Decades of research have shown that youths with disruptive behavior disorders (DBD) are a heterogeneous population. Over the past 20 years, researchers have distinguished youths with DBD as those displaying high (DBD/HCU) versus low (DBD/LCU) callous-unemotional (CU) traits. These traits include flat affect and reduced empathy and remorse, and are associated with more severe, varied, and persistent patterns of antisocial behavior and aggression. Conduct problems in youths with HCU and LCU are thought to reflect distinct causal vulnerabilities, with antisocial behavior in youths with DBD/HCU reflecting a predominantly genetic etiology, while antisocial behavior in youths with DBD/LCU is associated primarily with environmental influences. Here we selectively review recent functional (fMRI) and structural (sMRI) magnetic resonance imaging research on DBD, focusing particularly on the role of CU traits. First, fMRI studies examining the neural correlates of affective stimuli, emotional face processing, empathy, theory of mind, morality, and decision-making in DBD are discussed. This is followed by a review of the studies investigating brain structure and structural connectivity in DBD. Next, we highlight the need to further investigate females and the role of sex differences in this population. We conclude the review by identifying potential clinical implications of this research.

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Key words: Antisocial behavior, callous-unemotional traits, conduct disorder, conduct problems, disruptive behavior disorders, sex differences, fMRI, voxel-based morphometry, surface-based morphometry, diffusion tensor imaging.
behavioral, experimental, and neuroimaging studies have shown that youths with DBD/HCU and those with DBD/LCU are characterized by different vulnerabilities.9 This resulted in the recent inclusion of CU traits as the “with Limited Prosocial Emotions” specifier for the diagnosis of conduct disorder in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Twin studies indicate that conduct problems in youths with DBD/HCU are highly heritable, while conduct problems in youths with DBD/LCU are moderately heritable, but largely influenced by environmental factors.10 Unlike youths with DBD/LCU, youths with DBD/HCU display behaviors akin to adults with psychopathy, notably committing violent crimes at a younger age and displaying a more severe and varied pattern of conduct problems, including instrumental aggression and sadistic acts of violence.6,11 Youths with DBD/HCU have a preference for novel and dangerous activities, present with a lack of emotional responsiveness to negative emotional stimuli, are impaired at processing others’ fearful and sad facial expressions and vocal tones, and are relatively insensitive to punishment,8 all of which are consistent with a low fearfulness temperament style.5 By contrast, youths with DBD/LCU are typically less aggressive, mostly displaying threat-based reactive aggression.9 This most likely reflects a hostile attributional bias in response to real or perceived social threat, such as angry faces or ambiguous neutral faces.12 Finally, youths with DBD/LCU have problems regulating their emotions, and display a low frustration tolerance and high levels of anger, impulsivity, and emotional distress.6,11 They are also more responsive and empathic to the distress of others12 and to negative stimuli.3,11

In addition to distinguishing among subtypes of youths with DBD, there is a growing need to explore the influence of sex, particularly in the context of neuroimaging research.14 Male and female adolescents with DBD may express antisocial behavior in different ways, and show structural differences in the brain and different abnormalities in brain function. However, very little neuroimaging research has investigated females with DBD or directly compared males and females with DBD. While 13.8% of male adolescents present with conduct disorder, only 6.7% of female adolescents show DBD. While 13.8% of male adolescents present with DBD or directly compared males and females with DBD, there is a growing need to explore the influence of sex, particularly in the context of neuroimaging research.14 Male and female adolescents with DBD may express antisocial behavior in different ways, and show structural differences in the brain and different abnormalities in brain function. However, very little neuroimaging research has investigated females with DBD or directly compared males and females with DBD. While 13.8% of male adolescents present with conduct disorder, only 6.7% of female adolescents show the same presentation.15 Further, males aged 10–17 years are more likely to have been contacted by the police and convicted for a criminal offence than females.16 Similarly, the age of onset of antisocial behavior is different between the sexes; while more males are diagnosed with conduct disorder aged 10, with a downward trend after this age, the rate of conduct disorder in females peaks at 16 years.15 One possible reason behind these skewed diagnosis rates could be that the DSM-5 criteria for conduct disorder show a bias towards behaviors more often exhibited by males.14 While males are more likely to show overt behaviors, such as vandalism and aggressive stealing, females are more likely to show covert behaviors, such as lying and sabotaging relationships.17 With the aim of extending research on females with DBD, the FemNAT-CD consortium (http://www.femnat-ed.eu) – a large multisite European study, of which our group is a part – will assess the environmental and neurobiological factors that might underpin sex differences in conduct disorder. For the purposes of this review, the few published neuroimaging studies that have examined females with DBD and considered the influence of sex differences in DBD will be discussed.

In this article, we selectively review recent functional (fMRI) and structural (sMRI) magnetic resonance imaging research on DBD, focusing particularly on the role of CU traits. First, fMRI studies examining the neural correlates of affective stimuli, emotional face processing, empathy, theory of mind, morality, and decision-making in DBD will be discussed (see Table 1). This is followed by a review of the studies investigating brain structure and structural connectivity in DBD (see Table 2). Next, recent studies investigating female samples and the role of sex differences are discussed. We conclude the review by identifying potential clinical implications of this research.

