

15 - Disruptive, Impulse Control, and Conduct Disorders

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Disruptive, Impulse-Control, and Conduct Disorders Disruptive, impulse-control, and conduct disorders include conditions involving problems in the self-control of emotions and behaviors. While other disorders in DSM5 may also involve problems in emotional and/or behavioral regulation, the disorders in this chapter are unique in that these problems are manifested in behaviors that violate the rights of others (e.g., aggression, destruction of property) and/or that bring the individual into significant conflict with societal norms or authority figures. The underlying causes of the problems in the self-control of emotions and behaviors can vary greatly across the disorders in this chapter and among individuals within a given diagnostic category. The chapter includes oppositional defiant disorder, intermittent explosive disorder, conduct disorder, antisocial personality disorder (which is described in the chapter “Personality Disorders”), pyromania, kleptomania, and other specified and unspecified disruptive, impulsecontrol, and conduct disorders. Although all the disorders in the chapter involve problems in both emotional and behavioral regulation, the source of variation among the disorders is the relative emphasis on problems in the two types of self-control. For example, the criteria for conduct disorder focus largely on poorly controlled behaviors that violate the rights of others or that violate major societal norms. These behaviors may or may not result from poorly controlled emotions. Some symptoms of conduct disorder (e.g., certain forms of aggression) can be attributable to constricted emotional responses. At the other extreme, the criteria for intermittent explosive disorder focus largely on poorly controlled emotion, outbursts of anger that are disproportionate to the interpersonal or other provocation or to other psychosocial stressors. Intermediate in impact to these two disorders is oppositional defiant disorder, in which the criteria are more evenly distributed between emotions (anger and irritation) and behaviors (argumentativeness and defiance). Pyromania and kleptomania are characterized by poor impulse control related to specific behaviors (fire setting or stealing) that relieve internal tension. Other specified disruptive, impulse-control, and conduct disorder is a category for conditions in which there are symptoms of conduct disorder, oppositional defiant disorder, or other disruptive, impulse-control, and conduct disorders, but the number or type of symptoms does not meet the diagnostic

threshold for any of the disorders in this chapter, even though there is evidence of clinically significant impairment associated with the symptoms. The disruptive, impulse-control, and conduct disorders all tend to be more common in boys and men than in girls and women, although the relative degree of male predominance may differ both across disorders and within a disorder at different ages. The disorders in this chapter tend to have first onset in childhood or adolescence. In fact, it is very rare for either conduct disorder or oppositional defiant disorder to first emerge in adulthood. There is a developmental relationship between oppositional defiant disorder and conduct disorder, in that most cases of conduct

F91.3 disorder previously would have had symptoms that met criteria for oppositional defiant disorder, at least in those cases in which conduct disorder emerges prior to adolescence. However, most children with oppositional defiant disorder do not eventually develop conduct disorder. Furthermore, children with oppositional defiant disorder are at risk for eventually developing other problems besides conduct disorder, including anxiety and depressive disorders. Many of the symptoms that define the disruptive, impulse-control, and conduct disorders are behaviors that can occur to some degree in typically developing persons. Thus, it is critical that the frequency, persistence, pervasiveness across situations, and impairment associated with the behaviors indicative of the diagnosis be considered relative to what is normative for a person's age, gender, and culture when determining if they are symptomatic of a disorder. The disruptive, impulse-control, and conduct disorders have been linked to a common externalizing spectrum associated with the personality dimensions of disinhibition and negative emotionality (some facets); and inversely with constraint and agreeableness. These shared personality dimensions could account for the high level of comorbidity among these disorders and their frequent comorbidity with substance use disorders and antisocial personality disorder. However, the specific nature of the shared diathesis that constitutes the externalizing spectrum remains unknown. Oppositional Defiant Disorder Diagnostic Criteria A. A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling. Angry/Irritable Mood

1. Often loses temper.
2. Is often touchy or easily annoyed.
3. Is often angry and resentful. Argumentative/Defiant Behavior
4. Often argues with authority figures or, for children and adolescents, with adults.
5. Often actively defies or refuses to comply with requests from authority figures or with rules.
6. Often deliberately annoys others.
7. Often blames others for his or her mistakes or misbehavior.

Vindictiveness 8. Has been spiteful or vindictive at least twice within the past 6 months. Note: The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic. For children younger than 5 years, the behavior should occur on most days for a period of at least 6 months unless otherwise noted (Criterion A8). For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8). While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be

considered, such as whether the frequency and intensity of the behaviors are outside a range that is normative for the individual's developmental level, gender, and culture. B. The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning. C. The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder. Specify current severity: Mild: Symptoms are confined to only one setting (e.g., at home, at school, at work, with peers). Moderate: Some symptoms are present in at least two settings. Severe: Some symptoms are present in three or more settings. Specifiers It is not uncommon for individuals with oppositional defiant disorder to show symptoms only at home and only with family members. However, the pervasiveness of the symptoms is an indicator of the severity of the disorder. Diagnostic Features The essential feature of oppositional defiant disorder is a frequent and persistent pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness (Criterion A). It is not unusual for individuals with oppositional defiant disorder to show the behavioral features of the disorder without problems of negative mood. However, individuals with the disorder who show the angry/irritable mood symptoms typically show the behavioral features as well. The symptoms of oppositional defiant disorder may be confined to only one setting, and this is most frequently the home. Individuals who show enough symptoms to meet the diagnostic threshold, even if it is only at home, may be significantly impaired in their social functioning.

However, in more severe cases, the symptoms of the disorder are present in multiple settings. Given that the pervasiveness of symptoms is an indicator of the severity of the disorder, it is critical that the individual's behavior be assessed across multiple settings and relationships. Because these behaviors are common among siblings, they must be observed during interactions with persons other than siblings. Also, because symptoms of the disorder are typically more evident in interactions with adults or peers whom the individual knows well, they may not be apparent during a clinical examination. The symptoms of oppositional defiant disorder can occur to some degree in persons without this disorder. There are several key considerations for determining if the behaviors are symptomatic of oppositional defiant disorder. First, the diagnostic threshold of four or more symptoms within the preceding 6 months must be met. Second, the persistence and frequency of the symptoms should exceed what is normative for an individual's age, gender, and culture. Temper outbursts for a preschool child would be considered a symptom of oppositional defiant disorder only if they occurred on most days for the preceding 6 months, if they occurred with at least three other symptoms of the disorder, and if the temper outbursts contributed to the significant impairment associated with the disorder (e.g., led to destruction of property during outbursts, resulted in the child being asked to leave a preschool). It should be noted that temper loss need not always involve tantrum behavior and can be displayed by angry facial expressions, verbal expressions of anger, and subjective feelings of anger that would not typically be considered a tantrum. The symptoms of the disorder often are part of a pattern of problematic interactions with others. Furthermore, individuals with this disorder typically do not regard themselves as angry, oppositional, or defiant. Instead, they often justify their behavior as a response to unreasonable demands or circumstances. Thus, it can be difficult to disentangle the relative contribution of the individual with the disorder to the problematic interactions he or she experiences. For example, children with oppositional defiant disorder may have experienced a history of hostile parenting, and it is often impossible to determine if the child's behavior caused

