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Review Article

The psychopathological evolution of “Behavior and Conduct Disorder in Childhood”: Deviant and criminal traits in preadolescence and adolescence. A review

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Abstract

Starting from the general concept of “Behavior and Conduct Disorder in Childhood”, the present review seeks to highlight the main predictive elements that, in preadolescent and adolescent age, can correlate with the symptomatological picture of distinctive disorders in deviant and criminal conduct. Early educational intervention, prevention in all its forms and the use of therapeutic corrective tools can encourage expected and expected behavioural improvement, especially in subjects who are still not adults and with a family and social environment that responds to corrective stimuli. Understanding such passages is functional from a strategic point of view, to prevent, educate, plan, intervene, and/or correct certain psychopathological inclinations, also from a socio-environmental, family, and personal perspective.

Behavior Disorders in Childhood (BDC): Introduction and clinical profiles

Behaviour represents the set of attitudes and conducts that define the way an individual act and reacts to the surrounding environment and the individuals in it. It is thus the set of external manifestations of an individual that define temperament (understood as the set of innate, genetically determined tendencies of the individual to react to environmental stimuli in certain ways), character (understood as the unified and organized complex of the psyche in direct relation to the environment), experiences (the emotions recorded in the memory of interactions) and thus personality (understood as the complex organization of ways of being, knowing and acting that ensures unity, coherence and continuity, stability and planning to the individual’s relations with the world) [1].

“Behavior and Conduct Disorder in Childhood” encompasses a range of attitudes and behaviours referred to as

externalizing, in that they include behaviours in which internal distress is directed outward through dysfunctional conduct such as aggression, impulsivity, defiance, rule-breaking, and other behaviours considered socially inappropriate. At preschool and school age, behavioural accessions may occur in isolation and temporarily, such as when they are related to situational aspects or the particular developmental stage the child is in, or they may represent true alarm bells for the onset of future behavioural disorders. Of great importance is the time when the child moves from adjustment based on external adult support to true self-regulation, that is, when he or she no longer needs to rely on external help and can have self-control even when the adult is not present. The critical period for the acquisition of this ability is usually between 24 and 36 months, the age when the child begins to show that he can internalize the adult’s rules, that he can wait to get something desired, and that he can flexibly control his behaviour in the presence of environmental changes. Toward the end of the second year of



life, children also begin to show awareness of the existence of social norms and their possible violations. Studies have shown that behavioural problems may be related to 1) low levels of fear in potentially harmful situations and reduced empathy toward peers, along with increased impulsivity; 2) extremely high levels of emotional activation in the face of possible rewards, especially when associated with rather high negative emotionality and low levels of self-control. Other studies also show that deficits in self-regulation are more associated with reactive aggression (defensive response to a threat or provocation) than with proactive aggression (aggression expressed to gain advantage or dominance over others) [2-12].

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) defines the “Behavior and Conduct Disorder in Childhood” using the wording of “*Disruptive Behavior, Impulse Control, and Conduct Disorders*”, as a macro category to refer to a family of disorders in which the behavioural components of aggression and norm-breaking are prevalent. In detail [13]:

1. **Intermittent explosive disturbance:** It refers to a behavioural picture where aggressiveness is dangerously acted out of the person’s control and without adequate connection with the extent of the events taking place. The disorder is characterised by recurrent behaviour of explosive aggressiveness, verbal or physical, towards people or things that are potentially destructive and capable of causing serious damage. The aggressiveness acted in the intermittent explosive disorder is not only impulsive and uncontrolled but disproportionate to any stressful event or contingent provocation. People suffering from such disorders may experience episodes of exaggerated, unjustified, and potentially damaging aggression for themselves or others, but such behaviour is a manifestation of a depressive or personality disorder and not primarily an expression of an inability to control impulses.
2. **Conduct disorder:** The main characteristic of this disorder is the systematic and persistent violation of the rights of others and social norms, with very serious consequences in terms of school and social functioning. Children and adolescents can show overbearing, threatening, or intimidating behaviour, intentionally triggering fights, stealing objects by confronting the victim, and forcing the other to suffer violence, even sexual abuse. The symptoms of the disorder are: assaults on people or animals; often bullies, threatening, or intimidating others; often starting physical fights; using a weapon that can cause serious physical harm to others (e.g. a stick, a bar, a broken bottle, a knife, a gun); has been physically cruel to people and animals; has stolen by confronting the victim (e.g. assault, mugging, extortion, armed robbery); has forced someone into sexual activities; destruction of property; serious violations of rules.
3. **Oppositional-provocative disorder:** It involves problems of self-control of one’s emotions and behaviour. In such disorders, the described problems are expressed through behaviours that violate the rights of others, as in the case of aggression, destruction of property, or that place the person in sharp contrast with social norms or figures representing authority. Emotions such as anger and irritation, together with controversial and defiant behaviour, prevail. The frequency of the provocative oppositional disorder is higher in families where a parent has an antisocial disorder and is more common in children of biological parents with alcohol addiction, mood disorders, schizophrenia, or parents with a history of attention deficit hyperactivity disorder or conduct disorder. The oppositional provoking disorder is characterised by the persistent presence of an angry/irritable mood (he often gets angry, is often touchy or upset, is often angry and resentful), polemic/provocative behaviour (he often quarrels with people who represent authority, openly challenges or refuses to respect the rules, deliberately irritates others, blames others for his own mistakes), vindictiveness. These symptoms must occur when interacting with at least one person other than a sibling and are often part of problematic ways of interacting with others.
4. **Attention deficit hyperactivity disorder:** It is an evolutionary disorder of self-control. It includes difficulties in attention and concentration, impulse control, and activity level. These problems derive substantially from the inability of the child to regulate his or her behaviour according to the passage of time, the objectives to be achieved, and the demands of the environment. It should be pointed out that this morbid condition is not a normal growth phase that every child has to overcome, nor is it the result of ineffective educational discipline, nor is it a problem due to the child’s “wickedness”.
5. **Reactive attachment disorder:** It is a developmental disorder of childhood attachment, referring to the disturbed and/or inadequate social relational mode, and is more related to disturbances caused by traumatic and stressful events, and can be of the “inhibited type” when the subject has difficulty engaging in interpersonal relationships and responding appropriately to them according to developmental level or of the “uninhibited type” when the subject exhibits the propensity to establish indiscriminate sociability and inadequate selectivity in choosing a reference figure.
6. **Attachment disorder interrupted:** In the child, it presents itself as the effect of traumatic separation from the attachment figure (parents or caregivers), frequent separation episodes, or the psychological impact of grief following the death of the caregiver. The child with interrupted attachment disorder displays an insecure disorganised behavioural pattern, i.e. highly dysfunctional to the objective of attachment, which is to ensure the closeness and protection of the mother and/or caregiver”.

Preadolescence and adolescence: The distinctive and characteristic features

Preadolescence (8–10 years) and adolescence (11–13 years) are stages in the evolutionary development of every human subject, characterized for being a transition in the social role of the person from childhood to adult and a real physiological change due to growth (defined by the term “puberty”), perfecting with the attainment of its reproductive capacity and thus with the increase of hormone levels in the blood, the growth of body mass, the conclusion of psychophysical development and the development of secondary sexual traits. These elements lead to frequent mood swings with what follows at the behavioural level. Recent studies have pointed out in particular that the decreasing age relative to the onset of the pre-pubertal period (from 10 years to 8 years) and pubertal period (from 13 years to 11 years), countertrend to the past, corresponds to the increasing tendency of the age relative to the social transition from adolescence to adulthood, i.e., from 16–18 years to 25 years [14,15].