Functional Magnetic Resonance Imaging Evidence

Affective stimuli and emotional face processing

Several fMRI studies have examined the neural correlates of negative affective stimuli (e.g., IAPS stimuli18) and face processing in DBD, and have identified an atypical response in this population within a set of cortical and subcortical regions including, among others, the orbitofrontal cortex (OFC), ventromedial prefrontal cortex (VMPFC), anterior cingulate cortex (ACC), insula, temporal lobe, and the amygdala.19,20 However, studies that do not take into account individual differences in CU traits have produced a mixed account of the reported amygdala response, with evidence of both amygdala hypo- and hyper-reactivity to negative affective stimuli.21,25 Given evidence indicating that youths with DBD/HCU and DBD/LCU are characterized by distinct emotional, cognitive, and behavioral responses to affective stimuli and faces,8,11 these inconsistent findings may partly result from variations in CU traits across samples.23 Compared to typically developing (TD) youths, youths with DBD/LCU have consistently been found to exhibit hyperactivity in the amygdala when processing both fearful faces23 and fearful eyes.24 These results might partly explain why youths with DBD/LCU have a propensity toward emotion regulation difficulties.
and reactive aggression when they feel threatened.\(^5\) By contrast, fMRI studies that have assessed CU traits have consistently shown that youths with DBD/HCU exhibit amygdala hypoactivity during the processing of conscious\(^25,26\) (but see Refs. \(^27,28\)) and unconscious fearful faces.\(^23\) These findings have been recently extended by White \textit{et al.}\(^29\) who showed that an atypical amygdala response to consciously processed fearful faces in youths with DBD/HCU is not secondary to an attentional deficit (ie, increased top-down control) but is specifically related to the CU component of psychopathic traits. These findings and others\(^30\) are inconsistent with the response modulation hypothesis, which posits that emotional deficits seen in psychopathy stem from a core deficit in selective attention that limits the processing of peripheral information.\(^31\) In sum, amygdala hypoactivity could partly explain the high propensity for proactive aggression seen in youths with DBD/HCU.\(^8\) In support of this view, a recent study showed that amygdala response to fearful faces in youths with DBD mediated the association between CU traits and proactive aggression.\(^32\)

**Empathy, theory of mind, and morality**

Empathy deficits in relation to DBD have been extensively documented,\(^3\) with recent fMRI studies examining differences in neural response to perceived pain in others. The experience and observation of perceiving others in pain elicits activation in a network of regions, including the ACC, anterior insula, amygdala, and striatum, which mediate the affective perception of pain, as well as the somatosensory cortex, supplementary motor cortex, and periaqueductal gray, which mediate the perceived somatosensory sensation of pain.\(^33\) Surprisingly, Decety \textit{et al.}\(^34\) found that when viewing others in pain, youths with DBD had an increased neural response in regions including the anterior insula, anterior mid-cingulate, dorsal striatum, and amygdala compared to TD youths. This pattern of results was interpreted as reflecting enjoyment in the DBD youths when seeing someone else in pain. However, because CU traits were not measured by Decety \textit{et al.}, it is also possible that the youths with DBD were characterized by low levels of CU traits and associated high emotional reactivity, which could have led to the observed increase in neural response. This hypothesis is supported by two recent studies that include a measure of CU traits.\(^35,36\) Youths with DBD, as compared to TD youths, showed reduced activation to the perceived pain in others in the ACC, anterior insula, and inferior frontal gyrus.\(^36\) Crucially, within the DBD group, unique variance associated with callous traits was negatively correlated with the response in the ACC and anterior insula. Consistent with these results, Marsh \textit{et al.}\(^32\) found that those with DBD/HCU, compared to TD youths, showed reduced response in the ACC and ventral striatum to perceived pain in others. These youths also showed reduced activity in the amygdala and insula in response to others’ pain, but not when imagining that the pain was their own. Importantly, the affective and interpersonal features of measured psychopathy were negatively related to the induced brain response to perceiving pain in others in the amygdala and ACC. Finally, using a more complex affective-processing task including cartoon vignettes, Sebastian \textit{et al.}\(^37\) found that cartoons requiring understanding of distress in others within the context of social situations produced reduced amygdala and anterior insula activity in youths with DBD relative to TD youths. This reduced activation was negatively correlated with the unique variance associated with CU traits. Using the same task, O’Nions \textit{et al.}\(^38\) found that cartoon scenarios that require the interpretation of others’ intentions did not induce a significantly different brain response in youths with DBD/HCU compared to TD youths. These results dovetail with behavioral and experimental data,\(^13\) and highlight the fact that youths with DBD/HCU do not have a deficit in understanding the mental states of others, as has been shown for children with autism spectrum disorder.\(^13,38\) Rather, they show reduced empathic responses to others’ distress cues.\(^13\)

The immoral judgment seen in youths with DBD/HCU may result from impairments in emotional empathy and decision-making (see decision-making section below)—deficits thought to reflect dysfunctions within the amygdala—VMPFC circuitry and striatum.\(^8\) Consistent with this view, a recent study found that compared to TD youths, those with DBD/HCU exhibited reduced amygdala response and reduced amygdala—OFC connectivity during moral judgments about legal actions.\(^39\)

Taken together, these results provide emerging evidence of neural vulnerabilities that might hamper successful socialization of youths with DBD/HCU, putting them at increased risk of displaying severe antisocial behavior and proactive aggression without feeling guilt or empathy for their victims.