the parents to act in a more hostile manner toward the child, if the parents' hostility led to the child's problematic behavior, or if there was some combination of both. Whether or not the clinician can separate the relative contributions of potential causal factors should not influence whether the diagnosis is made. In the event that the child may be living in particularly poor conditions where neglect or mistreatment may occur (e.g., in institutional settings), clinical attention to reducing the contribution of the environment may be helpful. Associated Features Two of the most common co-occurring conditions with oppositional defiant disorder are attention-deficit/hyperactivity disorder (ADHD) and conduct disorder (see the section "Comorbidity" for this disorder). Oppositional defiant disorder has been associated with increased risk for suicide attempts, even after comorbid disorders are controlled for.

Temperamental. Environmental. Prevalence The cross-national prevalence of oppositional defiant disorder ranges from 1% to 11%, with an average prevalence estimate of around 3.3%. The rate of oppositional defiant disorder may vary depending on the age and gender of the child. The disorder appears to be somewhat more prevalent in boys than in girls (1.59:1) prior to adolescence. This male predominance is not consistently found in samples of adolescents or adults. Development and Course The first symptoms of oppositional defiant disorder usually appear during the preschool years and rarely later than early adolescence. Oppositional defiant disorder often precedes the development of conduct disorder, especially for those with the childhood-onset type of conduct disorder. However, many children and adolescents with oppositional defiant disorder do not subsequently develop conduct disorder. Oppositional defiant disorder also conveys risk for the development of anxiety disorders and major depressive disorder, even in the absence of conduct disorder. The defiant, argumentative, and vindictive symptoms carry most of the risk for conduct disorder, whereas the angry/irritable mood symptoms carry most of the risk for mood and anxiety disorders. Manifestations of the disorder across development appear consistent. Children and adolescents with oppositional defiant disorder are at increased risk for a number of problems in adjustment as adults, including functional impairments (e.g., problems in relationships with family, peers, and romantic partners; lower educational attainment; more workplace stress), the persistence of oppositional defiant disorder, and other psychopathology, such as antisocial behavior, impulse-control problems, substance misuse, anxiety, and depression. Many of the behaviors associated with oppositional defiant disorder increase in frequency during the preschool period and in adolescence. Thus, it is especially critical during these development periods that the frequency and intensity of these behaviors be evaluated against normative levels before it is decided that they are symptoms of oppositional defiant disorder. For example, it is not unusual for preschool children to show temper tantrums on a weekly basis, but daily tantrums occur in only about 10% of preschool children. Risk and Prognostic Factors Temperamental factors related to problems in emotional regulation (e.g., high levels of emotional reactivity, poor frustration tolerance) have been predictive of the disorder. Children with oppositional defiant disorder influence their environments, which in turn can influence them. For example, harsh, inconsistent, or neglectful child-rearing practices predict increases in symptoms, and oppositional symptoms predict increases in harsh and inconsistent parenting. In children and adolescents, oppositional defiant disorder is more prevalent in families in which childcare is disrupted by a succession of different caregivers. Children with oppositional defiant disorder are also at greater risk for both bullying peers and being bullied by peers.

Genetic and physiological. Conduct disorder. Adjustment disorder. A number of neurobiological markers (e.g., lower heart rate and skin conductance reactivity; reduced basal cortisol reactivity; abnormalities in the prefrontal cortex and amygdala) have been associated with oppositional defiant disorder. Studies have demonstrated overlapping genetic influences for the irritability and anger symptoms of oppositional defiant disorder with depression and generalized anxiety disorder. To date, the vast majority of studies have not separated children with oppositional defiant disorder from those with conduct disorder. Further study of markers specific to oppositional defiant disorder is needed.

Culture-Related Diagnostic Issues The reported prevalence of oppositional defiant disorder or other disruptive disorders may be affected by misdiagnosis or overdiagnosis of individuals from some cultural backgrounds. Social norms may affect the prevalence of the disorder and its male gender predominance in children and adolescents. A meta-analysis of prevalence rates in middle childhood found that the disorder is more common in boys compared with girls in Western cultures, but that the prevalence is similar across genders in non-Western cultures. Also, despite adverse experiences, first-generation migrants and refugees may be at decreased risk of developing oppositional defiant disorder symptoms.

Sex- and Gender-Related Diagnostic Issues Some studies find few sex or gender differences for this disorder compared with, for example, conduct disorder. There may be slight differences in risk factors with harsh parenting more highly associated with oppositional defiant disorder in girls but not boys.

Functional Consequences of Oppositional Defiant Disorder When oppositional defiant disorder is persistent throughout development, individuals with the disorder experience frequent conflicts with parents, teachers, supervisors, peers, and romantic partners. Such problems often result in significant impairments in the individual's emotional, social, academic, and occupational adjustment.

Differential Diagnosis Conduct disorder and oppositional defiant disorder are both related to conduct problems that bring the individual in conflict with adults and other authority figures (e.g., teachers, work supervisors). The behaviors of oppositional defiant disorder are typically of a less severe nature than those of conduct disorder and do not include aggression toward people or animals, destruction of property, or a pattern of theft or deceit. However, evidence suggests that oppositional defiant disorder is associated with equivalent or even greater levels of impairment than conduct disorder. Furthermore, oppositional defiant disorder includes problems of emotion dysregulation (i.e., angry and irritable mood) that are not included in the definition of conduct disorder. Environmental and family stressors may be associated with externalizing manifestations of emotion dysregulation. In children, these may manifest as

