the stresses that contribute to anxiety.

Controlling or eliminating the physical symptoms of anxiety without medication is another method of treatment.

Title: Phobia
Source: ***The Gale Encyclopedia of Psychology.*** Ed. Bonnie Strickland. 2nd ed. Detroit: Gale, 2001. p498.

Phobia

An excessive, unrealistic fear of a specific object, situation, or activity that causes a person to avoid that object, situation, or activity.

Unlike generalized anxiety, phobias involve specific, identifiable but usually irrational fears. Phobias are common occurrences among a large segment of the population. People with phobias recognize that their fears are irrational, yet avoid the source to spare themselves of the resulting anxiety. Phobias are classified as disorders only when they interfere substantially with a person's daily life.

Psychologists have identified three categories of phobic disorders. The first, simple phobia, is defined in Diagnostic and Statistical Manual of Mental Disorders as a persistent, irrational **fear** of, and compelling desire to avoid, an object or a situation other than being alone, or in public places away from home (agoraphobia) or of humiliation or embarrassment in certain social situations (social phobia). Simple phobia causes considerable distress when confronted because the person realizes that the fear is excessive and irrational. Such phobias are not indicative of other mental disorders. Almost any object or situation can be the cause of a simple phobia. Common phobias include fear of snakes (ophidiophobia), enclosed places (claustrophobia), and spiders (arachnophobia). Fear of heights, doctors and dentists, loud noises, storms, and the sight of blood also are experienced by large numbers of people. Animal phobias, the most common type of simple phobia, usually develop in early **childhood**. Most people do not seek treatment for simple phobias; they simply avoid the object or situation.

Like other anxiety disorders, phobias can be treated with drugs, **behavior therapy** or both. **Drug therapy** usually includes minor tranquilizers like Librium or Valium, taken before a situation in

which a phobia is likely to be introduced. Behavior therapy attempts to reduce a patient's anxiety through exposure to the phobia. For example, patients are guided step-by-step from imaginary confrontation of the phobia (visualizing a snake, for example) to actually experiencing it (holding a real snake). Gradual desensitization is most successful in treating simple phobias

Codependence

A term used to describe a person who is intimately involved with a person who is abusing or addicted to alcohol or another substance.

The concept of codependence was first developed in relation to alcohol and other substance abuse addictions. The alcoholic or drug abuser was the *dependent,* and the person involved with the dependent person in any intimate way (spouse, lover, child, sibling, etc.) was the codependent. The definition of the term has been expanded to include anyone showing an extreme degree of certain **personality traits**: denial, silent or even cheerful tolerance of unreasonable behavior from others, rigid loyalty to **family** rules, a need to control others, finding identity through relationships with others, a lack of personal boundaries, and low **self-esteem**. Some consider it a progressive disease, one which gets worse without treatment until the codependent becomes unable to function successfully in the world. Progressive codependence can lead to **depression**, isolation, self-destructive behavior (such as **bulimia**, **anorexia**, self-mutilation) or even **suicide**. There is a large self-help movement to help codependents take charge of themselves and heal their lives.

There is some criticism of the "codependence movement" by those who feel it is only a fad that encourages labeling and a weak, dependent, victim mentality that obscures more important underlying truths of oppression. Many critics claim the definition of

codependence is too vague and the list of symptoms too long and broad to be meaningful. These critics believe that all families fit the "dysfunctional" label; by diagnosing a person as "codependent," all responsibility for the individual's dissatisfaction, shortcomings, and failures comes to rest on the individual and his or her family. Larger issues of cultural, societal, or institutional responsibility are ignored. However, some proponents of the codependence definition are widening their perspective to look at how society as a whole, as well as separate institutions within society, function in an addictive, dysfunctional, or codependent way.

Addiction/Addictive personality

Alcohol, which is classified as a depressant, is probably the most frequently abused psychoactive substance. Alcohol abuse and dependence affects over 20 million Americans— about 13 percent of the adult population. An alcoholic has been defined as a person whose drinking impairs his or her life adjustment, affecting health, personal relationships, and/or work. Alcohol dependence, sometimes called alcoholism, is about five times more common in men than women, although alcohol abuse by women and by teenagers of both sexes is growing.

When blood alcohol level reaches 0.1 percent, a person is considered to be intoxicated. Judgment and other rational processes are impaired, as well as motor coordination, speech, and vision. Alcohol abuse typically progresses through a series of stages from social drinking to chronic alcoholism. Danger signs that indicate the probable onset of a drinking problem include the frequent desire to drink, increased alcohol consumption, memory lapses ("blanks"), and morning drinking. Among the most acute reactions to alcohol are four conditions to as alcoholic psychoses: alcohol idiosyncratic intoxication (an acute reaction in persons with an abnormally low tolerance for alcohol); alcohol withdrawal delirium (delirium tremens); hallucinations; and Korsakoff's psychosis, an irreversible brain disorder involving severe memory loss.