**Decision-making**

Poor and rash decision-making is another central feature of DBD.\(^40\) A large body of experimental data has identified an association between DBD, CU traits, and impairments in decision-making.\(^8,39\) Neural correlates of these associations have recently been explored within the context of functional neuroimaging studies. For example, compared to TD youths and youths with ADHD, youths with DBD showed a reduced neural response in the OFC during rewarded responses.\(^41\) In another study, when deciding between a low-risk/low-reward or high-
risk/high-reward option, youths with DBD and substance use disorders displayed a reduced neural response in a number of regions, including the OFC, ACC, basal ganglia, insula, and amygdala, compared to TD youths. In response to wins, DBD youths also had a lower response in the ACC, among other regions, compared to TD youths, but a higher response to losses in the OFC, among other regions. However, as these studies did not take the influence of CU traits into account, it is unclear how these atypical responses relate to DBD and/or CU traits. Studies using standard learning (ie, passive avoidance learning) and reversal learning paradigms have also shown that, compared to TD youths and youths with ADHD, youths with DBD/HCU exhibit atypical responses to reward and punishment within the OFC/VMPFC and caudate. According to a recent study by White et al, these functional differences reflect compromised representations of reinforcement expectancies (ie, the expected value associated with a stimulus/action) within the VMPFC and aberrant prediction error signaling within the caudate (ie, the signal representing the difference between the level of reward/punishment received and the level expected, enabling reinforcement expectancies to be updated). These results are supported by a follow-up study that revealed that during a decision-making task with environmental (eg, threatening images) rather than monetary reinforcers, DBD youths showed reduced modulation of expected value information used to guide decision-making within bilateral caudate regions compared to TD youths (but see also Ref. ). Given the lack of association between CU traits and expected value signals in the caudate in these two studies by White et al, one interpretation is that caudate dysfunction may represent a shared impairment in DBD that is not influenced by levels of CU traits. These results fit with behavioral studies that have shown that youths with DBD, irrespective of level of CU traits, display altered decision-making under risk and altered temporal discounting of future rewards. Taken together, these results provide a potentially important account of why youths with DBD, including those with HCU, persistently engage in antisocial, aggressive, and risk-taking behaviors despite the resulting adverse consequences, such as exclusion from schools and imprisonment.

Structural Magnetic Resonance Imaging Evidence

Atypical neural responses in youths with DBD might be partly underpinned by differences in brain structure and/or connectivity. In this section, we first review sMRI studies on youths with DBD who were not subdivided using measures of CU traits. This is followed by a review of the small number of studies that have used sMRI data to examine the correlates of CU traits using group comparisons and/or parametric analyses.

sMRI studies on youths with DBD commonly report atypical brain structure in regions central to emotion processing and regulation, empathy, morality, and decision-making. The majority of these studies used whole-brain and automated imaging analysis methods, such as voxel-based morphometry (VBM) to examine gray matter volume (GMV) and surface-based morphometry (SBM) to measure cortical thickness and folding. VBM studies consistently observed reduced GMV in fronto-temporal regions, such as the OFC, insula, and amygdala, with two studies reporting an overall reduction in GMV in youths with DBD (13% ;6% ). Negative correlations were also reported between the volume of the anterior insula and lifetime CD symptoms and aggressive behavior. Studies using SBM have also shown that youths with DBD have thinner cortex or folding irregularities in areas of reduced GM, namely the OFC, insula, and ACC. Cortical thinning in more posterior regions, such as the superior temporal cortex and precuneus, was also detected, as well as reduced volume of the striatum and the amygdala. By contrast, studies using diffusion tensor imaging (DTI) to examine the integrity of white matter tracts have thus far yielded inconsistent results, notably for the uncinate fasciculus, which connects the OFC to the amygdala. While no microstructural differences in this fiber tract have been reported between youths with DBD and TD youths, others do report increased fractional anisotropy (FA). Interestingly, reduced FA in the arcuate fasciculus and increased FA in the corpus callosum in youths with DBD compared to TD youths has also been found. These mixed findings may partly reflect variation in methods of analysis (tract-based spatial statistics [TBSS] vs tractography), different age ranges, and, for some studies, a failure to account for levels of CU traits in the sample.