Posttraumatic stress disorder. Attention-deficit/hyperactivity disorder. Depressive and bipolar disorders. Disruptive mood dysregulation disorder. Intermittent explosive disorder. Intellectual developmental disorder (intellectual disability). Language disorder. Social anxiety disorder. tantrums and oppositional behavior; and in adolescents, as aggressive behaviors (e.g., rebellion and defiance). Temporal association with a stressor and symptom duration of less than 6 months after the resolution of the stressor may help distinguish adjustment disorder from oppositional defiant disorder. In children younger than 6 years, posttraumatic stress disorder may manifest initially as dysregulated behaviors, opposition, and tantrums; the association with a traumatic event and with other specific symptoms (traumatic play) are key to establishing the diagnosis. In adolescents, traumatic reenactment and risk-taking may be misinterpreted as defiance and opposition or as conduct problems. ADHD is often comorbid with oppositional defiant disorder. To make the additional diagnosis of oppositional defiant disorder, it is important to determine that the individual's failure to conform to requests of others is not solely in situations that demand

sustained effort and attention or demand that the individual sit still. Depressive and bipolar disorders often involve negative affect and irritability. As a result, a diagnosis of oppositional defiant disorder should not be made if the symptoms occur exclusively during the course of a mood disorder. Oppositional defiant disorder shares with disruptive mood dysregulation disorder the symptoms of chronic irritable mood and temper outbursts. However, if the irritable mood and other symptoms meet criteria for disruptive mood dysregulation disorder, a diagnosis of oppositional defiant disorder is not given, even if all criteria for oppositional defiant disorder are met. Intermittent explosive disorder also involves high rates of anger. However, individuals with this disorder show serious aggression toward others that is not part of the definition of oppositional defiant disorder. In individuals with intellectual developmental disorder, a diagnosis of oppositional defiant disorder is given only if the oppositional behavior is markedly greater than is commonly observed among individuals of comparable mental age and with comparable severity of intellectual disability. Oppositional defiant disorder must also be distinguished from a failure to follow directions that is the result of impaired language comprehension (e.g., hearing loss). Oppositional defiant disorder must also be distinguished from defiance because of fear of negative evaluation associated with social anxiety disorder. Comorbidity Rates of oppositional defiant disorder are much higher in samples of children, adolescents, and adults with ADHD, and this may be the result of shared temperamental risk factors. Also, oppositional defiant disorder often precedes conduct disorder, although this appears to be most common in children with the childhood-onset subtype. Individuals with oppositional defiant disorder are also at increased risk for anxiety disorders and major depressive disorder, and this seems largely attributable to the presence of the angry-irritable mood symptoms. Extremely high

F63.81 rates of comorbidity between disruptive mood dysregulation disorder and symptoms characteristic of oppositional defiant disorder have been reported, with most individuals with disruptive mood dysregulation disorder having symptoms that meet criteria for oppositional defiant disorder (such as showing argumentative/defiant symptoms); but because oppositional defiant disorder cannot be diagnosed if criteria are also met for disruptive mood dysregulation disorder, only disruptive mood dysregulation disorder would be diagnosed in such cases. Adolescents and adults with oppositional defiant disorder also show a higher rate of substance use disorders, although it is unclear if this association is independent of the comorbidity with conduct disorder. Intermittent Explosive Disorder Diagnostic Criteria A. Recurrent behavioral outbursts representing a failure to control aggressive impulses as manifested by either of the following:

1. Verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights) or physical aggression toward property, animals, or other individuals, occurring twice weekly, on average, for a period of 3 months. The physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals.
2. Three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period. B. The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors. C. The recurrent aggressive outbursts are not premeditated (i.e., they are impulsive and/or anger-based) and are not committed to achieve some tangible objective (e.g., money, power, intimidation). D. The recurrent aggressive outbursts cause

either marked distress in the individual or impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences. E. Chronological age is at least 6 years (or equivalent developmental level). F. The recurrent aggressive outbursts are not better explained by another mental disorder (e.g., major depressive disorder, bipolar disorder, disruptive mood dysregulation disorder, a psychotic disorder, antisocial personality disorder, borderline personality disorder) and are not attributable to another medical condition (e.g., head trauma, Alzheimer's disease) or to the physiological effects

of a substance (e.g., a drug of abuse, a medication). For children ages 6–18 years, aggressive behavior that occurs as part of an adjustment disorder should not be considered for this diagnosis. Note: This diagnosis can be made in addition to the diagnosis of attention deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder, or autism spectrum disorder when recurrent impulsive aggressive outbursts are in excess of those usually seen in these disorders and warrant independent clinical attention. Diagnostic Features The impulsive (or anger-based) aggressive outbursts in intermittent explosive disorder have a rapid onset and, typically, little or no prodromal period. Outbursts typically last for less than 30 minutes and commonly occur in response to a minor provocation by a close intimate or associate. Individuals with intermittent explosive disorder often have less severe episodes of verbal or nondamaging, nondestructive, or noninjurious physical assault (Criterion A1) in between more severe destructive/assaultive episodes (Criterion A2). Criterion A1 defines frequent (i.e., twice weekly, on average, for a period of 3 months) aggressive outbursts characterized by temper tantrums, tirades, verbal arguments or fights, or assault without damage to objects or without injury to animals or other individuals. Criterion A2 defines infrequent (i.e., three in a 1-year period) impulsive aggressive outbursts characterized by damaging or destroying an object, regardless of its tangible value, or by assaulting/striking or otherwise causing physical injury to an animal or to another individual. Regardless of the nature of the impulsive aggressive outburst, the core feature of intermittent explosive disorder is failure to control impulsive aggressive behavior in response to subjectively experienced provocation (i.e., psychosocial stressor) that would not typically result in an aggressive outburst (Criterion B). The aggressive outbursts are generally impulsive or anger-based rather than premeditated or instrumental (Criterion C) and cause significant distress or impairment in occupational or interpersonal functioning or are associated with financial or legal consequences (Criterion D). A diagnosis of intermittent explosive disorder should not be given to individuals younger than 6 years, or the equivalent developmental level (Criterion E), or to individuals whose aggressive outbursts are better explained by another mental disorder (Criterion F). A diagnosis of intermittent explosive disorder should not be given to individuals with disruptive mood dysregulation disorder or to individuals whose impulsive aggressive outbursts are attributable to another medical condition or to the physiological effects of a substance (Criterion F). In addition, children ages 6–18 years should not receive this diagnosis when impulsive aggressive outbursts occur in the context of an adjustment disorder (Criterion F). Associated Features Depressive disorders, anxiety disorders, and substance use disorders are associated with intermittent explosive disorder, although onset of these disorders is typically later than that of intermittent explosive disorder.

Environmental. Genetic and physiological. Research provides neurobiological support for the presence of serotonergic abnormalities, globally and in the brain, specifically in areas of the limbic system (anterior cingulate) and orbitofrontal cortex in individuals with intermittent explosive

disorder. Amygdala responses to anger stimuli, during functional magnetic resonance imaging scanning, are greater in individuals with intermittent explosive disorder compared with healthy persons. In addition, the volume of gray matter in several frontolimbic regions is reduced and correlates inversely with measures of aggression in individuals with intermittent explosive disorder, although these brain differences are not always seen.

Prevalence The 1-year prevalence for intermittent explosive disorder in the United States is about 2.6%, with a lifetime prevalence of 4.0%. Higher 1-year prevalences of 3.9% and 6.9% (narrow definition) are present among African Americans and Caribbean Black adolescents, respectively, in the United States, especially among males. This is consistent with higher 12-month rates of psychiatric disorder among immigrant Caribbean Black men and their second- and third-generation offspring, possibly associated with downward social mobility and the effects of racism. However, the reported prevalence of conduct disorder or other disruptive disorders may be affected by misdiagnosis or overdiagnosis of individuals from some cultural backgrounds. Intermittent explosive disorder is more prevalent among younger individuals (e.g., younger than 35–40 years), compared with individuals older than 50 years, and individuals with a high school education or less. In some studies, the prevalence of intermittent explosive disorder is greater in men and boys than in women and girls; other studies have found no sex or gender differences.