The increasing maturational complexity of preadolescence and adolescence, by the dramatic physical and social changes of recent decades, necessitates new valid tools that can enable the prediction of healthy and balanced development. The advancement of the age of puberty and the delay in role transition have produced a de facto need to redefine the classical developmental stages, such as childhood, adolescence, adulthood, and old age, with a more recent redefinition of the stages, namely infancy (first, second and third), preadolescence and adolescence, youth or pre-adulthood, maturity, and old age, going to consider more facets of the transition between adolescence and adulthood [16].

The conclusion of adolescence can be defined as the subject's ability to be able to create stable and fruitful relationships between self and others and the conclusion of self-definition [17].

In this complex developmental dynamic, the factors that can negatively impact a person's psychophysical development are intrinsic (individual and family factors) and extrinsic (socio-environmental and cultural factors). Specifically [18]: 1) the “individual factors” such as mental health problems, behavioural disorders, low self-esteem and self-efficacy, low emotional intelligence, history of abuse or neglect, and early involvement in antisocial behaviour; 2) the “family factors” such as dysfunctional or problematic families, poor supervision and strict discipline in the family, exposure to family conflict and domestic violence, lack of family support and affection, and absence of positive role models; 3) “socio-environmental factors” such as poverty and socio-economic deprivation, low quality of schools and lack of educational opportunities, proximity to high-crime communities, membership in deviant peer groups, exposure to violent media and negative content; 4) “cultural factors” such as social norms that legitimize violence or deviance, social inequality and discrimination, the influence of media and popular culture, and deviant or antisocial subcultures.

Definition and contextual profiles

“Deviance” is a complex phenomenon influencing both macro and micro-level aspects, which has been widely studied by social scientists. The results of studies have highlighted four main groups of topics, namely predictors of deviance (among the most frequent: family patterns, socio-demographic aspects, socialization, victimization, and school and individual factors), online deviance, socio-constructivist theories, and research-based theories of deviant behaviour; moreover, the results showed that researchers often use strain theory, social learning, self-control, and social control in their studies. Very often the sociology of deviance has dealt with criminal phenomena, generating in many people the misconception of identification between crime and deviance. In reality, while it is true that crime is part of deviance, the two phenomena nevertheless do not coincide. “Crime” refers to those activities in concrete terms that break a criminal legal norm and are subject to the application of penalties. The term “deviance”, on the other hand, is broader and inclusive not only of criminal phenomena but also of other behaviours, as advocated by Dinitz, who identifies five categories of deviance: deviance as a contrast to the prevailing physical, physiological, or intellectual pattern (this is the case with deformed individuals and the mentally handicapped); deviance as an infraction of religious and ideological norms and rejecting orthodoxy (this is the case with heretics and dissidents); deviance as an infraction of legal norms (this is the case of thieves and murderers); deviance as behaviour that differs from the cultural definition of mental health (this is the case of psychopathic individuals and neurotics); deviance as a rejection of dominant cultural values (this is the case of hippies or punks). According to this definition, what is normally referred to by the term “criminality” is nothing more than one of several aspects of a broader phenomenon that, for simplicity's sake, could be summarized as the implementation of behaviour contrary to a social and legal norm imposed by the community to which it belongs and which may underlie one or more psychological and psychiatric disorders. For reasons of argumentative simplicity and conciseness, therefore, the writers prefer to distinguish even more sharply between “deviant behaviour” and “criminal behaviour”, defining the former as “active behaviours that result in a violation of a social norm determined by the community and that does not provide for a sanction of a legal nature (e.g. personal use of drugs)”, while the latter as “active behaviours that result in a violation of an exclusively legal norm and that provides for a sanction of a civil-administrative nature (compensation for damages, restitution, demolition, suspension, disbarment, and administrative detention) or criminal nature (fine, fine, imprisonment and arrest)”. And even more succinctly, we can consider “deviant and criminal behaviour” (DCB) as all those “actual and active human acts that constitute a violation of a social and/or legal rule, and their transgression provides for the application of a punitive sanction” [19].

Over time, the term deviance has undergone different shades of meaning. Generally, people associate deviance with criminal actions, although this is not always true. According



to this line of thinking, the pressure of consequences would allow people to be able to reject the enactment of deviant behaviour. The fear of running into a negative consequence has the function of motivating the person to avoid such behaviours. For example, the “punishment” of ostracism within Jehovah’s Witness communities, involves the total marginalization of the person, by the religious community to which he or she belongs including family and relatives, this often discourages any kind of change of faith. Goode’s contribution leads to seeing deviance not necessarily as synonymous with the transgression of the law with criminal actions but can express a different way of approaching things (outside the statistical norm). Following this thought, author Simon Dinitz identifies 5 categories of deviance definable as 1) deviation from the norm of physical, physiological or intellectual functionality such as physical impairments or mental deficits; 2) deviation from the religious or ideological norm such as heretics and dissidents; 3) transgression of the legislative norm such as theft, drug dealing or murder; 4) deviation from the predominant definition of mental health in a society such as people who exhibit psychopathic or neurotic traits; and 5) deviation from dominant cultural values such as the Hippy movement or the Punk movement. In this sense, the definition of deviance cannot be considered only as the transgression of rules, but as the evolution of possible deviant behaviour from dominant cultural contexts. For example, the Hippy movement, which strongly criticized the customs of the time, brought a wave of new civil rights to sexuality and the figure of women (see right to abortion). In general, defining deviance requires having a cultural context of reference. Only then is it possible to know and understand what values drive that specific community and consequently understand what is being evaluated as deviant? The same goes for criminal actions since in part these are subject to variations in evaluation from state to state. For example, in Italy until the age of 14, the person is not given the capacity to understand what he or she is doing, and therefore the consequences will be mitigated; on the contrary, from the age of 14 on, the situation will be evaluated on a case-by-case basis. In America, however, a 13-year-old boy was convicted of murder as if he were an adult because of his premeditation and the heinousness of the act. In this sense, one should begin to consider deviance no longer as a phenomenon that coincides with crime, but rather consider it on the one hand as a different expression of values and customs, on the other hand, one should know what and how many signs of “diversity” may or may not predict negative evolution into criminal pathologies [20–22].