To date, only three sMRI studies (two using VBM) have compared youths with DBD/HCU traits to TD youths. One study showed that a subclinical sample of boys with DBD/HCU traits compared to TD youths presented with increased GM concentration in the medial orbitofrontal and rostral/dorsal anterior cingulate cortices and bilateral temporal lobes—regions that are implicated in decision-making, morality, and empathy. Given evidence of reduction in GM with increasing age in typical development, these results were interpreted as reflecting delayed cortical maturation in the DBD/HCU sample. A follow-up study by De Brito et al using the same sample supports this claim, with decreased white matter concentration observed in boys with DBD/HCU compared to TD youths in frontal, ACC, and temporal regions, consistent with the previous study by De Brito et al. Follow-up analyses on twins revealed
<table>
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<tr>
<th>Study</th>
<th>Nature of sample</th>
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<th>fMRI paradigm</th>
<th>Measure of CU traits</th>
<th>Main Results*</th>
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</thead>
<tbody>
<tr>
<td>Sterzer et al. (2005)²²</td>
<td>Clinical</td>
<td>27 males: 13 CD (8 comorbid for ADHD); 14 TD controls, aged 9–15 years (M: 12.7)</td>
<td>Passive viewing of emotional stimuli</td>
<td>None</td>
<td>CD &gt; Controls: Deactivation within right anterior cingulate cortex and left amygdala in response to negative pictures (after controlling for anxiety and depression symptoms).</td>
</tr>
<tr>
<td>Stadler et al. (2007)²⁷</td>
<td>Community</td>
<td>27 males: 13 CD; 14 TD controls aged 9–14 years (M: 12.8)</td>
<td>Passive viewing of emotional stimuli</td>
<td>None</td>
<td>CD &gt; Controls: reduced activation in the right ACC in response to negative affective pictures.</td>
</tr>
<tr>
<td>Herpertz et al. (2008)²¹</td>
<td>Clinical</td>
<td>44 males: 22 CD/childhood-onset (16 comorbid for ADHD); 22 TD controls, aged 12–17 years (M: 14.7)</td>
<td>Passive viewing of emotional stimuli</td>
<td>None</td>
<td>CD (childhood-onset) &gt; Controls: Increased left amygdala activation to negative relative to neutral pictures.</td>
</tr>
<tr>
<td>Marsh et al. (2008)²⁵</td>
<td>Community</td>
<td>36 children/adolescents: 12 CD/ODD/HCU (7 male); 12 ADHD (8 male); 12 TD controls (6 male), aged 10–17 years (M: 14.2)</td>
<td>Implicit processing of emotional facial expressions</td>
<td>YPI, APSD &amp; PCL-YV</td>
<td>CD/ODD/HCU &lt; ADHD/Controls: Reduced amygdala activation while processing fearful faces. CU trait severity negatively correlated with connectivity between the amygdala and VMPFC.</td>
</tr>
<tr>
<td>Finger et al. (2008)⁴³</td>
<td>Community</td>
<td>42 adolescents: 14 CD/ODD (HCU) (9 male); 14 ADHD (10 male); 14 TD controls (9 male), aged 10–17 years (M: 13.6)</td>
<td>Probabilistic response reversal learning task</td>
<td>YPI, APSD &amp; PCL-YV</td>
<td>CD/ODD/HCU &gt; ADHD/Controls: Increased activity in bilateral medial frontal gyrus during punished reversal error learning. Increased caudate activity (decreased for controls) during punished reversal errors. Multiple regression analyses indicate that CU traits predicted variability in VMPFC response.</td>
</tr>
<tr>
<td>Rubia et al. (2009)⁴¹</td>
<td>Community</td>
<td>48 males: 14 CD; 18 ADHD; 16 TD controls, aged 9–16 years (M: 13.10)</td>
<td>Rewarded Continuous Performance Test</td>
<td>None</td>
<td>CD &lt; ADHD &amp; Controls: Decreased activation in the right OFC</td>
</tr>
<tr>
<td>Decety et al. (2009)³⁴</td>
<td>Community</td>
<td>16 male/female adolescents: 8 CD/childhood-onset; 8 TD controls, aged 16–18 years</td>
<td>Empathy for pain task</td>
<td>None</td>
<td>CD &gt; Controls: increased activation in anterior midcingulate cortex, amygdala, caudate, and temporal pole bilaterally for painful situations caused by accidents vs. non-painful situations.</td>
</tr>
<tr>
<td>Jones et al. (2009)⁷⁶</td>
<td>Community</td>
<td>30 males: 17 CP/HCU traits; 13 TD controls (M age: 11.6)</td>
<td>Implicit processing of emotional facial expressions</td>
<td>APSD</td>
<td>CP/HCU &lt; Controls: reduced right amygdala activation to fearful faces.</td>
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<tr>
<td>Crowley et al. (2010)⁶²</td>
<td>Community</td>
<td>40 males: 20 youths in treatment for antisocial substance dependence; 20 TD controls aged 14–18 years (M: 16.5)</td>
<td>Risky decision making task</td>
<td>None</td>
<td>ASD &lt; Controls: reduced activity during decision-making in OFC, DLPC, ACC, basal ganglia, insula, amygdala, hippocampus, and cerebellum. Reduced activity whilst experiencing wins in ACC, temporal regions, and cerebellum.</td>
</tr>
<tr>
<td>Marsh et al. (2011)³⁹</td>
<td>Community</td>
<td>28 adolescents: 14 CD/ODD/HCU (8 male); 14 TD controls (11 male), aged 10.9–16.9 years (M: 14)</td>
<td>Moral judgment implicit association task</td>
<td>YPI, APSD &amp; PCL-YV</td>
<td>CD/ODD/HCU &lt; Controls: reduced right amygdala activation when making judgments about legal actions. Significantly less functional connectivity between the amygdala and OFC, bilateral regions of temporal cortex and inferior parietal cortex during task performance.</td>
</tr>
<tr>
<td>Finger et al. (2011)⁴⁴</td>
<td>Community</td>
<td>30 adolescents: 15 CD/ODD/HCU (9 male); 15 TD controls (9 male) (M age: 13.7)</td>
<td>Passive avoidance learning task</td>
<td>APSD &amp; PCL-YV</td>
<td>CD/ODD/HCU &gt; ADHD/Controls: Increased activity in bilateral medial frontal gyrus during punished reversal error learning. Increased caudate activity during punished reversal errors. CU traits predicted variability in VMPFC response.</td>
</tr>
<tr>
<td>Viding et al. (2012)²³</td>
<td>Community</td>
<td>46 males: 15 CP/HCU, 15 CP/LCU, 16 TD controls, aged 10–16 years (M age: 14.2)</td>
<td>Backward masking of fearful faces</td>
<td>ICU</td>
<td>CP/HCU &lt; CP/LCU &amp; Controls: Reduced right amygdala activation during preattentive processing of masked fearful faces.</td>
</tr>
</tbody>
</table>
| Study                  | Nature of sample | Participants                                                                 | fMRI paradigm                              | Measure of CU traits                  | Main Results


Sebastian et al. (2012) | Community | 47 males: 31 CP; 16 TD controls, aged 10–16 years (M: 13.9) | Cognitive/affective theory of mind task     | ICU                                   | CP < Controls: reduced right amygdala activation for affective vs. cognitive theory of mind judgments. Unique variance on CD symptoms was positively associated with amygdala activity within the CP group, whilst unique variance associated with CU traits was negatively associated with amygdala activity.