Development and Course The onset of recurrent, problematic, impulsive aggressive behavior is most common in late childhood or adolescence and rarely begins for the first time after age 40 years. The course of the disorder may be episodic, with recurrent periods of impulsive aggressive outbursts. Intermittent explosive disorder appears to follow a chronic and persistent course over many years. It also appears to be quite common regardless of the presence or absence of attention-deficit/hyperactivity disorder (ADHD) or other disruptive, impulse-control, and conduct disorders (e.g., conduct disorder, oppositional defiant disorder).

Risk and Prognostic Factors Individuals with a history of physical and emotional trauma during the first 20 years of life are at increased risk for intermittent explosive disorder. Long-term displacement from home and separation from family members are risk factors in some refugee population settings. First-degree relatives of individuals with intermittent explosive disorder are at increased risk for intermittent explosive disorder, and twin studies have demonstrated a substantial genetic influence for impulsive aggression.

Disruptive mood dysregulation disorder. Antisocial personality disorder or borderline personality disorder.

Culture-Related Diagnostic Issues The lower prevalence of intermittent explosive disorder in some regions (Asia, Middle East) or countries (Romania, Nigeria), compared with the United States, suggests that information about recurrent, problematic, impulsive aggressive behaviors either is not elicited on questioning or is less likely to be present, because of cultural factors.

Association With Suicidal Thoughts or Behavior A study of 1,460 research volunteers found that intermittent explosive disorder comorbid with posttraumatic stress disorder was associated with a markedly elevated rate of lifetime suicide attempt (41%). Posttraumatic stress disorder and intermittent explosive disorder were the only disorders associated with suicide attempt among soldiers with suicidal ideation, although the role of intermittent explosive disorder was less clear in multivariate analyses.

Functional Consequences of Intermittent Explosive Disorder Social (e.g., loss of friends, relatives, marital instability), occupational (e.g., demotion, loss of employment), financial (e.g., because of value of objects destroyed), and legal (e.g., civil suits as a result of aggressive behavior against person or property; criminal charges for assault) problems often develop as a result of intermittent explosive disorder.

Differential Diagnosis A diagnosis of intermittent explosive disorder should not be made when Criteria A1 and/or A2 are only met during

an episode of another mental disorder (e.g., major depressive disorder, bipolar disorder, psychotic disorder), or when impulsive aggressive outbursts are attributable to another medical condition or to the physiological effects of a substance or medication. This diagnosis also should not be made, particularly in children and adolescents ages 6–18 years, when the impulsive aggressive outbursts occur in the context of an adjustment disorder. In contrast to intermittent explosive disorder, disruptive mood dysregulation disorder is characterized by a persistently negative mood state (i.e., irritability, anger) most of the day, nearly every day, between impulsive aggressive outbursts. A diagnosis of disruptive mood dysregulation disorder can only be given when the onset of recurrent, problematic, impulsive aggressive outbursts is before age 10 years. Finally, a diagnosis of disruptive mood dysregulation disorder should not be made for the first time after age 18 years. Otherwise, these diagnoses are mutually exclusive. Individuals with antisocial personality disorder or borderline personality disorder often display recurrent, problematic impulsive aggressive outbursts. However, the level of impulsive aggression in individuals with antisocial personality disorder or borderline personality disorder is lower than that in individuals with intermittent explosive disorder.

Delirium, major neurocognitive disorder, and personality change due to another medical condition, aggressive type. Substance intoxication or substance withdrawal. Attention-deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder, or autism spectrum disorder. A diagnosis of intermittent explosive disorder should not be made when aggressive outbursts are judged to result from the physiological effects of another diagnosable medical condition (e.g., brain injury associated with a change in personality characterized by aggressive outbursts; complex partial epilepsy). Nonspecific abnormalities on neurological examination (e.g., “soft signs”) and nonspecific electroencephalographic changes are compatible with a diagnosis of intermittent explosive disorder unless there is a diagnosable medical condition that better explains the impulsive aggressive outbursts. A diagnosis of intermittent explosive disorder should not be made when impulsive aggressive outbursts are nearly always associated with intoxication with or withdrawal from substances (e.g., alcohol, phencyclidine, cocaine and other stimulants, barbiturates, inhalants). However, when a sufficient number of impulsive aggressive outbursts also occur in the absence of substance intoxication or withdrawal, and these warrant independent clinical attention, a diagnosis of intermittent explosive disorder may be given. Individuals with any of these childhood-onset disorders may exhibit impulsive aggressive outbursts. Individuals with ADHD are typically impulsive and, as a result, may also exhibit impulsive aggressive outbursts. While individuals with conduct disorder can exhibit impulsive aggressive outbursts, the form of aggression characterized by the diagnostic criteria is proactive and predatory. Aggression in oppositional defiant disorder is typically characterized by temper tantrums and verbal arguments with authority figures, whereas impulsive aggressive outbursts in intermittent explosive disorder are in response to a broader array of provocation and include physical assault. The level of impulsive aggression in individuals with a history of one or more of these disorders has been reported as lower than that in comparable individuals whose symptoms also meet intermittent explosive disorder Criteria A through E. Accordingly, if Criteria A through E are also met, and the impulsive aggressive outbursts warrant independent clinical attention, a diagnosis of intermittent explosive disorder may be given. Comorbidity Depressive disorders, anxiety disorders, posttraumatic stress disorder, bulimia nervosa, binge-eating disorder, and substance use disorders are most commonly comorbid with intermittent explosive disorder in community samples. In addition, individuals with antisocial personality disorder or borderline personality disorder, and

individuals with a history of disorders with disruptive behaviors (e.g., ADHD, conduct disorder, oppositional defiant disorder), are at greater risk for comorbid intermittent explosive disorder. Conduct Disorder Diagnostic Criteria A. A repetitive and persistent pattern of behavior in which the basic rights of others

or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months: Aggression to People and Animals

