

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. 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

312.34 (F63.81)

- 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 and/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 and/or anger-based, rather than premeditated or instrumental (Criterion C) and are associated with significant distress or impairment in psychosocial function (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 Supporting Diagnosis

Mood disorders (unipolar), 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.

Prevalence

One-year prevalence data for intermittent explosive disorder in the United States is about 2.7% (narrow definition). Intermittent explosive disorder is more prevalent among younger individuals (e.g., younger than 35–40 years), compared with older individuals (older than 50 years), and in individuals with a high school education or less.

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 core features of intermittent explosive disorder, typically, are persistent and continue for many 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 disruptive, impulse-control, and conduct disorders (e.g., conduct disorder, oppositional defiant disorder).

Risk and Prognostic Factors

Environmental. Individuals with a history of physical and emotional trauma during the first two decades of life are at increased risk for intermittent explosive disorder.

Genetic and physiological. 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.

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 individuals.

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.

Gender-Related Diagnostic Issues

In some studies the prevalence of intermittent explosive disorder is greater in males than in females (odds ratio = 1.4–2.3); other studies have found no gender difference.

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., due to 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. Other examples in which recurrent, problematic, impulsive aggressive outbursts may, or may not, be diagnosed as intermittent explosive disorder include the following.

Disruptive mood dysregulation 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.

Antisocial personality disorder or borderline personality disorder. 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. 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.

Substance intoxication or substance withdrawal. 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.

Attention-deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder, or autism spectrum disorder. 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, and substance use disorders are most commonly comorbid with intermittent explosive disorder. 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:

312.81 (F91.1) Childhood-onset type: Individuals show at least one symptom characteristic of conduct disorder prior to age 10 years.

312.82 (F91.2) Adolescent-onset type: Individuals show no symptom characteristic of conduct disorder prior to age 10 years.

312.89 (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 person 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. Onset is most accurately estimated with information from both the youth and the caregiver; estimates are often 2 years later than actual onset. Both 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, frequently display physical aggression toward others, 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. 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. As compared with individuals with childhood-onset type, individuals with adolescent-onset conduct disorder are less likely to display aggressive behaviors and tend to have more normative peer relationships (although they often display conduct problems in the company of others). These individuals are less likely to have conduct disorder that persists into adulthood. The ratio of males to females with conduct disorder is more balanced for the adolescent-onset type than for the childhood-onset type.

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); non-aggressive 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 non-trivial 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).

Associated Features Supporting Diagnosis

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 females. Suicidal ideation, suicide attempts, and completed suicide occur at a higher-than-expected rate in individuals with conduct disorder.

Prevalence

One-year population prevalence estimates range from 2% to more than 10%, with a median of 4%. The prevalence of conduct disorder appears to be fairly consistent across various countries that differ in race and ethnicity. Prevalence rates rise from childhood to adolescence and are higher among males than among females. 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. 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 early-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 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. Temperamental risk factors include a difficult undercontrolled infant temperament and lower-than-average intelligence, particularly with regard to verbal IQ.

Environmental. 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, and neighborhood 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.

Genetic and physiological. Conduct disorder is influenced by both genetic and environmental factors. 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.

Course modifiers. 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

Conduct disorder diagnosis may at times be potentially 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.

Gender-Related Diagnostic Issues

Males with a diagnosis of conduct disorder frequently exhibit fighting, stealing, vandalism, and school discipline problems. Females with a diagnosis of conduct disorder are more likely to exhibit lying, truancy, running away, substance use, and prostitution. Whereas males tend to exhibit both physical aggression and relational aggression (behavior that harms social relationships of others), females tend to exhibit relatively more relational aggression.

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 risk-taking 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 predict 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

Oppositional defiant disorder. Conduct disorder and oppositional defiant disorder are both related to symptoms that bring the individual in conflict with adults and other au-

thority 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 individuals or animals, destruction of property, or a pattern of theft or deceit. Furthermore, oppositional defiant disorder includes problems of emotional 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.

Attention-deficit/hyperactivity disorder. 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.

Depressive and bipolar disorders. Irritability, aggression, and conduct problems can occur in children or adolescents with a major depressive disorder, a 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, persons with conduct disorder will display substantial levels of aggressive or non-aggressive 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.

Intermittent explosive disorder. 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.

Adjustment disorders. 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 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 dual coded here as well as in the chapter “Personality Disorders.”

Pyromania

Diagnostic Criteria

312.33 (F63.1)

- 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 disability [intellectual developmental disorder], 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 disability [intellectual developmental disorder]). 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 Supporting Diagnosis

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, which is just one component of pyromania and not sufficient for a diagnosis by itself, was reported as 1.13% in a population sample, but the most common comorbidities were antisocial personality disorder, substance use disorder, bipolar disorder, and pathological gambling (gambling disorder). In contrast, pyromania as a primary diagnosis appears to be very rare. Among a sample of persons reaching the criminal system with repeated fire setting, only 3.3% had symptoms that met full criteria for pyromania.

Development and Course

There are insufficient data to establish a 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.

Gender-Related Diagnostic Issues

Pyromania occurs much more often in males, especially those with poorer social skills and learning difficulties.

Differential Diagnosis

Other causes of intentional fire setting. 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).

Other mental disorders. 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 disability, 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.