White et al. (2012) | Community | 36 children/adolescents: 17 DBD/HCU (13 male); 19 TD controls (9 male), aged 10–17 years (M: 15.4) | Spatial attention task with emotional faces | APSD                                 | DBD/NUC < Controls: reduced activity within the dorsal endogenous orienting network (comprising of superior parietal lobule and inferior parietal sulcus) for fearful face congruent relative to incongruent trials. Significant negative correlation between amygdala activation to fearful faces and neutral faces and CU trait scores.

White et al. (2013) | Community | 38 children/adolescents: 20 DBD (17 male), 18 TD controls (10 male), aged 10–18 years (M: 15.1) | Passive avoidance task                      | APSD                                 | DBD > Controls: reduced sensitivity to expected value information in VMFC (when choosing objects) and anterior insular cortex (when refusing objects). Reduced modulation of activity by prediction error following reward in the caudate, but increased modulation following punishment.

Cohn et al. (2013) | Community | 76 adolescents: 25 DBD + CD/ODD (desistant) (20 male); 25 DBD + CD/ODD (persistent) (18 male); 26 TD controls (23 male) (M age: 17.5) (DBD onset mean age: 6.6) | Fear conditioning task                      | YPI                                 | DBD + CD/ODD (desistant & persistent) > Controls: increased activation within left anterior cingulate cortex, right insula and left amygdala. Unique variance on YPI CU traits was negatively associated with activation in the ACC whilst unique variance associated with the impulsive-irresponsible facets was positively correlated with activation in the amygdala, insula and ACC.

Lockwood et al. (2013) | Community | 55 males: 37 CP; 18 TD controls, aged 10–16 years (M: 13.9) | Empathy for pain task                       | ICU                                 | CP < Controls: reduced neural activation to other’s pain observed within bilateral anterior insula, ACC and inferior frontal gyrus. Unique variance on CU traits was negatively associated with response to pain in the anterior insula and ACC in the CP group.

Marsh et al. (2013) | Community | 35 adolescents: 14 ODD/CD/HCU (8 male); 21 TD controls (15 male), aged 10–17 years (M: 14.9) | Empathy for pain task                       | YPI, APSD & PCL-YV                   | CD/ODD/HCU < Controls: reduced activity in rostral ACC, putamen and amygdala. Activation observed in the amygdala and ACC negatively correlated with CU severity. |
<table>
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<tr>
<td>White et al. (2013)</td>
<td>Community</td>
<td>38 children/adolescents: 20 DBD (17 male); 18 TD controls (10 male), aged 10–18 years (M: 15.1)</td>
<td>Passive avoidance probabilistic reward task APSD</td>
<td>DBD &lt; Controls: reduced modulation of activity as a function of expected value of avoidance within ventromedial PFC, anterior insula and caudate regions of interest. Significantly reduced modulation of caudate activity as a function of prediction error related to punishment. No association between activity within these regions and CU trait severity.</td>
</tr>
<tr>
<td>Lozier et al. (2014)</td>
<td>Community</td>
<td>46 children/adolescents: 14 CP/HCU (7 male); 16 CP/LCU (9 males); 16 TD controls (10 males), aged 10–17 years (M: 13.8)</td>
<td>Implicit processing of emotional facial expressions ICU</td>
<td>No significant group differences within right amygdala in response to fearful expressions. Across CP/HCU &amp; CP/LCU groups, unique variance on CU traits was negatively associated with right amygdala response to fearful expressions, whilst unique variance on CP symptoms was positively correlated with amygdala response. Reduced amygdala activity mediated the association between CU traits and proactive aggression.</td>
</tr>
<tr>
<td>Fairchild et al. (2014)</td>
<td>Community</td>
<td>40 females: 20 CD, 20 TD controls, aged 14–20 years (M: 17.3)</td>
<td>Implicit processing of emotional facial expressions YPI &amp; ICU</td>
<td>CD &lt; Controls: Reduced medial OFC activation. CU traits negatively correlated with activation in the fusiform gyrus for sad vs. neutral faces. CD &gt; Controls. Increased anterior insula activation.</td>
</tr>
<tr>
<td>Sebastian et al. (2014)</td>
<td>Community</td>
<td>55 males: 17 CP/HCU, 17 CP/LCU, 17 TD controls, aged 10–16 years (M: 14.0)</td>
<td>Implicit processing of emotional facial expressions ICU</td>
<td>CPA/LCU &gt; Controls: Increased amygdala and ACC/OFC activation to fearful eyes. Correlation between RTs and amygdala activation to fearful eyes.</td>
</tr>
<tr>
<td>O’Nions et al. (2014)</td>
<td>Community</td>
<td>48 males: 16 CP/HCU, 16 ASD, 16 TD controls, aged 10–16 years (M: 13.9)</td>
<td>Cognitive theory of mind task ICU</td>
<td>CD/HCU = Controls: No difference in neural response between groups. Children with ASD exhibited atypical neural processing within the context of the task.</td>
</tr>
</tbody>
</table>