To provide for the analysis of individual psychophysical development, one would need a series of psychometric tests that are capable of investigating all areas of social and clinical interest; however, to date, beyond psychometric investigations of cognitive functional complexes, investigations are oriented on the study of deviant and criminal behaviour. When the first deviant behaviours occur, the clinician checks whether a conduct disorder and/or possible hyperactivity disorder is present in the child through a differential diagnosis. To do

this, the most popular instruments in North America and Europe are the Parent Interview for Child Symptoms (PICS) and Conners’ Parent Rating Scale (CPRS); in addition, these types of structured interviews are accompanied by semi-structured interviews. If necessary, a personality test such as the Minnesota (MMPI-II) can also be administered. Recently, research has proposed: a) the Graded Antisocial Model (GA-M), which considers antisociality as a graded phenomenon that is reinforced over time through active behaviours that are not limited by the social context of reference, becoming a structured personality disorder only when the individual’s self-centeredness becomes rigid and dysfunctional; b) the Antisocial Severity Scale (AS-S), which draws the pathological and dysfunctional evolution of antisociality, in five levels (yellow for emotional dysfunctionality, orange for self-centeredness, red for violation of social rules and violence to property, animals, and people, purple for severe violation of legal rules and black for structured psychopathology); c) Starting from the Graded Antisocial Model (GA-M) and the Antisocial Severity Scale (AS-S), a questionnaire was designed to analyze the state of awareness of one’s deviant and criminal behaviors (Perrotta–Marciano Questionnaire on the state of awareness of one’s deviant and criminal behaviors, ADCB-Q-2), not to make a personality diagnosis but to define the presence or absence of deviant and criminal behaviors and the degree of awareness of one’s deviant or criminal behavior and the diagnosis of the “criminal spectrum”, understood as a macro-category encompassing all those deviant, antisocial and psychopathic behaviors (“Dysfunctional pattern consisting of a clinically relevant cross-sectional condition in which the subject manifests deviant, borderline, histrionic, narcissistic, antisocial and psychopathic behaviors, such that they foster their emotional, cognitive and behavioral dysfunctionality with respect to conduct related to social and legal norms that would be expected from another member of their same environmental context”). In 40 items on a revised Lo-5 scale (as originally the first version of the test was calibrated on the L1-6 scale with 30 items), this test was validated with a representative population sample, comparing it with the Behavior Variety Scale (DBVS) for the preadolescent and adolescent population and the Hare Psychopathy Checklist-Revised (PCL-R) for the adult and mature population, as standardized tests that can study antisocial and psychopathic behaviors, but without assessing the whole of these behaviors as is the case with the ADCB-Q-2 [19,23–26].

The predictive and facilitating factors

The aspect that most affects development in individual factors is the experiences of emotional and physical violence experienced in childhood. Below are some studies we have selected. In an interesting research conducted in the Middle East, they administered tests that measured emotional maltreatment in childhood, affiliation among deviant peer groups, depression, violent behaviour, and suicidal ideations. It was found that emotional maltreatment suffered in childhood can elicit both deviant affiliation and depression, both of which can increase the likelihood of violent behaviour toward self or others [27].



Another study aimed to investigate the types of abuse by correlating them with age; this study found that emotional abuse could increase difficulties in recognizing one's own emotions such as anger, fear, and sadness. Sexual abuse, moreover, could increase difficulties in young adults in engaging in purpose-driven relationships, while physical abuse would increase difficulties in recognizing fear in the other [28].

In yet another study, they completed questionnaires to test whether Childhood Emotional Abuse (CEA) was related to the development of depression in adolescence and how much it was mediated by deviant peer affiliation; the results confirmed this hypothesis [29]. Finally, a study that reviewed 18 different studies wanted to detect whether associations between physical activity and sedentary behaviour could be related to bullying victimization. From the findings, there are associations between bullying and cyberbullying [30]. From all these studies, it appears that poor empathizing skills in children from the earliest days of birth would seem to be a predictor for the development of antisocial personality disorders and psychopathy [31]. These studies would confirm the extent to which the presence of possible abuse as well as poor stimulation of minors can increase the likelihood of developing difficulties in relationships, increasing the likelihood of joining deviant peer groups. Among the highlights of scientific research is neuroscience, which, reiterates how the achievement of balanced psycho-physical growth cannot transcend the acclaimed character and personal elements of the adolescent. These studies eliminate any automatism in considering determinants in the complex system of individual maturity, in addition to the elements learned from multiple educational agencies, as well as the incisive influence of family and social events [32].

The findings expected from the experiments *de quo* concerned the morphological encephalic structure of the young person as early as puberty. In the incisive research on what position to take in the social-dynamic sphere, the aggression factor finds its essential connotation and interpretive evolution in the evolutionary processes assumed by the MAO-A gene as the determining factor underlying juvenile deviance. The genetic element of reference would stand as an origin to the ascertained diagnosis of childhood trauma, which, based on an examination of encephalic etymology, constitute factors apt to affect not only the infant but also the mother from the first months of pregnancy. Neuroimaging tools, demonstrate how specific fractures of the encephalon underlying acute depression in mothers eventually trigger specific infant trauma and find relevance in the different *modus operandi* assumed by the aforementioned MAO-A gene. On the point, at a predominantly statistical level, it is clear to note how in 5% of women diagnosed with acute depression the impulsive or self-control mechanisms, stand at the basis of the devastating psychic growth of the minor realizing systemic childhood traumas underlying the triggering of aggression to be understood as a violent reaction to the threat to one's identity, i.e., perception of danger to existential changes in sharp contrast to the values learned in the family context. It is also recalled how the perception of a drastic change to the

etymology of one's personality comes to be perceived as an imminent danger, resulting in the most characteristic form of aggression: transgressiveness. It is plausible how the young person ravaged by a sense of anguish and guilt for not being confident in assuring adults of the attainment of the ideology of goals, becomes gripped in a strong sense of inferiority such that he or she accumulates with those who present the same discomfort i.e., we have prematurely abandoned healthy ideals for the attainment of typically deviant goals [33].

The resulting boomerang effect determines the unleashing of the violence factor as the only solution to the irretrievable sense of social and individual neglect advanced by the lack of awareness about the unlawful value of the conduct enacted. In the contextual experience of countering socially shared values, the individual's transition to the baby gang is plausible *ipso iure* (by the law itself). The axiom can only find affirmation in the common determinations of the individual with the group to which he or she belongs the sharing of ideals finds support in the status of frustration typical of the distressed and transgressive individual who finds maximum anchorage in the discomfort suffered by his or her peers [34].

From the axiom between the two components comes conformity: they become the same. Multifactoriality ensues where statistical data note, how subjects not necessarily belonging to uncomfortable family backgrounds join in the determination of antisocial factors. Marginalization underlies the *modus operandi* of the baby gang, such behavior within the phenomenon of bullying, is functional in developing a well-defined hierarchy. With the identification of a leader, group members are required to pass incisive tests of strength, the negative outcome of which determines the victim's inferiority and thus isolation. This mechanism often grips the victim, in existential problems, in this way, he may see the suicidal act as the only solution to the sense of inferiority protracted by the group. The writer observes, how for the ascertainment of disorders related to juvenile deviance, an incisive preventive revisitation is in order: the strengthening of the role assumed by educational agencies using the latest regulatory interventions, does not appear to be sufficiently suitable requiring the hoarding of more specialized figures for new mechanisms of early diagnosis. The studies of neuroscience, show how it is possible to intervene in the encephalic lesion mechanisms already at the landing in the first depressive manifestations in pregnancy and based on which it is possible to outline a scientific framework of prevention from which the legislator will not be able to escape, also with a view to an easier consideration of the dramatic situation of penitentiary institutions [35].

The first extrinsic factor, on the other hand, that conditions preadolescence and adolescence, according to Developmental Psychology, is the type of attachment bond developed in childhood (secure, insecure ambivalent, insecure-avoidant, insecure disorganized, etc.), this is because of the type of attachment the subject will develop characteristic Internal Operating Models (MOIs) that will later guide the relationship with self with others and with the world [36].