Aside from alcohol, other psychoactive substances most frequently associated with abuse and dependence are barbiturates (which, like alcohol, are depressants); narcotics (opium and its derivatives, including heroin); stimulants (amphetamines and cocaine); anti-anxiety drugs (tranquilizers such as Librium and Valium); and psychedelics and hallucinogens (marijuana, mescaline, psilocybin, LSD, and PCP). While drug abuse and dependence can occur at any age, they are most frequent in adolescence and early adulthood.

The causes of substance abuse are multiple. Some people are at high risk for dependence due to genetic or physiological factors. Researchers have found the sons of alcoholics to be twice as prone to alcoholism as other people. Among pairs of identical twins, if one is an alcoholic, there is a 60 percent chance that the other will be also. In spite of an apparent inherited tendency toward alcoholism, the fact that the majority of people with alcoholic parents do not become alcoholics themselves demonstrates the influence of psychosocial factors, including personality factors and a variety of environmental stressors, such as occupational or marital problems.

Variations in the incidence of alcoholism among different ethnic groups show that social learning also plays a role in addiction. Parental influence, especially in terms of modeling the use of alcohol and other drugs, has a strong influence on the behavior of children and adolescents, as does peer behavior.

Alcohol dependence and abuse

The abuse of alcohol in any of its various forms, exhibited by repeated episodes of excessive drinking often to the point of physical illness during which increasing amounts of alcohol must be consumed to achieve the desired effects.

The American Psychiatric Association ranks alcohol dependence and abuse into three categories (what society normally thinks of as "alcoholics"): 1) individuals who consume alcohol regularly, usually daily, in large amounts 2) those who consume alcohol regularly and heavily, but, unlike the first group, have the control to confine their excessive drinking to times when there are fewer social consequences, such as the weekend and 3) drinkers defined by the APA who endure long periods of sobriety before going on a binge of alcohol consumption. A binge can last a night, a weekend, a week, or longer. People in the latter two categories often resist seeking help because the control they exercise over their intake usually allows them to maintain a normal daily schedule and function well at work or at school aside from binges.

Other psychologists categorize alcohol dependence and abuse into "species." There are several species currently recognized by some in the medical community, including *alpha*, a minor, controllable dependence; *beta,* a dependence that has brought on physical complaints; *epsilon*, a dependence that occurs in sprees or binges; *gamma*, a severe biological dependence; and *delta*, an advanced form of *gamma* where the drinker has great difficulty going 24 to 48 hours without getting drunk. It should be noted, however, that many psychologists dispute these particular subdivisions on the grounds that the original data behind their creation has been shown to be flawed.

Alcohol dependence and abuse in adolescents and persons under 30 years of age is often accompanied by abuse of other substances, including marijuana, cocaine, amphetamines, and nicotine, the primary drug in cigarettes. These conditions may also be accompanied by depression, but current thinking is unclear as to whether depression is a symptom or a cause of alcohol dependence and abuse. Heredity appears to play a

major role in the contraction of this disorder, with recent discoveries of genes that influence vulnerability to alcoholism. Studies of adopted children who are genetically related to alcohol abusers but raised in families free of the condition suggest that environment plays a smaller role in alcoholism's onset than heredity. Recent studies suggest that between 10 to 12 percent of the adult population of the United States suffers from some form of alcohol abuse or dependence.

Alcohol dependence and abuse typically appear in males and females at different ages. Males are more likely to begin heavy drinking as teenagers, while females are more likely to begin drinking in their mid-to-late twenties. In males, the disease is likely to progress rapidly; debilitating symptoms in females can take years to develop. According to the U.S. Department of Health and Human Services, 14 percent of males aged 18 to 29 report symptoms of alcohol dependence, and 20 percent revealed that their drinking has brought about negative consequences in their lives. As age progresses, these figures drop steadily. In females aged 18 to 29, similar statistics demonstrated that 5 to 6 percent admit to symptoms of dependence and that this number stays essentially the same until age 49, at which point it plummets to one percent. Females reporting negative consequences of drinking, however, begins at 12 percent but drops to statistical insignificance after age 60.

QUESTIONS TO ASK BEFORE ALCOHOL OR SUBSTANCE ABUSE TREATMENT

The following key issues should be considered in determining which option is the most appropriate for given circumstances:

- How severe is the substance abuse problem and is there any evidence (e.g., suicide attempts) to suggest that there may be other problems (e.g., depression)?

- What are the credentials of the staff and what form(s) of therapy (e.g., family, group, medications) are to be used?
- How will the family be involved in the treatment and how long will it be from treatment entry to discharge? Is there a follow-up phase of treatment?
- How will the adolescent continue his/her education during the treatment?
- How much of the treatment will our insurance cover and how much will we need to pay "out of pocket?"