* CU traits in the Main Results refer to lack of empathy and guilt, and shallow affect. Individual authors may have used a different label, i.e. psychopathic traits, in their paper, but for ease of reading we have used CU traits consistently. The Measures of CU traits column lists the specific measure used.
<table>
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<tr>
<th>Study</th>
<th>Nature of sample</th>
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<th>Measures of CU-traits</th>
<th>Main Results</th>
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<tbody>
<tr>
<td>Sterzer et al. (2007)55</td>
<td>Clinical</td>
<td>24 males (12 CD/childhood-onset; 12 TD controls) aged 12 years (M: 12.6)</td>
<td>VBM</td>
<td>None</td>
<td>CD &lt; Controls: Significantly reduced grey matter in left amygdala and bilateral anterior insula. In the CD group, bilateral anterior insula grey matter volume correlated positively with empathy score.</td>
</tr>
<tr>
<td>Huebner et al. (2008)51</td>
<td>Clinical</td>
<td>46 males (23 CD/childhood-onset (17 co-morbid for ADHD); 23 TD controls) aged 12–17 years (M: 14.4)</td>
<td>VBM</td>
<td>None</td>
<td>CD &lt; Controls: 6% reduction in average grey matter volume. Significantly reduced grey matter volume in bilateral temporal cortex, left amygdala, left hippocampus, orbitofrontal &amp; ventromedial regions. CD symptom severity inversely correlated with grey matter volume within limbic structures.</td>
</tr>
<tr>
<td>De Brito et al. (2009)54</td>
<td>Community</td>
<td>48 males (23 CP/HCU traits; 25 TD controls) aged 10–13.3 years (M: 11.7)</td>
<td>VBM</td>
<td>APSD</td>
<td>CP &gt; Controls: Boys with elevated CU traits showed increased grey matter concentration within medial OFC and ACC. Increased grey matter volume and concentration observed in bilateral temporal regions.</td>
</tr>
<tr>
<td>De Brito et al. (2011)66</td>
<td>Community</td>
<td>48 males (23 CP/HCU traits; 25 TD controls) aged 10–13.3 years (M: 11.7)</td>
<td>VBM</td>
<td>APSD</td>
<td>CP &lt; Controls: Significantly decreased white matter concentration in right superior frontal lobe, right dorsal ACC, right superior temporal gyrus and left precuneus. CP &gt; Controls: Increased white matter concentration within bilateral middle frontal gyrus.</td>
</tr>
<tr>
<td>Dalwani et al. (2011)55</td>
<td>Clinical</td>
<td>44 males (25 antisocial substance dependence; 19 TD controls) aged 14–18 years (M: 16.6)</td>
<td>VBM</td>
<td>None</td>
<td>Patients &lt; Controls: Whole-brain analysis revealed significantly reduced grey matter volume in left DLPFC, right lingual gyrus and bilateral cerebellum. Grey matter volume in left DLPFC negatively associated with severity of substance dependence. Patients &gt; Controls: Significantly increased grey matter volume in right precuneus.</td>
</tr>
<tr>
<td>Fahim et al. (2011)32</td>
<td>Community</td>
<td>47 males (22 DBD; 25 TD controls) aged 8 years (M: 8.4)</td>
<td>VBM &amp; SBM</td>
<td>None</td>
<td>DBD &lt; Controls: Significantly decreased grey matter density in left medial OFC, cingulate, and bilateral insula cortices. Increased DBD score associated with decreased grey matter density in left medial middle and superior frontal cortex, prefrontus, and right superior temporal and occipital/cuneus regions.</td>
</tr>
<tr>
<td>Fairchild et al. (2011)54</td>
<td>Community</td>
<td>90 males (36 CD/childhood-onset; 27 CD/adolescent-onset; 27 TD controls) aged 16–21 years (M: 18.0)</td>
<td>VBM</td>
<td>YPI &amp; ICU</td>
<td>CD &lt; Controls: Reduced grey matter volume in amygdala bilaterally (including the insula). CD (adolescent-onset) &lt; Controls: Reduced amygdala and right insula grey matter volume. CD (childhood-onset) &lt; Controls: Reduced amygdala grey matter volume. Right insula volume was negatively correlated with CD-symptom severity in both sub-groups.</td>
</tr>
<tr>
<td>Hyatt et al. (2012)56</td>
<td>Community</td>
<td>43 male/female adolescents (19 CD (10 male); 24 TD control (14 male) aged 12–18 years (M: 16.2)</td>
<td>SBM</td>
<td>None</td>
<td>CD &lt; Controls: Reduced cortical thickness mainly in several posterior brain regions across the temporal and parietal lobes. Reduced gyrification primarily located in anterior brain regions (insula, inferior and dorsal frontal regions including lateral OFC, VMPC, and ACC), but also in the temporal and parietal lobes.</td>