1. Often bullies, threatens, or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).
4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
7. Has forced someone into sexual activity. Destruction of Property
8. Has deliberately engaged in fire setting with the intention of causing serious damage.
9. Has deliberately destroyed others' property (other than by fire setting). Deceitfulness or Theft
10. Has broken into someone else's house, building, or car.
11. Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery). Serious Violations of Rules
13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
15. Is often truant from school, beginning before age 13 years. B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning. C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder. Specify whether: F91.1 Childhood-onset type: Individuals show at least one symptom characteristic of conduct disorder prior to age 10 years. F91.2 Adolescent-onset type: Individuals show no symptom characteristic of

conduct disorder prior to age 10 years. F91.9 Unspecified onset: Criteria for a diagnosis of conduct disorder are met, but there is not enough information available to determine whether the onset of the first symptom was before or after age 10 years. Specify if: With limited prosocial emotions: To qualify for this specifier, an individual must have displayed at least two of the following characteristics persistently over at least 12 months and in multiple relationships and settings. These characteristics reflect the individual's typical pattern of interpersonal and emotional functioning over this period and not just occasional occurrences in some situations. Thus, to assess the criteria for the specifier, multiple information sources are necessary. In addition to the individual's self-report, it is necessary to consider reports by others who have known the individual for extended periods of time (e.g., parents, teachers, co-workers, extended family members, peers). Lack of remorse or guilt: Does not feel bad or guilty when he or she does something wrong

(exclude remorse when expressed only when caught and/or facing punishment). The individual shows a general lack of concern about the negative consequences of his or her actions. For example, the individual is not remorseful after hurting someone or does not care about the consequences of breaking rules. Callous—lack of empathy: Disregards and is unconcerned about the feelings of others. The individual is described as cold and uncaring. The individual appears more concerned about the effects of his or her actions on himself or herself, rather than their effects on others, even when they result in substantial harm to others. Unconcerned about performance: Does not show concern about poor/problematic performance at school, at work, or in other important activities. The individual does not put forth the effort necessary to perform well, even when expectations are clear, and typically blames others for his or her poor performance. Shallow or deficient affect: Does not express feelings or show emotions to others, except in ways that seem shallow, insincere, or superficial (e.g., actions contradict the emotion displayed; can turn emotions “on” or “off” quickly) or when emotional expressions are used for gain (e.g., emotions displayed to manipulate or intimidate others). Specify current severity: Mild: Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause relatively minor harm to others (e.g., lying, truancy, staying out after dark without permission, other rule

breaking). Moderate: The number of conduct problems and the effect on others are intermediate between those specified in “mild” and those in “severe” (e.g., stealing without confronting a victim, vandalism). Severe: Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others (e.g., forced sex, physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering). Subtypes Three subtypes of conduct disorder are provided based on the age at onset of the disorder. Both childhood-onset and adolescent-onset subtypes can occur in a mild, moderate, or severe form. An unspecified-onset subtype is designated when there is insufficient information to determine age at onset. In childhood-onset conduct disorder, individuals are usually male, have disturbed peer relationships, may have had oppositional defiant disorder during early childhood, and usually have symptoms that meet full criteria for conduct disorder prior to puberty. Individuals with the childhood-onset type may be more likely to display aggression toward others than individuals with the adolescent-onset type. Many children with this subtype also have concurrent attention deficit/hyperactivity disorder (ADHD) or other neurodevelopmental difficulties. Individuals with childhood-onset type are more likely to have persistent conduct disorder into adulthood than are those with adolescent-onset type. Individuals with adolescent-onset conduct disorder tend to have more normative peer relationships (although they often display conduct problems in the company of others). Specifiers A minority of individuals with conduct disorder exhibit characteristics that qualify for the “with limited prosocial emotions” specifier. The indicators of this specifier are those that have often been labeled as callous and unemotional traits in research. Other personality features, such as thrill seeking, fearlessness, and insensitivity to punishment, may also distinguish those with characteristics described in the specifier. Individuals with characteristics described in this specifier may be more likely than other individuals with conduct disorder to engage in aggression that is planned for instrumental gain. Individuals with conduct disorder of any subtype or any level of severity can have characteristics that qualify for the specifier “with limited prosocial emotions,” although individuals with the specifier are more likely to have childhood-onset type and a severity specifier rating of severe. Although the validity of self-report to assess the presence of the specifier has been supported in some research contexts,

individuals with conduct disorder with this specifier may not readily admit to the traits in a clinical interview. Thus, to assess the criteria for the specifier, multiple information sources are necessary. Also, because the indicators of the specifier are characteristics

that reflect the individual's typical pattern of interpersonal and emotional functioning, it is important to consider reports by others who have known the individual for extended periods of time and across relationships and settings (e.g., parents, teachers, co-workers, extended family members, peers).

Diagnostic Features The essential feature of conduct disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated (Criterion A). These behaviors fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals (Criteria A1–A7); nonaggressive conduct that causes property loss or damage (Criteria A8–A9); deceitfulness or theft (Criteria A10–A12); and serious violations of rules (Criteria A13–A15). Three or more characteristic behaviors must have been present during the past 12 months, with at least one behavior present in the past 6 months. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning (Criterion B). The behavior pattern is usually present in a variety of settings, such as home, at school, or in the community. Because individuals with conduct disorder are likely to minimize their conduct problems, the clinician often must rely on additional informants. However, informants' knowledge of the individual's conduct problems may be limited if they have inadequately supervised the individual or the individual has concealed symptom behaviors. Individuals with conduct disorder often initiate aggressive behavior and react aggressively to others. They may display bullying, threatening, or intimidating behavior (including bullying via messaging on web-based social media) (Criterion A1); initiate frequent physical fights (Criterion A2); use a weapon that can cause serious physical harm (e.g., a bat, brick, broken bottle, knife, gun) (Criterion A3); be physically cruel to people (Criterion A4) or animals (Criterion A5); steal while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery) (Criterion A6); or force someone into sexual activity (Criterion A7). Physical violence may take the form of rape, assault, or, in rare cases, homicide. Deliberate destruction of others' property may include deliberate fire setting with the intention of causing serious damage (Criterion A8) or deliberate destroying of other people's property in other ways (e.g., smashing car windows, vandalizing school property) (Criterion A9). Acts of deceitfulness or theft may include breaking into someone else's house, building, or car (Criterion A10); frequently lying or breaking promises to obtain goods or favors or to avoid debts or obligations (e.g., "conning" other individuals) (Criterion A11); or stealing items of nontrivial value without confronting the victim (e.g., shoplifting, forgery, fraud) (Criterion A12). Individuals with conduct disorder may also frequently commit serious violations of rules (e.g., school, parental, workplace). Children with conduct disorder often have a pattern, beginning before age 13 years, of staying out late at night despite parental prohibitions (Criterion A13). Children may also show a pattern of running away from home overnight (Criterion A14). To be considered a symptom of conduct disorder, the running away must have occurred at least twice (or only once if the individual did not return for a lengthy period). Runaway episodes that occur as a direct consequence of physical or sexual abuse do not typically qualify for this criterion. Children with conduct disorder may often be truant from school, beginning prior to age 13 years (Criterion A15).