An interesting research conducted in the age of transition from puberty to adolescence aimed to test whether attachment patterns and Locus of Control could be predictive elements for the development in adolescence of internal psychological distress (anxiety and mood disorders) or dangerous behaviours such as aggressive behaviour. The research showed a significant effect given by insecure attachment and the perception of external Locus of Control. Specifically, it was found that the presence of these two aspects significantly affects the dimensions of anxiety, depression, obsessive-compulsive symptoms, eating, and psychosomatic. In contrast, aggressive behaviours are only influenced by insecure attachment [37].

Another study sought to detect, in individuals involved in bullying-related events (bullies, victims, bully-victims, and uninvolved) the types of attachment and their mental patterns. It was found that the “bullies” in comparison with the uninvolved subjects have ambivalent and avoidant as their predominant attachment styles. Bully victims and victims exhibit more ambivalent types of attachment. To mental schemata: bullies, bully-victims, and victims present higher levels of aggression, avoidance tendency in confrontation with peers, and more inappropriate behaviours [38].

This research provides insight into how attachment styles are a dimension of clinical interest. Socio-cultural factors are among the most important factors to consider in juvenile deviance and its possible development into pathology. The first factor highlighted by a systemic review on the topic is economic inequality among minors, the latter of which can double or triple the development of mental pathology [39].

Another review study aimed to identify whether psychosocial risk factors, both intrapersonal and interpersonal, are greater in the “juvenile delinquent” population. They also wanted to test whether these factors were correlated. The study confirms both hypotheses. In these situations of social distress, it is common to detect how parental figures are lacking in care, which, combined with poor economic conditions, can create distress in juveniles. In addition, drug use is a constant variable in all these situations as is the relationship with the deviant peer group that evolves into criminal behavior [40].

We also point out how some behavioural addictions can be indicators of possible deviance. For example, sex addiction if it is very pronounced could lead the subject to engage in deviant behaviors that are dangerous to self and others [41].

The first interesting study was conducted in 23 countries to test whether physical health, lifestyle, and psychosocial adjustment could be predictive factors to victimization by physical or virtual bullying. The results that emerged point out that in countries (at the national level) where the quality of human development and socio-cultural level is higher, adolescents are less likely to become victims of bullying [42].

A very innovative study was conducted to test whether the link between SSS (subjective social status that included factors such as wealth education and health) and rabies control through CRP (biomarker C-reactive protein) had differences at the cultural level. Research shows that in the U.S. population:

a lower level of SSS corresponded to a higher presence of CRP in the blood; in contrast, in the Japanese population this correspondence was not verifiable. This confirms how cultural factors may mediate the relationship between social status and aggressive behaviour [43].

Another research conducted showed how the use of the internet and social platforms, without adequate parental control over the content minors, see on their devices, greatly increases the learning of inappropriate behaviours, showing how uncontrolled use of such technologies can alter minors’ psychophysical development [44].

Finally, we point out how the use of some social [45] and listening to certain genres of music [46], can be indicators of possible deviance (Table 1).

The clinical profiles

Behaviour disorders in childhood are estimated to be diagnosed in about 10% of the youth population; of these, about 25% are estimated to evolve into a full-blown psychopathological-related disorder [47], including borderline and substance addiction personality disorders, narcissistic, histrionic, antisocial, and psychopathic, according to the nosography of the DSM-5-TR [48].

People with *borderline personality disorder* have a pervasive mode of instability, in relationships, mood, and self-image,

Table 1: Factors that negatively influence human evolutionary development.

Influential factors	Type of factors
INTRINSIC	
Individual factors	1) Individual mental health 2) Deviant behavioural disorders not directly correlated with specifically classified personality disorders 3) Low self-esteem 4) Low emotional intelligence 5) History of physical and psychological abuse 6) History of abandonment 7) Early involvement in antisocial behaviour
Family factors	1) Family mental health 2) Dysfunctional or problematic families 3) Poor supervision 4) Strict discipline in the family 5) Exposure to family conflicts and domestic violence 6) Lack of family support and affection 7) Absence of positive role models
EXTRINSIC	
Socio-environmental factors	1) Poverty 2) Socio-economic deprivation 3) Low quality of schools 4) Lack of educational opportunities 5) Proximity to communities with high crime rates 6) Membership in deviant peer groups 7) Exposure to violent media and negative content
Cultural factors	1) Deviant, aggressive, and violent social contexts 2) Social inequality 3) Discrimination 4) Influence of the mass media and popular musical culture 5) Social influence by deviant and antisocial subcultures



often presenting impulsive behaviours; they have a strong fear of being abandoned, which is why they may enact crises or suicidal gestures to keep the other person in the relationship. Many people with this disorder have histories in childhood of physical and/or sexual violence, abandonment, separation, or loss of a parent. There are several hypotheses of genetic predisposition, although more studies need to be done in this regard. To diagnose this disorder, the person must have unstable interpersonal relationships, unstable self-image, emotional dysregulation, and overt impulsivity; in addition, the person must have at least 5 of the following symptoms: 1) desperate attempts to avoid abandonment; 2) interpersonal relationships that oscillate between devaluing and idealizing the other; 3) instability in self-image; 4) having impulsive behaviours in at least 2 dangerous activities (sex, driving, food); 5) self-harm or suicidal gestures; 6) sudden mood changes; 7) feelings of emptiness; 8) difficulty in anger management; 9) temporary paranoid thoughts. Borderline personality disorder must be differentiated: from bipolar disorder, histrionic personality disorder or narcissistic personality disorder, depressive or anxiety disorders, substance use disorder, and post-traumatic stress disorder [49-52].

Borderline individuals tend to have *behavioural dependence on alcohol and drugs*. All these substances activate the reward system in the brain, which by causing the feeling of pleasure fuels the consumption of the substance itself. Depending on the type of substance, there are different effects. These people are often characterized by low self-control and high levels of risk-taking. Substance use generates in the body the phenomena of intoxication, withdrawal, and substance-induced psychiatric disorders. Substance addiction is highly variable so it can only be described through the elements involved: the type of person, the type of substance used, and the context of use. Environmental and social factors seem to be the elements that weigh most heavily in the expression of this pathology. Psychopathological disorders caused by substance use must have these characteristics: 1) symptoms of discomfort must appear within 1 month of intoxication or withdrawal; 2) this state must cause high discomfort or impaired functioning; 3) have no manifestations before substance use; 4) discomfort must not occur during the delirium caused by the substance; and 5) not persist for a long time. For the diagnosis of substance abuse disorder, one must have 2 or more symptoms: 1) increase in time of consumption or amount; 2) desire to reduce substance use; 3) long time taken to obtain the substance, intake of the substance, and termination of the effect; 4) intense desire to consume the substance; 5) use of the substance even if it compromises social relationships; 6) avoidance of other activities for substance use; 7) use of the substance in dangerous situations; 8) use of the substance even if it compromises a psychological or medical problem; 9) pharmacological symptoms, determined by need to increase the dose and withdrawal [53].

People with *narcissistic personality disorder* have low self-esteem even if they perceive themselves as great. To maintain the feeling of grandiosity these people must compensate for it through the other, seeking adulation or devaluing the other

to maintain their position of dominance. They present a lack of empathy in relationships. Their tendency to dominate others leads them to carry out deviant behaviours up to actual transgressions of the law. The only etiological hypotheses seem to be related to the relationship with parents or other substitute figures, capable of undermining their security. For the diagnosis, at least 5 of the following criteria are needed: 1) unfounded perception of grandiosity; 2) fantasies characterized by successes in all areas without limits; 3) feeling special and unique; 4) need to be admired; 5) a feeling of being privileged; 6) antagonistic behaviours to obtain benefits; 7) lack of empathy 8) often feel envy: 9) arrogance and pride. Furthermore, symptoms must be present in early adulthood [54].