</tr>
<tr>
<td>Stevens et al. (2012)53</td>
<td>Community</td>
<td>72 male/female adolescents (24 CD; 24 ADHD; 24 TD controls; 51Male) aged 15–16 years (M: 15.9)</td>
<td>VBM</td>
<td>None</td>
<td>CD &lt; Controls: 13% reduction in grey matter volume reflecting deficits in frontal, temporal, parietal and subcortical regions. Increased grey matter in right OFC, bilateral amygdala and bilateral temporal cortices associated with increased symptom severity in CD adolescents. No correlation between size of cavum septum pellucida and CU traits.</td>
</tr>
<tr>
<td>White et al. (2013)56</td>
<td>Community</td>
<td>59 adolescents (32 DBD (25 male); 27 TD controls) (19 male (M age: 14.9)</td>
<td>Manual Tracing</td>
<td>ASPD &amp; ICU</td>
<td>Large cavum septum pellucidum observed in 7/32 DBD adolescents but not for any of the controls. No correlation between size of cavum septum pellucida and CU traits.</td>
</tr>
<tr>
<td>Ermer et al. (2013)59</td>
<td>Prison</td>
<td>191 male prisoners (M age: 17.3)</td>
<td>VBM</td>
<td>PCL-YV</td>
<td>Psychopathic trait scores negatively associated with grey matter volume in regions of interest: PCC and OFC (extending into parahippocampal cortex and temporal poles). Increased grey matter volume in pre-frontal cortex positively associated with psychopathic traits.</td>
</tr>
<tr>
<td>Study</td>
<td>Sample/Group</td>
<td>Controls</td>
<td>Imaging Method(s)</td>
<td>Results and Findings</td>
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<tr>
<td>Fairchild et al. (2013)</td>
<td>Community</td>
<td>42 females (22 CD, 17 adolescent-onset, 20 TD controls) aged 14–20 years (M: 17.3)</td>
<td>VBM</td>
<td>YPI</td>
<td>CD &lt; Controls. Significantly reduced bilateral anterior insula and right striatal grey matter volumes. Right DLPFC volume was negatively correlated with CD symptom severity whilst CU traits were positively correlated with bilateral OFC volume.</td>
</tr>
<tr>
<td>Olvera et al. (2014)</td>
<td>Prison</td>
<td>72 male/female adolescents (24 CD with bipolar disorder (15 male), 24 CD (21 male), 24 TD controls (16 male) (M age: 15.8)</td>
<td>VBM</td>
<td>None</td>
<td>CD + bipolar disorder &lt; Controls. Decreased grey matter volume of the right medial PFC, superior and inferior frontal gyrus, ACC and temporal gyrus.</td>
</tr>
<tr>
<td>Wallace et al. (2014)</td>
<td>Community</td>
<td>49 male/female adolescents (22 CD, 27 TD controls) aged 10–18 years (M: 14.9)</td>
<td>SBM</td>
<td>ICU</td>
<td>Controls: Decreased grey matter volume of the right medial PFC, superior and inferior frontal gyrus, ACC and temporal gyrus. Right temporal cortical thickness was inversely correlated with CU trait severity.</td>
</tr>
<tr>
<td>Li et al. (2005)</td>
<td>Community</td>
<td>76 adolescents (36 with ODD (25 male); 40 TD controls (21 male) (M age: 14.0)</td>
<td>DTI tractography</td>
<td>K-SADS</td>
<td>Controls: No differences in brain volume.</td>
</tr>
<tr>
<td>Finger et al. (2012)</td>
<td>Community</td>
<td>31 adolescents (15 with psychopathic traits (ODD/CD; 11 male), 16 TD controls (10 male)) (M age: 14.3)</td>
<td>DTI tractography &amp; TBSS</td>
<td>YPI, APSD &amp; PCL-YV</td>
<td>Controls: No differences in brain volume.</td>
</tr>
<tr>
<td>Sarkar et al. (2013)</td>
<td>Community</td>
<td>43 male children/adolescents (27 CD; 16 TD controls) aged 12–19 years (M: 16.0)</td>
<td>DTI tractography</td>
<td>APSD</td>
<td>Controls: No differences in brain volume.</td>
</tr>
<tr>
<td>Haney-Caron et al. (2014)</td>
<td>Community</td>
<td>41 children/adolescents (17 CD (10 male); 24 TD controls (15 male)) aged 12–18 years (M: 15.8)</td>
<td>TBSS</td>
<td>None</td>
<td>Controls: No differences in brain volume.</td>
</tr>
<tr>
<td>Zhang et al. (2014)</td>
<td>Clinical</td>
<td>69 males (36 CD; 33 TD controls) (M age: 15.1)</td>
<td>TBSS and quantitative tractography</td>
<td>APSD</td>
<td>Controls: No differences in brain volume.</td>
</tr>
<tr>
<td>Zhang et al. (2014)</td>
<td>Clinical</td>
<td>56 adolescents (27 CD (14 males); 29 TD controls (16 males) aged 13–16 years (M: 14.0)</td>
<td>TBSS and quantitative tractography</td>
<td>APSD</td>
<td>Controls: No differences in brain volume.</td>
</tr>
</tbody>
</table>


