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.

Kleptomania

Diagnostic Criteria **312.32 (F63.2)**

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 Supporting Diagnosis

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

Kleptomania occurs in about 4%–24% of individuals arrested for shoplifting. Its prevalence in the general population is very rare, at approximately 0.3%–0.6%. Females outnumber males 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 shoplifting.

Risk and Prognostic Factors

Genetic and physiological. There are no controlled family history studies of kleptomania. However, first-degree relatives of individuals with kleptomania may have higher rates of obsessive-compulsive disorder than the general population. There also appears to be a higher rate of substance use disorders, including alcohol use disorder, in relatives of individuals with kleptomania than in the general population.

Functional Consequences of Kleptomania

The disorder may cause legal, family, career, and personal difficulties.

Differential Diagnosis

Ordinary theft. 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 individuals, 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 exceedingly rare, whereas shoplifting is relatively common.

Malingering. In malingering, individuals may simulate the symptoms of kleptomania to avoid criminal prosecution.

Antisocial personality disorder and conduct disorder. Antisocial personality disorder and conduct disorder are distinguished from kleptomania by a general pattern of antisocial behavior.

Manic episodes, psychotic episodes, and major neurocognitive disorder. Kleptomania should be distinguished from intentional or inadvertent stealing that may occur during a manic episode, in response to delusions or hallucinations (as in, e.g., 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

312.89 (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").