Disruptive, Impulse-Control, and Conduct Disorders

Characterized by impulses, drives, temptations, that result in violations done to others, behaviors that are contrary to societal norms/rules and/or conflicts with authority figures.

They are not subsumed under another category of disorders (e.g., Bipolar Related Disorders, Personality Disorders, Substance-Related Disorders).

Oppositional Defiant Disorder

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 (Angry/Irritable Mood, Argumentative/Defiant Behavior, and Vindictiveness), and exhibited with at least one individual who is not a sibling.

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.

Oppositional Defiant Disorder

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.

Oppositional Defiant Disorder

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.

Severity Specifiers:

Mild (symptoms present in one setting)

Moderate (symptoms present in two settings)

Severe (symptoms present in three or more setting)

Oppositional Defiant Disorder

Associated with low self-esteem, low frustration tolerance, early substance use, swearing, and lowered school functioning.

Associated with inconsistent, harsh, or neglectful parenting.

Prevalence of 1-11%

More common in males prior to puberty (1.4 to 1), rates more equal after puberty

ODD often precedes CD

Assessment re: conflicts with others can show specific patterns of primarily conflicts with parents, or only with teachers, or across different groups including peers

Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months, of Aggression to People and Animals, Destruction of Property, Deceitfulness or Theft, and/or Serious Violation of Rules.

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.

Conduct Disorder

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)

Conduct Disorder

Deceitfulness or Theft

10. has broken into someone else's house, building, or car
11. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
12. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious Violation of Rules

13. often stays out at night despite parental prohibitions, beginning before age 13 years
14. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
15. is often truant from school, beginning before age 13 years

Conduct Disorder

Onset Specifiers:

- Child-Onset (< 10 years old)
- Adolescent-Onset (0 symptoms prior to age 10)
- Unspecified Onset

Severity Specifiers:

- Mild (few symptoms and symptoms cause less harm)
- Moderate
- Severe (many symptoms and/or they cause notable harm to others)

Other Specifiers:

- With limited prosocial emotions
  - (2 of the following need to be present:
    - Lack of remorse or guilt, Callous—lack of empathy,
    - Unconcerned about performance, Shallow or deficient affect)

Conduct Disorder

Associated with little empathy, little concern for the feelings and well-being of others, and lack of remorse/guilt.

Also associated with low self-esteem, low frustration tolerance, recklessness, early substance use, early sexual behavior, poor school functioning, physically-aggressive behaviors, removal from the home, and SI/SA/completed suicides.

Need to consider context because aggressive self-protection is not considered CD (e.g., contexts of war, lack of safety)

Males under 18, 6-16%, females 2-9%

Earlier onset predicts poorer prognosis and increased likelihood of progression to Antisocial Personality Disorder.

Etiological factors include low SES, large family size, inconsistent and harsh discipline (particularly physical), early institutional living/frequent changes of residential placement, association with delinquent peer group.

Intermittent Explosive Disorder

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 towards 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.

Intermittent Explosive Disorder

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).

Intermittent Explosive Disorder

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.

Intermittent Explosive Disorder

Onset – late childhood/adolescence to 30s

Often characterized by generalized impulsivity and aggressiveness (hence the rule out for ASPD, Conduct Disorder)

Individuals with narcissistic, obsessive, paranoid, or schizoid traits may be prone to explosive outbursts of anger when under stress

Prevalence rates of 2.7%

- More common in males than females
- More common in young (< 40 years of age) than elderly

Intermittent Explosive Disorder

Amok – See Appendix I in DSM-IV-TR

A dissociative episode characterized by a period of brooding followed by an outburst of violent, aggressive, or homicidal behavior directed at people and objects. The episode tends to be precipitated by a perceived slight or insult and seems to be prevalent only among males. The episode is often accompanied by persecutory ideas, automatism, amnesia, exhaustion, and a return to premorbid state following the episode. Some instances of amok may occur during a brief psychotic episode or constitute the onset or an exacerbation of a chronic psychotic process. The original reports that used this term were from Malaysia. A similar behavior pattern is found in Laos, Philippines, Polynesia, Papua New Guinea, and Puerto Rico (mal de pelea) and among the Navajo.

Kleptomania

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 accounted for by Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder.

Kleptomania

Rare in general population (0.3-0.6%). In shoplifters, reportedly 4%-24% (which means that most shoplifters steal deliberately, with “felt” control)

More common in females than males (3:1)

Course may be sporadic to chronic, despite legal convictions

Are aware that stealing is wrong and experience stealing as ego-dystonic.

May feel guilty or depressed about the thefts and return or donate them afterwards.

Pyromania

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 a hallucination, or as a result of impaired judgment (e.g., in Major Neurocognitive Disorder, Intellectual Disability, Substance Intoxication)

F. The fire setting is not better explained by Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder.

Pyromania

Rare, more common in males, particular those with poorer social skills and learning difficulties

40% of arson offenses are caused by people under the age of 18

Treatment

What Disruptive, Impulse-Control, and Conduct Disorders have in common is destructive or disruptive actions that are initiated in response to either an internal or external stimulus (e.g., seeing something that catches one's eye in Kleptomania, boredom in Pyromania or Conduct Disorder, anger and resentment when asked/told to do something in Oppositional Defiant Disorder or Conduct Disorder, etc.), treatment usually consists of Cognitive Behavioral Therapy to address maladaptive behaviors through positive or negative punishment and to facilitate more adaptive/prosocial behaviors through positive or negative reinforcement. Imaginal exposure and emotion regulation strategies are also often used.

Cognitive therapy is used to explore and facilitate alternative ways of thinking in order to suppress or utilize an alternative behavioral response to the impulse rather than the maladaptive behaviors (e.g., lighting candles vs. burning property)