* CU traits in the Main Results refer to lack of empathy and guilt, and shallow affect. Individual authors may have used a different label, i.e. psychopathic traits, in their paper, but for ease of reading we have used CU traits consistently. The Measures of CU traits column lists the specific measure used.
that some of the GM differences observed by De Brito et al. might represent a potential endophenotype for DBD/HCU. Despite evidence of group differences in functional connectivity, Finger et al. did not observe differences in structural connectivity within the uncinate fasciculus or other white matter tracts when comparing DBD/HCU youths and TD youths using DTI.

sMRI studies investigating the association between CU traits and VBM, SBM, and DTI metrics have revealed somewhat inconsistent findings. For example, a VBM study using a large sample of male adolescent prisoners with DBD (N = 191) revealed negative associations between GM volume and psychopathic traits in the posterior cingulate cortex and OFC, extending into temporal poles and parahippocampal cortex. This pattern of results was recently replicated in females. In contrast, Fairchild et al. found that, across DBD and TD females, CU traits were positively correlated with bilateral OFC GM volume, but negatively correlated with anterior insula and striatal GM volume. In a large sample of males with DBD (N = 63), Fairchild et al. found no relationship between GM volumes and CU traits. Using SBM, a negative association between CU traits and cortical thickness in the superior temporal cortex has also been reported in youths with DBD. Whilst Finger et al. did not find an association between CU traits and DTI metrics, a recent study reported a positive trend between psychopathic traits and FA in the left uncinate fasciculus, and yet another revealed a negative trend between CU traits and FA values in the left uncinate fasciculus in males with DBD.

**Neuroimaging Evidence: Sex Matters**

Sex differences in DBD are presently overlooked, with most samples in neuroimaging studies of DBD including males only. Thus, it is unclear whether the current evidence base also applies to females. Given evidence of sex differences in brain development and brain functioning in TD youths, it is conceivable that females with DBD might present different impairments from those observed in males with DBD. Yet, to date, only one fMRI study has compared females with DBD to TD females, reporting that those with DBD exhibited reduced medial OFC and increased anterior insula activity to sad, angry, and neutral faces, which is indicative of general face processing impairments. These results contrast with those observed in males using the same task, whereby males with DBD, compared to TD youths, exhibited increased activity to neutral faces and reduced activity to angry faces, which is indicative of more specific impairments in emotion processing.

In terms of sMRI studies, Fairchild et al. found that both males and females with CD showed similar reduction in GM volume in the amygdala compared to TD youths, which is consistent with evidence that both males and females with DBD show impaired fear conditioning. Crucially, however, a sex by diagnosis interaction was observed in the bilateral anterior insula: DBD females showed reduced GM volume compared to TD females, with the opposite pattern observed among males. A recent DTI study also reported a sex by diagnosis interaction whereby males with DBD, compared to TD males, had higher FA and lower radial diffusivity of the bilateral uncinate fasciculus, but no group differences were observed between the females with DBD and the TD females. Interestingly, higher FA and lower radial diffusivity in the uncinate fasciculus were found in males with DBD compared to females with DBD.

The above results suggest that both males and females with DBD are characterized by functional and structural abnormalities in key regions implicated in affective processing, empathy, and decision-making, but the nature of these deficits within a number of regions varies across sex. Our group is currently investigating the potential origins and implications of these differences within the context of the FemNAT CD study (http://www.femnat-cd.eu), a large multisite European study examining environmental and neurobiological factors associated with the development of DBD in male and female youths.

**Implications for Treatment**

The neuroimaging findings reviewed in this article add to the existing body of genetic, behavioral, and experimental evidence by highlighting that youths with DBD/HCU and DBD/LCU are characterized by different neurocognitive vulnerabilities, which are likely to influence intervention implementations and outcomes. Treatments for these subgroups should be tailored to their unique affective, neurocognitive, and motivational styles to maximize their effectiveness. Despite evidence that youths with DBD/HCU are less responsive to treatment, and that their antisocial behavior is under strong genetic influence, these youths should not be considered “untreatable.” An increasing body of evidence shows that intensive and tailored treatments can reduce antisocial behavior and levels of CU traits in these youths, particularly when their reward-oriented style is primed. Neuroimaging evidence suggests that such interventions should seek to increase sensitivity to other’s distress cues, and improve prediction error and expected value signaling during decision-making, possibly through a two-pronged approach that combines behavioral and pharmacological interventions. While youths with DBD/LCU might also benefit from behavioral and pharmacological interventions that target decision-making, in contrast to youths with DBD/HCU, they are more likely to respond to interventions that focus on increasing anger control/emotion regulation and reducing harsh and inconsistent
parenting, given that these children are more likely to come from dysfunctional families.\textsuperscript{11} Clearly, any form of intervention should systematically account for the influence of the level of CU traits on treatment response.\textsuperscript{36,37}

**Conclusions**

There is increasing recognition among the research and clinical community that youths with DBD are characterized by different patterns of behavioral problems and affective profiles, reflecting different underlying causal mechanisms.\textsuperscript{11} The evidence base accumulated over the last 20 years has shown that subtyping youths with DBD based on their level of CU traits identifies two subgroups of antisocial youths, who are characterized by different vulnerabilities and behavioral profiles.\textsuperscript{9,11} Consistent with experimental data showing high emotional reactivity in DBD/LCU and low emotional reactivity in DBD/HCU, recent fMRI evidence has shown that high levels of CU traits in DBD are associated with hyporesponsivity to affective stimuli and others’ distress in cortical and subcortical regions, such as the anterior insula, ACC, and amygdala. In contrast, low levels of CU traits are associated with heightened response in those regions. No sMRI study has directly compared these two subgroups, and those studies that have examined the associations between CU traits and sMRI indices have produced mixed findings. The paucity of neuroimaging investigations that have focused on females and on the role of sex differences is another important gap in this work. It is hoped that the mounting body of neuroimaging evidence investigating the role of CU traits on brain function and structure could inform the development of tailored treatments for both male and female youths with DBD.

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**REFERENCES:**