Furthermore, people affected by the histrionic disorder tend to seek the attention of others and demonstrate excessive and pervasive emotionality. Often, to seek such attention, an improper or provocative seduction is carried out. Through taking care of their appearance, seeking people's attention, and suffering if they don't get it. These people are easily influenced by others and trends. It is hypothesized that repeated maladaptive experiences in childhood in the relationship with parents are the most relevant element together with genetic factors. People affected by this disorder must present a pervasive tendency to seek attention and in their emotionality. Furthermore, they must present at least 5 of these symptoms: 1) discomfort if they are not the centre of attention; 2) in interactions they are inappropriately provocative and sexually seductive; 3) emotional instability and superficiality; 4) using your body to attract attention; 5) the language is theatrical and impressionistic; 6) self-dramatization and theatricality; 7) suggestibility; 8) unmotivated intimacy in relationships [55,56].

Those affected, however, by *antisocial personality disorder* feel aversion and contempt for rules and laws. This type of person tends to engage in deviant behaviors which sometimes result in criminal actions. They tend to justify their actions through the mechanism of rationalization, belittle the other, or be indifferent to the consequences of their actions and/or the negative effects experienced by the other. They also have difficulty planning their life, showing inconstancy. They are often people who lack empathy towards others, which is why they hardly feel remorse. The weight of environmental causes is more evident in these subjects, especially in the developmental phase due to the family or social environment or the quality of the substances ingested or breathed. Genetic factors have a greater weight for adulthood. The main diagnostic criterion is contempt for the rights of others and at least 3 of the following characteristics: 1) repeatedly breaking the law; 2) deceptive methods of using pseudonyms or to defraud others; 3) impulsive actions and lack of planning in life; 4) being involved in physical fights or assaults; 5) lack of assumption of responsibility; 6) they feel no remorse for their actions. Furthermore, the diagnosis cannot be made before the age of 18 and there must be a diagnosis of conduct disorder received before the age of 15 [57-61].



Finally, to date, the DSM-V-TR does not make any differentiation between Antisocial Personality Disorder (APD) and *Psychopathy* (DPP). In our opinion, it seems important to list the specific characteristics that could allow the differentiation between antisociality and psychopathy. Psychopathy can be defined through different deficit characteristics of an affective, relational, and behavioural nature in relationships with others and the world in general. The causes are not yet certain, among the different hypotheses we have: a biological cause that sees a deficit in the amygdala which blocks both the experiences of empathy and the lack of fear; the relationship with dysfunctional parental figures who can vary between the absence of control or a pervasive coldness and rigidity. The person who develops Psychopathy as opposed to APD often presents the following characteristics that emerge through a structured interview: 1) superficial charm (communicative ability to present oneself in a positive way, but only in the first impact and therefore superficially); 2) Grandiose self (systematic overestimation of oneself which leads one to behave as arrogant and opinionated); 3) sensation seeking (the tendency towards boredom that is counteracted by dangerous behaviours); 4) pathological lying (the subject has an uncontrollable need to lie); 5) manipulative skills (they manipulate people through lies or deception to obtain their own benefits); 6) absence of a sense of guilt; 7) superficial affectivity (cold behaviors or mimed displays of affection), 8) absence of empathy (they are unable to identify with the emotions of others); 9) promiscuous sexual behavior; 10) lack of behavioral control (when they feel pressured or criticized they become aggressive, difficulty controlling anger), 11) lack of long-term goals; 12) high impulsivity; 13) delinquent actions in adolescence; 14) behavioral problems in developmental age. The term “psychopath” was coined with Cleckley’s (1976) work, *The Mask of Sanity*, in which he outlined the salient traits of the psychopathic personality; it fell into disuse in the decades following its publication. The term “sociopath” was used for a time, apparently reflecting the social rather than psychological origins of some of the difficulties presented by these individuals. Since the publication of the DSM-II in 1968, the expression “antisocial personality” became the preferred denomination. With the publication of the DSM-III in 1980, antisocial personality disorder was significantly modified from Cleckley’s original description: the DSM-III criteria provided more diagnostic details than those of any other personality disorder, but they restricted the focal point of the disorder to a criminal population likely connected to oppressed and economically disadvantaged lower social classes (Halleck, 1981; Meloy, 1988; Modlin, 1983). Some researchers found that when the DSM-III criteria were applied to criminals in prison, in the majority of cases (50–80%) it was possible to diagnose antisocial personality disorder (Hare, 1983; Hart & Hare, 1998). However, clearly different results were obtained by using diagnostic criteria more closely following what was expounded by Cleckley, in which psychopathy was emphasised. For example, if Hare’s Psychopathy Checklist-Revised (PCL-R) was used, only in 25% of cases the inmates examined were classifiable as psychopathic (Hare, 1991; Hare et al., 1991). In a study of 137 cocaine-dependent women who had sought treatment (Rutherford et al., 1999) it was possible to diagnose

antisocial personality disorder according to DSM criteria in over 25% of cases, but only in 1.5% of cases. these women could be diagnosed with a moderate degree of psychopathy according to the PCL-R. The scholars who contributed to the drafting of the DSM-IV (American Psychiatric Association, 1994) deliberately tried to place greater emphasis on the personality traits associated with psychopathy, also attempting to simplify the criteria without substantially modifying the clinical picture described by the diagnosis (Widiger et al., 1996). The term “psychopath” has enjoyed growing popularity in recent years as a diagnostic term that implies particular psychodynamic and even biological characteristics that are not reflected in the DSM-IV criteria for antisocial personality disorder (Hart, Hare, 1998; Meloy, 1988; Person, 1986; Reid et al., 1986). Meloy (1988) used this definition to describe individuals with a total absence of empathy and a sadomasochistic relational style based on power rather than emotional bonding. The available literature regarding antisocial personality disorder and psychopathy is quite vast; However, it most often presents a limit in the use of the terminology indicating the two disorders: the terms are often used as synonyms, and this certainly does not favor their understanding and differentiation. In the psychological field, this problem was quite strong; in the criminological field the texts have tried to remedy this by referring to the criminal suffering from one or another disorder as a “sociopath”, thus creating greater confusion. The diagnosis of antisocial disorder is made more frequently than that of psychopathy, as the latter disorder has more severe diagnostic criteria. In the two disorders, attention is concentrated on different aspects: in the antisocial one, more reference is made to the behavior of the subject, to the fact that he has the tendency to put all his impulses into practice, while in the case of psychopathy, the focus is on the affective and interpersonal. This becomes evident by observing the main symptoms present in patients suffering from these disorders: in the case of antisocial disorder we have the failure to conform to social norms, the tendency to manipulation, impulsiveness, lack of planning, strong irritability, and aggressiveness, disinterest in one’s own safety and that of others, total irresponsibility, lack of remorse after harming other people, frequent problems with the law, the inability to create and manage interpersonal relationships. In the case of the psychopathic subject, we talk about superficial charm, grandiose sense of personal value, great intelligence, absence of signs of irrational thinking or nervousness, pathological egocentrism, inability to feel love or affection, need for stimulation, pathological use of lies and manipulation, lack of remorse and sense of guilt, insensitivity and lack of empathy and insight, poor behavioral control, lack of realistic goals, impulsiveness, irresponsibility, short romantic relationships, tendency towards criminality. It, therefore, appears clear that the psychopathic subject presents a wider range of symptoms and focuses on affection and the establishment of harmful relationships with others. Furthermore, while the actions of the antisocial subject are dictated by impulsiveness as an end in itself, in the case of the pure psychopath we find thoughts aimed at action, detailed and elaborate forms of planning, always aimed at one’s own gain, and the damage of others; they arise, however, from sudden impulses. Another aspect