534 Associated Features Especially in ambiguous situations, aggressive individuals with conduct disorder frequently misperceive the intentions of others as more hostile and threatening than is the

case and respond with aggression that they then feel is reasonable and justified. Personality features of trait negative emotionality and poor self-control, including poor frustration tolerance, irritability, temper outbursts, suspiciousness, insensitivity to punishment, thrill seeking, and recklessness, frequently co-occur with conduct disorder. Substance misuse is often an associated feature, particularly in adolescent girls. Prevalence One-year population prevalence estimates in the United States and other largely high-income countries range from 2% to more than 10%, with a median of 4%. In the United States, the lifetime prevalence was found to be 12.0% among men and 7.1% among women. The prevalence of conduct disorder in largely Western samples appears to be fairly consistent across various countries. Prevalence rates rise from childhood to adolescence. Prevalence of adolescent-onset conduct disorder is more frequently associated with psychosocial stressors—for example, being a member of a socially oppressed ethnic group facing discrimination. Few children with impairing conduct disorder receive treatment. Development and Course The onset of conduct disorder may occur as early as the preschool years, but the first significant symptoms usually emerge during the period from middle childhood through middle adolescence. Oppositional defiant disorder is a common precursor to the childhood-onset type of conduct disorder. Physically aggressive symptoms are more common than nonaggressive symptoms during childhood, but nonaggressive symptoms become more common than aggressive symptoms during adolescence. Conduct disorder may be diagnosed in adults; however, symptoms of conduct disorder usually emerge in childhood or adolescence, and onset is rare after age 16 years. The course of conduct disorder after onset is variable. In a majority of individuals, the disorder remits by adulthood. Many individuals with conduct disorder—particularly those with adolescent-onset type and those with few and milder symptoms—achieve adequate social and occupational adjustment as adults. However, the childhood-onset type predicts a worse prognosis and an increased risk of criminal behavior, conduct disorder, and substance-related disorders in adulthood. Individuals with conduct disorder are at risk for later mood disorders, anxiety disorders, posttraumatic stress disorder, impulse-control disorders, psychotic disorders, somatic symptom disorders, and substance-related disorders as adults. Symptoms of the disorder vary with age as the individual develops increased physical strength, cognitive abilities, and sexual maturity. Symptom behaviors that emerge first tend to be less serious (e.g., lying, shoplifting), whereas conduct problems that emerge last tend to be more severe (e.g., rape, theft while confronting a victim). However, there are wide differences among individuals, with some engaging in the more damaging behaviors at an early age (which is

Temperamental. Environmental. Genetic and physiological. Course modifiers. predictive of a worse prognosis). When individuals with conduct disorder reach adulthood, symptoms of aggression, property destruction, deceitfulness, and rule violation, including violence against co-workers, partners, and children, may be exhibited in the workplace and the home, such that antisocial personality disorder may be considered. Risk and Prognostic Factors Temperamental risk factors include a difficult undercontrolled infant temperament and lower-than-average intelligence, particularly with regard to verbal IQ. Family-level risk factors include parental rejection and neglect, inconsistent child-rearing practices, harsh discipline, physical or sexual abuse, lack of supervision, early institutional living, frequent changes of caregivers, large family size, parental criminality, and certain kinds of familial psychopathology (e.g., substance-related disorders). Community-level risk factors include peer rejection, association with a delinquent peer group, neighborhood disadvantage, and exposure to violence. Both types of risk factors tend to be more common and severe among individuals with the childhood-onset subtype of conduct disorder. On

the other hand, parental migration is a risk factor for children who are left in the country of origin as well as for those who migrated with their parents, with conduct problems being attributable to acculturation processes. Nevertheless, first-generation immigrants and refugees often have fewer conduct problems than their peers. Conduct disorder is influenced by both genetic and environmental factors. Genetic associations may be stronger for aggressive symptoms. The risk is increased in children with a biological or adoptive parent or a sibling with conduct disorder. The disorder also appears to be more common in children of biological parents with severe alcohol use disorder, depressive and bipolar disorders, or schizophrenia or biological parents who have a history of ADHD or conduct disorder. Family history particularly characterizes individuals with the childhood-onset subtype of conduct disorder. Slower resting heart rate has been reliably noted in individuals with conduct disorder compared with those without the disorder, and this marker is not characteristic of any other mental disorder. Reduced autonomic fear conditioning, particularly low skin conductance, is also well documented. However, these psychophysiological findings are not diagnostic of the disorder. Structural and functional differences in brain areas associated with affect regulation and affect processing, particularly frontotemporal-limbic connections involving the brain's ventral prefrontal cortex and amygdala, have been consistently noted in individuals with conduct disorder compared with those without the disorder. However, neuroimaging findings are not diagnostic of the disorder. Persistence is more likely for individuals with behaviors that meet criteria for the childhood-onset subtype and qualify for the specifier "with limited prosocial emotions." The risk that conduct disorder will persist is also increased by co-occurring ADHD and by substance abuse. Culture-Related Diagnostic Issues

Oppositional defiant disorder. Conduct disorder diagnosis may at times be misapplied to individuals in settings where patterns of disruptive behavior are viewed as near-normative (e.g., in very threatening, high-crime areas or war zones). Therefore, the context in which the undesirable behaviors have occurred should be considered. In youth from underserved ethnic and racialized groups, reactions to racism that involve anger and resistance-based coping may be misdiagnosed as conduct disorder by uninformed practitioners, as suggested by the association between experiences of discrimination and adolescent-onset conduct disorder in these groups. Sex- and Gender-Related Diagnostic Issues Boys and men with a diagnosis of conduct disorder frequently exhibit fighting, stealing, vandalism, and school discipline problems. Girls and women with a diagnosis of conduct disorder are more likely to exhibit lying, truancy, running away, and prostitution. Whereas boys and men and girls and women exhibit relational aggression (behavior that harms social relationships of others), girls and women exhibit considerably less physical aggression than do boys and men. Association With Suicidal Thoughts or Behavior Suicidal thoughts, suicide attempts, and suicide occur at a higher-than-expected rate in individuals with conduct disorder. A large study conducted in Taiwan that followed adolescents with conduct disorder over 10 years found that conduct disorder was associated with a higher rate of suicide attempts even after adjustment for comorbid mood, anxiety, and substance use disorders. Functional Consequences of Conduct Disorder Conduct disorder behaviors may lead to school suspension or expulsion, problems in work adjustment, legal difficulties, sexually transmitted diseases, unplanned pregnancy, and physical injury from accidents or fights. These problems may preclude attendance in ordinary schools or living in a parental or foster home. Conduct disorder is often associated with an early onset of sexual behavior, alcohol use, tobacco smoking, use of illegal substances, and reckless and risktaking acts. Accident rates appear to be higher among individuals with conduct disorder compared with those without the disorder. These functional consequences of

conduct disorder may increase the risk for health difficulties when individuals reach midlife. It is not uncommon for individuals with conduct disorder to come into contact with the criminal justice system for engaging in illegal behavior. Conduct disorder is a common reason for treatment referral and is frequently diagnosed in mental health facilities for children, especially in forensic practice. It is associated with impairment that is more severe and chronic than that experienced by other clinic-referred children. Differential Diagnosis Conduct disorder and oppositional defiant disorder are both related