A key physiological component of alcohol dependence is what is referred to as neurological **adaptation**, or, more commonly, tolerance, whereby the **brain** adapts itself to the level of alcohol contained in the body and in the bloodstream. This process occurs over time as the drinker drinks more regularly while increasing intake in order to achieve the desired effect. In some cases, however, high levels of tolerance to alcohol is an inborn physical trait, independent of drinking history.

There is considerable debate as to the exact nature of alcoholism (the biological disease) and alcohol dependence and **abuse** (the psychological disorders). The disease model, which has been embraced by physicians and Alcoholics Anonymous for more than 50 years, is undergoing reexamination, particularly for its view that total abstinence is the only method for recovery. Many psychologists now believe that some victims of alcohol dependence and **abuse** can safely return to controlled drinking without plunging back into self-destructive binges. Experiments have been conducted that indicate the consumption of a few drinks after a lengthy period of abstinence can lessen the resolve to remain totally abstinent, but that a devastating return to abusive drinking is not the inevitable result. In fact, some psychologists contend that the binge drinking that occurs after initially "falling off the wagon" is less a result of the return of alcohol to the body than to the feelings of uselessness and self-pity that typically accompany such a failure to keep a promise to one self.

CHILDREN OF ALCOHOLICS

A number of researchers have studied children of alcoholics (COAs) and their counterparts, children of non-alcoholic parents (nonCOAs). These points summarize their findings:

COAs and non-COAs are most likely to differ in cognitive performance: scores on tests of abstract and conceptual reasoning and verbal skills were lower among children of alcoholic fathers than among children of non-alcoholic fathers in one study (Ervin, Little, Streissguth, and Beck).

A research team (Johnson and Rolf) found that both COAs and mothers of COAs were found to underestimate the child's abilities.

School records indicate that COAs are more likely to repeat grades, fail to graduate from high school, and require referral to the school psychologist than their non-COA classmates. (Miller and Jang; Knop and Teasdale)

Researchers (West and Prinz) found that COAs exhibit behavior problems such as lying, stealing, fighting, truancy, and are often diagnosed as having conduct disorders.

Although it may be premature to suggest that a paradigm shift has occurred in the psychological community regarding alcohol dependence and abuse, many researchers do in fact believe that the disease model, requiring total, lifelong abstinence, no longer adequately addresses the wide variety of disorders related to excessive, harmful intake of alcohol. It is important to note, however, that the human body has no physical requirement for alcohol and that persons with a history of uncontrollable drinking should be very careful in experimenting with alcohol after having achieved a hard-won abstinence. Other factors to keep in mind are problems alcohol can cause to the fetuses of pregnant women, a condition known as **fetal alcohol syndrome** (FAS). Some researchers believe that children born with FAS are prone to learning disabilities, behavior problems, and cognitive deficits, although others feel the evidence is

insufficient to establish a reliable link between these problems and FAS. Alcohol also has a negative effect on human organs, especially the liver, and a lifetime of drinking can cause terminal illnesses of the liver, stomach, and brain. Finally, drunk driving is a tremendous problem in the United States, as are violent crimes committed by people who are under the influence of alcohol. Findings for alcohol expectancies among school-age children indicate increasingly positive alcohol expectancies across the grade levels. By fourth grade children tended to believe that use of alcohol led to positive outcomes, such as higher levels of acceptance and liking by peers and a good **mood** with positive feelings about oneself. Findings also indicate that 25% of fourth graders studied reported feeling at least some **peer pressure** to consume alcoholic beverages; this figure increased to 60% among seventh graders

Dr. John Ewing developed a four-question test, known as the "CAGE" test, that therapists and the medical community frequently use as a first step to evaluate alcohol dependence and/or **abuse**. The test takes its name from a key word in each question: 1) Have you ever felt you should Cut down on your drinking? 2) Have people Annoyed you by criticizing your drinking? 3) Have you ever felt bad or Guilty about your drinking? And 4) Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)? One yes suggests a possible alcohol problem.

Treatment modalities vary. Professionals frequently employ a combination of modalities. Studies indicate cognitive behavioral therapies improve self-control and social skills. Behavioral and **group therapy** have also proven effective. Self-help programs include Alcoholics Anonymous, Smart Recovery, and Rational Recovery. In some cases medications designed to ease drug cravings or block the effects of alcohol are prescribed. To reduce cravings, even acupuncture is being tried. The managed care environment has contributed to a belief that treatment should occur in the least restrictive settings that provide safety and effectiveness. Treatment settings vary from hospitalization to partial hospital care to outpatient treatment to **self-help groups**.