characterizing psychopathy is the use and ability to simulate emotions: this shows how psychopaths are actually able to use forms of metacognition to achieve their goals; these subjects are completely devoid of empathy but are particularly capable of recognizing what others feel from an intellectual point of view. This makes them particularly good at manipulating people. From a sociological point of view, it has been observed that patients suffering from antisocial personality disorder come from disadvantaged families, and seem to live on the margins of society; psychopathic patients, on the other hand, appear well-integrated and belong to the upper-middle class. The former see crime as a way of survival, while the latter are employed and engage in crime for different purposes. Starting from the different socio-cultural origins, it has been observed that the education of the antisocial patient is significantly lower than that of the psychopath. Even the so-called “modus operandi” within society is profoundly different: the antisocial person appears in public as having little respect for his own safety and that of others and for the rules, as well as being very impulsive and not hiding his disrespectful behaviour, while the psychopath shows himself particularly sophisticated, he acts weighing every action and in a prudent and methodical manner in order to carry out his harmful plans. Finally, from the point of view of the crimes committed, it seems that antisocial patients have a long history of arrests for various crimes such as robberies or murders, while psychopaths have a shorter one, precisely due to their avoidance of acting in the open which leads to a rather late knowledge of the crimes committed by the judicial authorities [62–68] (Table 2).

Adhering instead to the basic model of the Perrotta-Marciano Questionnaire on the state of awareness of one's deviant and criminal behaviours (ADCB-Q-2) [19], it is necessary to refer to the structuring of the Perrotta Integrative Clinical Interviews-3 (PICI-3) [69]. (Table 3).

In particular, for PICI, the psychological disorders of childhood are:

1. **Disruptive mood dysregulation disorder:** It is a habitual, persistent and pervasive pattern, with onset between the ages of five and ten, characterized by systematic and persistent irritability which involves outbursts of anger, aggression, and frequent mood swings: serious explosions of anger; recurrent outbursts of anger, at least three episodes a week; violent physical and/or verbal reactions; physical and/or verbal reactions disproportionate in both duration and intensity; reactions of anger and/or violence incompatible with age; irritable mood for much of the day; negative feelings directed towards the family, friend and/or school environment; low tolerance to anxiety and/or frustration; intolerance towards any form of education contrary to the child's wishes and/or expectations.
2. **Maladaptive separation disorder:** It is a habitual, persistent, and pervasive pattern, with onset between two and four years, characterized by systematic and persistent difficulty in letting go of parents or one's caregiver, constant and excessive fear that something

Table 2: Correlation between behavioural disorders in childhood and developmental pathological risk, for DSM-5-TR.

Behavioural disorders in childhood	Evolutionary psychopathological risk
✓ Intermittent explosive disturbance	✓ Borderline personality disorder
✓ Conduct disorder	✓ Behavioural dependence on alcohol and drugs
✓ Oppositional-provocative disorder	✓ Narcissistic personality disorder
✓ Attention deficit hyperactivity disorder	✓ Histrionic personality disorder
✓ Reactive attachment disorder	✓ Antisocial personality disorder
✓ Attachment disorder interrupted	✓ Psychopathy

Table 3: Correlation between behavioural disorders in childhood and developmental pathological risk, for PICI-3.

Behavioural disorders in childhood	Evolutionary psychopathological risk
✓ Disruptive mood dysregulation disorder	✓ Bipolar disorder
✓ Maladaptive separation disorder	✓ Manic disorder
✓ Oppositional defiant disorder	✓ Depressive disorder
✓ Explosive-intermittent disorder	✓ Borderline disorder
✓ Uninhibited social engagement disorder	✓ Histrionic disorder
✓ Attachment disorder (inhibited/disinhibited type)	✓ Narcissistic disorder (overt/covert type)
✓ Selfish disorder	✓ Antisocial disorder
✓ Libidinal disorder	✓ Sadistic/masochistic disorder
✓ Psychopathic disorder	✓ Psychopathic disorder
	✓ Psychotic symptoms (delusions, hallucinations, paranoia, dissociations)

tragic could happen to them and systematic rejection to move away from home or remain alone at home: difficulty in letting go of parents and/or one's caregiver; outbursts of anger; violent physical and/or verbal reactions; physical and/or verbal reactions disproportionate in both duration and intensity; constant and/or excessive fear that something tragic could happen to the parents or caregiver; easily irritable, anxious and/or depressed mood (with notes of apathy, restlessness and strong melancholy) in the presence of a separating circumstance; negative feelings directed towards the separating event; low tolerance to anxiety and/or frustration; systematic refusal to leave home and/or remain alone at home.

3. **Oppositional-defiant disorder:** It is a habitual, persistent, and pervasive pattern, with onset between the ages of five and ten, characterized by systematic and persistent difficulty in regulating and controlling one's emotions and behaviours: choleric and/or easily irritable mood; outbursts of anger; violent physical and/or verbal reactions; physical and/or verbal reactions disproportionate in both duration and intensity; oppositional behaviours; vengeful behaviour; negative feelings directed towards those who exercise authority; low tolerance to anxiety and/or frustration; traits of hyperactivity.
4. **Explosive-intermittent disorder:** It is a habitual, persistent, and pervasive pattern, with onset between the ages of four and eight, characterized by systematic and persistent difficulty in managing anger and anger:



choleric and/or easily irritable mood; outbursts of anger; violent physical and/or verbal reactions; physical and/or verbal reactions disproportionate in both duration and intensity; behaviours in reaction to events wrongly perceived as harmful to one's sphere; poor management of anger and/or anger, even in completely harmless events; negative feelings directed towards third parties; low tolerance to anxiety and/or frustration; poor ability to resist aggressive and/or violent impulses.