Attention-deficit/hyperactivity disorder. Depressive and bipolar disorders. Intermittent explosive disorder. Adjustment disorders. to symptoms that bring the individual in conflict with adults and other authority figures (e.g., parents, teachers, work supervisors). The behaviors of oppositional defiant disorder are typically of a less severe nature than those of individuals with conduct disorder and do not include aggression toward people or animals, destruction of property, or a pattern of theft or deceit. Furthermore, oppositional defiant disorder includes problems of emotion dysregulation (i.e., angry and irritable mood) that are not included in the definition of conduct disorder. When criteria are met for both oppositional defiant disorder and conduct disorder, both diagnoses can be given. Although children with ADHD often exhibit hyperactive and impulsive behavior that may be disruptive, this behavior does not by itself violate societal norms or the rights of others and therefore does not usually meet criteria for conduct disorder. When criteria are met for both ADHD and conduct disorder, both diagnoses should be given. Irritability, aggression, and conduct problems can occur in children or adolescents with major depressive disorder, bipolar disorder, or disruptive mood dysregulation disorder. The behavioral problems associated with these mood disorders can usually be distinguished from the pattern of conduct problems seen in conduct disorder based on their course. Specifically, individuals with conduct disorder will display substantial levels of aggressive or nonaggressive conduct problems during periods in which there is no mood disturbance, either historically (i.e., a history of conduct problems predating the onset of the mood disturbance) or concurrently (i.e., display of some conduct problems that are premeditated and do not occur during periods of intense emotional arousal). In those cases in which criteria for conduct disorder and a mood disorder are met, both diagnoses can be given. Both conduct disorder and intermittent explosive disorder involve high rates of aggression. However, the aggression in individuals with intermittent explosive disorder is limited to impulsive aggression and is not premeditated, and it is not committed in order to achieve some tangible objective (e.g., money, power, intimidation). Also, the definition of intermittent explosive disorder does not include the non-aggressive symptoms of conduct disorder. If criteria for both disorders are met, the diagnosis of intermittent explosive disorder should be given only when the recurrent impulsive aggressive outbursts warrant independent clinical attention. The diagnosis of an adjustment disorder (with disturbance of conduct or with mixed disturbance of emotions and conduct) should be considered if clinically significant conduct problems that do not meet the criteria for another specific disorder develop in clear association with the onset of a psychosocial stressor and do not resolve within 6 months of the termination of the stressor (or its consequences). Conduct disorder is diagnosed only when the conduct problems represent a repetitive and persistent pattern that is associated with impairment in social, academic, or occupational functioning. Comorbidity ADHD and oppositional defiant disorder are both common in individuals with conduct disorder, and this comorbid presentation predicts worse outcomes. Individuals who show the personality

F63.1 features associated with antisocial personality disorder often violate the basic rights of others or violate major age-appropriate societal norms, and as a result their pattern of behavior often meets criteria for conduct disorder. Conduct disorder may also co-occur with one or more of the following mental disorders: specific learning disorder, anxiety disorders, depressive or bipolar disorders, and substance-related disorders. Academic achievement, particularly in reading and other verbal skills, is often below the level expected on the basis of age and intelligence and may justify the additional diagnosis of specific learning disorder or a communication disorder. Antisocial Personality Disorder Criteria and text for antisocial personality disorder can be found in the chapter "Personality Disorders." Because this disorder is closely connected to the spectrum of "externalizing" conduct disorders in this chapter, as well as to the disorders in the adjoining chapter "Substance-Related and Addictive Disorders," it is listed here as well as in the chapter "Personality Disorders." Pyromania Diagnostic Criteria A. Deliberate and purposeful fire setting on more than one occasion. B. Tension or affective arousal before the act. C. Fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses, consequences). D. Pleasure, gratification, or relief when setting fires or when witnessing or participating in their aftermath. E. The fire setting is not done for monetary gain, as an expression of sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve one's living circumstances, in response to a delusion or hallucination, or as a result of impaired judgment (e.g., in major neurocognitive disorder, intellectual developmental disorder [intellectual disability], substance intoxication). F. The fire setting is not better explained by conduct disorder, a manic episode, or antisocial personality disorder. Diagnostic Features The essential feature of pyromania is the presence of multiple episodes of deliberate and purposeful fire setting (Criterion A). Individuals with this disorder experience tension or affective arousal before setting a fire (Criterion B). There is a fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses,

consequences) (Criterion C). Individuals with this disorder are often regular "watchers" at fires in their neighborhoods, may set off false alarms, and derive pleasure from institutions, equipment, and personnel associated with fire. They may spend time at the local fire department, set fires to be affiliated with the fire department, or even become firefighters. Individuals with this disorder experience pleasure, gratification, or relief when setting the fire, witnessing its effects, or participating in its aftermath (Criterion D). The fire setting is not done for monetary gain, as an expression of sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve one's living circumstances, or in response to a delusion or a hallucination (Criterion E). The fire setting does not result from impaired judgment (e.g., in major neurocognitive disorder or intellectual developmental disorder [intellectual disability]). The diagnosis is not made if the fire setting is better explained by conduct disorder, a manic episode, or antisocial personality disorder (Criterion F). Associated Features Individuals with pyromania may make considerable advance preparation for starting a fire. They may be indifferent to the consequences to life or property caused by the fire, or they may derive satisfaction from the resulting property destruction. The behaviors may lead to property damage, legal consequences, or injury or loss of life to the fire setter or to others. Individuals who impulsively set fires (who may or may not have pyromania) often have a current or past history of alcohol use disorder. Prevalence The population prevalence of pyromania is not known. The lifetime prevalence of fire-setting behavior, which is just one component of pyromania and not sufficient for a diagnosis by itself, was reported as 1.0%–1.1% in a population sample. Fire-setting behavior occurs more often in men than in women (lifetime

prevalence 1.7% vs. 0.4%); however, whether this also holds true for pyromania is unknown. The most common comorbidities of fire-setting behavior were antisocial personality disorder, substance use disorder, bipolar disorder, and gambling disorder. In contrast to fire setting, pyromania as a primary diagnosis appears to be very rare. Among a sample of persons in a Finnish hospital reaching the criminal system because of repeated fire setting, only 3.3% had symptoms that met full criteria for pyromania. In a U.S. study, 3.4% of a sample of adults hospitalized for psychiatric reasons had symptoms that met full criteria for current pyromania. Development and Course Although data are limited, some research suggests that late adolescence may be the typical age at onset of pyromania. The relationship between fire setting in childhood and pyromania in adulthood has not been documented. In individuals with pyromania, fire-setting incidents are episodic and may wax and wane in frequency. Longitudinal course is unknown. Although fire setting is a major problem in children and adolescents (over 40% of those arrested for arson offenses in the United States are younger than 18 years), pyromania in childhood appears to be rare. Juvenile fire setting is usually associated with conduct disorder, attention deficit/hyperactivity disorder, or an adjustment disorder.