5. **Uninhibited social engagement disorder:** It is a habitual, persistent, and pervasive pattern, with onset between the ages of five and ten, characterized by the systematic and persistent manifestation of excessively physical and uninhibited behaviour towards third parties: unstable mood; uninhibited verbal behaviour with people outside the family unit; uninhibited physical behaviour with people outside the family unit; direct and excessively friendly approach with people not belonging to the family unit; seeking attention with strangers or strangers; constant need for physical contact with people not belonging to the family unit; excessively trusting feelings towards third parties (not previously known); low tolerance to anxiety and/or frustration regarding the search for contact and attention; absence of reticence or hesitation in leaving the safe place with unknown people.
6. **Attachment disorder:** It is a habitual, persistent, and pervasive model, with onset between two and five years, which refers to the disturbed and/or inadequate social relational modality that characterizes the child to his level of psycho-social development, both due to a distortion of the secure base, either due to a total or partial absence of attachment. Two main clinical forms are known: "inhibited type": difficulty in establishing interpersonal relationships; dysfunctional adaptation to common life circumstances; excessive inhibition; excessive hypervigilance; contradictory attitude towards those who take care of him; little social involvement; difficulties in affective regulation; low tolerance to anxiety and/or frustration; inexplicable fear and/or outbursts of anger. "uninhibited type": ease in engaging in interpersonal relationships; independent and all too functional adaptation to the circumstances of common life; excessive disinhibition; excessive hypovigilance; seeking detachment and excessive separation from those who care for him; excessive social involvement and/or excessive sociability; affective hyperregulation; low tolerance to anxiety and/or frustration with loneliness; absence of shyness towards the stranger with whom he has contact.
7. **Selfish disorder:** It is a habitual, persistent, and pervasive pattern, with onset between the ages of five and ten, characterized by marked selfishness, emotional instability, and sudden mood swings: emotional instability; sudden mood swings; marked selfishness and/or empathy deficit; desperate efforts

to avoid estrangement and/or abandonment (real and/or imaginary); excessive need for attention to the detriment of other people; theatricality and/or drama; active and/or passive-aggressive manipulation; sudden anger and unjustified aggression, with use of physical, verbal and/or psychological violence, with or without aggression; failure to comply with the rules and civil norms of coexistence.

8. **Libidinal disorder:** It is a habitual, persistent, and pervasive pattern, with onset around three-four years of age, characterized by an inability to control the libidinal impulse and one's unconscious energies: selfish tendencies and/or empathy deficit; manipulation of people and circumstances for personal gain, to the detriment of other people; marked sense of possession and ownership over people and/or objects; lacking or absent feeling of sharing; high emotional sensitivity; impatience and/or manic or hypomanic behavior; unconscious abuse of primitive defense mechanisms; low tolerance to anxiety and/or frustration; total or partial inability to resist impulses and desires, to be realized immediately.
9. **Psychopathic disorder:** It is a habitual, persistent, and pervasive pattern, with onset around the age of five, characterized by destructive and/or self-destructive tendencies, high emotional sensitivity and psychotic symptoms: destructive and self-destructive tendencies; high emotional sensitivity with a tendency towards active and/or passive manipulation and deception; seeking attention, to the detriment of third parties; aggressive, violent and/or in violation of social and/or behavioural norms, more or less manifest actions and/or attitudes; lack or absence of sensitivity, marked selfishness and/or empathy deficit; absence or lack of remorse, sense of guilt and/or sense of shame; egocentrism; excessive use of primitive defence mechanisms; psychotic symptoms.

Again for the PICI, the psychopathological personality disorders of adolescents and adults are as follows[Tab. 3]:

1. **Bipolar personality disorder:** It is a habitual, stable, persistent, and pervasive pattern, with onset between the ages of five and ten but structurally evolves in adolescence, characterized by sudden fluctuations in mood, manic and/or depressive states, and/or sudden alternation and emotional instability: sudden mood fluctuations; emotional instability; relational and/or social instability; manic, depressive and/or mixed episodes; tendency towards active and/or passive manipulation; low tolerance to frustration and anxiety; tendency towards irritability; low tolerance for criticism; tendency towards dysphoric mood (with or without unpleasant feelings, frustration, pessimism, tension, irritability, anxiety, and psychomotor agitation).
2. **Emotional-behavioural personality disorder:** It is a habitual, stable, persistent, and pervasive pattern, with onset around the age of five but evolving structurally



in adolescence, characterized by the systematic and persistent violation of social norms and civil community (not necessarily in violation of the law), negative consequences resulting from behaviours and dysfunctional management of one's basic emotions; systematic and persistent violation of social norms and/or civil community; negative consequences resulting from behaviours; dysfunctional management of one's basic emotions; low tolerance to anxiety and/or frustration; episodes of explosive and/or uncontrolled or in any case, unjustified anger regarding the event, then compensated with a sense of guilt, shame or remorse; impulsiveness and/or tendency towards active manipulation; recklessness and/or excessive instinctiveness; verbal and/or physical aggression to objects, people and/or animals; violation of rules and/or regulatory provisions relevant to national law. The symptoms suffered do not have to meet the requirements of antisocial personality disorder.

3. **Depressive personality disorder:** It is a habitual, stable, persistent and pervasive pattern, with onset around the age of six but structurally evolves in adolescence and adulthood, characterized by depressed mood, low self-esteem and a marked decrease in interests and pleasures: depressed mood; low self-esteem and/or tendency towards passive manipulation; marked decrease in pleasure in carrying out interests and activities and/or tendency towards boredom; significant weight gain or decrease; agitation and/or psychomotor slowing; lack of energy and/or easy tiredness; feelings of self-worth, inappropriateness and/or marked guilt; reduced ability to concentrate on activities; recurrent negative or melancholic thoughts and/or related to the theme of death, not caused by real events (for example, mourning).
4. **Borderline personality disorder:** It is a habitual, stable, persistent, and pervasive pattern, with onset around the age of eight but it evolves structurally in adolescence and adulthood characterized by emotional instability, sudden mood swings, and impulsiveness: emotional instability and/or impulsiveness in relationships interpersonal; sudden mood swings; active and/or passive manipulative tendency; desperate efforts to avoid abandonment (real and/or imaginary); dysfunctional and/or unstable self-image; marked impulsiveness capable of harming them; persistent feelings of emptiness; sudden anger and unjustified aggression; irrational thoughts and beliefs, resulting in whole or in part in the psychotic sphere.
5. **Histrionic personality disorder:** It is a habitual, stable, persistent, and pervasive model, with onset around the age of eight but it evolves structurally in adolescence and adulthood characterized by an immense need for attention, fear of abandonment (real or presumed), theatricality, and drama. of actions: the immense need for attention; discomfort when they are not the

centre of attention; real and/or presumed fear of abandonment; theatricality and drama of their Self; high suggestibility; vague and/or impressionistic language; changing personal and/or relational instability; constant use of physical appearance to attract attention, including through more or less explicit sexual conduct; manipulative, provocative and/or seductive expressive mode.

6. **Narcissistic personality disorder:** It is a habitual, stable, persistent, and pervasive model, with onset around the age of four but it evolves structurally in adolescence and adulthood characterized in the "overt" form by poor empathy, ideas of grandiosity, and excessive self-esteem, while it is characterized by low self-esteem, intolerance to criticism and judgement, complaints and passive-aggressive behaviour in the "covert" form. "Overt": poor or absent empathy; wholly or partially unfounded beliefs that you are unique and special and/or ideas of grandeur; excessive self-esteem and/or arrogance; irrational beliefs of being envied by others for his position and/or for his intrinsic human, personal and/or moral qualities; worries related to fantasies of success and/or perfection; need for admiration; the irrational belief that he deserves what he desires and/or dreams and/or aspires to; manipulative exploitation of people and/or circumstances for one's gain, using or not using guilt, shame, personal relationships, professional activity and/or sex; use of physical, verbal and/or psychological violence, with or without aggression. "Covert": low self-esteem, aimed at attracting attention; low tolerance for criticism and/or judgment; use of complaints and/or complaints to get attention; passive-aggressive conduct; exaggerated undervaluation; irrational fixations and/or beliefs; striking somatic and/or hysterical symptoms; lack of empathy and/or little or no sensitivity towards the needs of others; excessive need for control.
7. **Antisocial personality disorder:** It is a habitual, stable, persistent, and pervasive model, with onset around the age of eight but it evolves structurally in adolescence and adulthood characterized by lack of empathy, lack of remorse, lack of respect for rules and social roles: narcissistic tendencies; lack of empathy; lack of remorse, guilt and/or shame; lack of respect for rules and social roles; marked tendency to commit crime and/or active manipulation, even without a criminal record or judicial problems; tendency towards aggression and/or provocation; low tolerance to frustration and/or anxiety; prevalence of negative feelings; tendency towards impulsiveness and/or irresponsibility.
8. **Sadistic personality disorder:** It is a habitual, stable, persistent, and pervasive model, with onset around the age of eight but it evolves structurally in adolescence and adulthood characterized by taking pleasure in the suffering of others (outside the sexual sphere), manipulation of people and/or o situations for personal



advantages (to the detriment of other people) and prevalence of negative feelings: enjoyment from the suffering of others, outside the sexual sphere; manipulation of people and circumstances for personal gain, to the detriment of other people; the prevalence of negative feelings; discomfort in the presence of pleasant events and positive feelings; the need to suffer, humiliate and inflict pain, to gain pleasure from it; the pathogenic belief that one has the right to make others suffer; unconscious abuse of primitive defence mechanisms; narcissistic tendencies; emotional and/or situational reversal of pleasure/pain.

9. **Masochistic (or self-destructive) personality disorder:** It is a habitual, stable, persistent and pervasive pattern, with onset around the age of eight but it evolves structurally in adolescence and adulthood characterized by self-destructive tendencies, submission, and high emotional sensitivity: self-destructive tendencies; submission and/or desires to be dominated (outside the sexual context); high emotional sensitivity with a tendency towards passive manipulation; unconscious search for people and/or situations that can cause disappointment and/or failure and/or live in situations of discomfort and/or mistreatment; refusal to receive help and/or concrete support; response to positive events with depression and guilt; discomfort in the presence of pleasant and/or playful situations; inability to stay focused on assigned tasks; withdrawal from any form of positive attention from others.
10. **Psychopathic personality disorder:** It is a habitual, stable, persistent, and pervasive pattern, with onset around the age of eight but it evolves structurally in adolescence and adulthood characterized by antisocial behaviour and narcissistic tendencies, manipulation, deficits in empathy, remorse, and a sense of guilt: more or less manifest antisocial behaviour; deficit or absence of empathy; absence of remorse, guilt and/or sense of shame; egocentrism and/or strong propensity to impress the interlocutor; use of deception and/or manipulation to obtain personal benefits and advantages; impulsiveness and/or poor sense of judgment; irresponsibility and/or unreliability; narcissistic tendencies; poor or absent awareness of one's condition and/or emotions.
11. **Psychotic symptoms (paranoia, delusions, hallucinations, dissociations):** Clearly, the factors at play are diverse, ranging from intrasubjective ones related to family and health context to ultra-subjective ones related to the socio-environmental context, so it is not possible to state with certainty that the diagnosis of a certain disorder (e.g., conduct disorder) in childhood and preadolescence necessarily evolves into a borderline or antisocial disorder in adulthood; certainly, health intervention (with prevention, correction and rehabilitation actions) to modify certain deviant and/or antisocial behaviors already at a young age can reduce

this risk, net of family and social contexts that foster and reinforce deviance and criminality because they are themselves “toxic” feeders of these mechanisms.

Intervention therapies regarding the psychopathological evolution of behavioural disorders in childhood

Prevention strategies are the first tool to identify and correct certain deviant behaviours before they can take root and become markedly structural, to the point of evolving into anti-sociality (or criminality). In this sense, the literature consistently underlines that the best way to stem the phenomenon of deviance is through primary prevention projects that can support families in the education of their children, mapping the areas where such phenomena are more frequent and carrying out prosocial education interventions, involving the entire territory (schools, families and meeting points).

The first major “Communities That Care” (CTC) program was created by the American Department of Justice to reduce drug consumption, which is often linked to the evolution from deviant behaviour to criminal behaviour. This program involves the involvement of the mass media in making a population active through volunteering, to stem drug consumption. This intervention aims on the one hand to strengthen protected factors such as family, school, and community ties; on the other hand, to reduce negative peer pressure for drug use. Over time it was understood that this program was in a broader sense useful for the recovery of young deviants this program was also introduced in Europe with positive results.

In Italy, the Istituto Superiore di Sanità (ISS) has developed guidelines for the strengthening of psychophysical health in school age (primary and secondary schools for the 6-14 age groups), also to stem the phenomena of deviance such as bullying. These guidelines aim to improve: the school environment, enhance community discussion on issues relating to psychophysical health, develop participation and responsible behaviour, and train operators toward the culture of health. It specifically describes the Life Skills that encourage the adoption of positive behaviours such as the ability to make decisions, problem-solving, creativity, effective communication, etc. Furthermore, guidelines are provided for strengthening stress management, conscious use of the media, prevention of bullying, sexual education, etc.

Among the tools widely used in this direction is Peer Education. A systemic review of scholastic Peer Education has confirmed in many cases its validity and ability to develop well-being, curbing the phenomena of juvenile delinquency. This type of strategy has also been applied in other contexts, not always satisfactorily. Although the effectiveness of these programs has often been demonstrated, these types of projects are very expensive and are poorly supported by governments. In our opinion, this is a waste of resources given that the social cost of deviance is much higher than the profit that this type of project brings.



As regards secondary prevention interventions, these are implemented when the minor shows the first deviant behaviours, and an attempt is made through various interventions to stem the phenomenon by preventing its evolution. In the literature, the most frequent interventions are individual and group psychotherapy and support for families and within the school environment, even within a clinical-pharmacological framework if necessary and prescribed by specialist medical personnel and specific behavioural analysis therapies.

Another form of intervention is family-type communities for minors, where minors are hosted who may find themselves in situations of social risk or because they have already had relationships with Juvenile Justice. This type of intervention is based on the hypothesis that removing the minor from negative contexts can increase the minor's chances of recovery. Another type of intervention is "street education": these projects are concentrated in the outskirts of large urban areas, to intercept all deviant minors in the area, allowing them to learn about the services that can support them towards the path of legality [70–80].

Finally, tertiary prevention is aimed at all minors who have come into contact with justice due to their criminal behaviour.

Conclusion

The scientific literature on the subject of "Behavior and Conduct Disorder in Childhood" is clear and compact in defining them as a pathological expression of dysfunctional care and education received in the first years of life, which impacts the relational, behavioural, and emotional quality of the child. infant during the first stages of maturational development of its evolution; the literature always agrees in maintaining that other factors also facilitate the development of these pathological conditions, such as the negative influence of the family and social context, psychophysical childhood traumas, and genetic predispositions. This descriptive framework is at the basis of the onset in preadolescence (10–13 years) and adolescence (14–18 years) of those psychopathological forms that could evolve into real personality mood disorders. These factors, partly predictive and partly facilitating, cannot condemn a subject to mental illness, but rather it is the product of them, with adequate reinforcements over the years. Early educational intervention, prevention in all its forms and the use of therapeutic corrective tools can encourage expected and expected behavioural improvement, especially in subjects who are still not adults and with a family and social environment that responds to corrective stimuli hoped for, and to disfavour the toxic and dysfunctional dynamics determined by a behavioural reinforcement of deviant and antisocial conduct, which are at the basis of the "criminal spectrum".

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