Other causes of intentional fire setting. Other mental disorders. F63.2 Sex- and Gender-Related Diagnostic Issues While fire setting is associated with antisocial behavior in men and women, they differ on some of the antisocial behaviors that accompany fire setting. Whether this holds for pyromania, which is a subset of those with fire setting, is unknown. Association With Suicidal Thoughts or Behavior A study of a consecutive sample of male fire setters who had a forensic assessment compared each case with four age-, sex-, and place of birth-matched controls and found that fire setting was associated during follow-up with higher rates of suicide and also suicide attempt. Whether these differences apply to pyromania is unknown. Differential Diagnosis It is important to rule out other causes of fire setting before giving the diagnosis of pyromania. Intentional fire setting may occur for profit, sabotage, or revenge; to conceal a crime; to make a political statement (e.g., an act of terrorism or protest); or to attract attention or recognition (e.g., setting a fire in order to discover it and save the day). Fire setting may also occur as part of developmental experimentation in childhood (e.g., playing with matches, lighters, or fire). A separate diagnosis of pyromania is not given when fire setting occurs as part of conduct disorder, a manic episode, or antisocial personality disorder, or if it occurs in response to a delusion or a hallucination (e.g., in schizophrenia) or is attributable to the physiological effects of another medical condition (e.g., epilepsy). The diagnosis of pyromania should also not be given when fire setting results from impaired judgment associated with major neurocognitive disorder, intellectual developmental disorder, or substance intoxication. Comorbidity There appears to be a high co-occurrence of substance use disorders, gambling disorder, depressive and bipolar disorders, and other disruptive, impulse-control, and conduct disorders with pyromania. Kleptomania Diagnostic Criteria A. Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value. B. Increasing sense of tension immediately before committing the theft. C. Pleasure, gratification, or relief at the time of committing the theft.

D. The stealing is not committed to express anger or vengeance and is not in response to a delusion or a hallucination. E. The stealing is not better explained by conduct disorder, a manic episode, or antisocial personality disorder. Diagnostic Features The essential feature of kleptomania is the recurrent failure to resist impulses to steal items even though the items are not needed for personal use or for their monetary value (Criterion A). The individual experiences a

rising subjective sense of tension before the theft (Criterion B) and feels pleasure, gratification, or relief when committing the theft (Criterion C). The stealing is not committed to express anger or vengeance, is not done in response to a delusion or hallucination (Criterion D), and is not better explained by conduct disorder, a manic episode, or antisocial personality disorder (Criterion E). The objects are stolen despite the fact that they are typically of little value to the individual, who could have afforded to pay for them and often gives them away or discards them. Occasionally the individual may hoard the stolen objects or surreptitiously return them. Although individuals with this disorder will generally avoid stealing when immediate arrest is probable (e.g., in full view of a police officer), they usually do not preplan the thefts or fully take into account the chances of apprehension. The stealing is done without assistance from, or collaboration with, others.

Associated Features Individuals with kleptomania typically attempt to resist the impulse to steal, and they are aware that the act is wrong and senseless. The individual frequently fears being apprehended and often feels depressed or guilty about the thefts. Neurotransmitter pathways associated with behavioral addictions, including those associated with the serotonin, dopamine, and opioid systems, appear to play a role in kleptomania as well. **Prevalence** In the United States and Canada, kleptomania occurs in about 4%–24% of individuals arrested for shoplifting. Its prevalence in the U.S. general population is very rare, at approximately 0.3%–0.6%. Women outnumber men at a ratio of 3:1. **Development and Course** Age at onset of kleptomania is variable, but the disorder often begins in adolescence. However, the disorder may begin in childhood, adolescence, or adulthood, and in rare cases in late adulthood. There is little systematic information on the course of kleptomania, but three typical courses have been described: sporadic with brief episodes and long periods of remission; episodic with protracted periods of stealing and periods of remission; and chronic with some degree of fluctuation. The disorder may continue for years, despite multiple convictions for

Genetic and physiological. Ordinary theft. Malingering. Antisocial personality disorder and conduct disorder. Manic episodes, psychotic episodes, and major neurocognitive disorder. shoplifting. **Risk and Prognostic Factors** There appears to be a higher rate of alcohol use disorders in first-degree relatives of individuals with kleptomania than in the general population. **Association With Suicidal Thoughts or Behavior** Kleptomania has been associated with an increased risk for suicide attempts. **Functional Consequences of Kleptomania** The disorder may cause legal, family, career, and personal difficulties. **Differential Diagnosis** Kleptomania should be distinguished from ordinary acts of theft or shoplifting. Ordinary theft (whether planned or impulsive) is deliberate and is motivated by the usefulness of the object or its monetary worth. Some persons, especially adolescents, may also steal on a dare, as an act of rebellion, or as a rite of passage. The diagnosis is not made unless other characteristic features of kleptomania are also present. Kleptomania is rare, whereas shoplifting is relatively common. In malingering, individuals may simulate the symptoms of kleptomania to avoid criminal prosecution. Antisocial personality disorder and conduct disorder are distinguished from kleptomania by a general pattern of antisocial behavior. Kleptomania should be distinguished from intentional or inadvertent stealing that may occur during a manic episode, in response to delusions or hallucinations (e.g., in schizophrenia), or as a result of a major neurocognitive disorder. **Comorbidity** Kleptomania may be associated with compulsive buying as well as with depressive and bipolar disorders (especially major depressive disorder), anxiety disorders, eating disorders (particularly bulimia nervosa), personality disorders, substance use disorders (especially alcohol use disorder), and other disruptive, impulse-control, and conduct disorders. **Other Specified Disruptive, Impulse-Control, and Conduct Disorder F91.8**

This category applies to presentations in which symptoms characteristic of a disruptive, impulse-control, and conduct disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the disruptive, impulse-control, and conduct disorders diagnostic class. The other specified disruptive, impulse-control, and conduct disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific disruptive, impulse-control, and conduct disorder. This is done by recording “other specified disruptive, impulse-control, and conduct disorder” followed by the specific reason (e.g., “recurrent behavioral outbursts of insufficient frequency”).

Unspecified Disruptive, Impulse-Control, and Conduct Disorder F91.9 This category applies to presentations in which symptoms characteristic of a disruptive, impulse-control, and conduct disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the disruptive, impulse-control, and conduct disorders diagnostic class. The unspecified disruptive, impulse-control, and conduct disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific disruptive, impulse-control, and conduct disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

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