



# DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

## OVERVIEW

A child being disagreeable is normal. Oppositional behavior is a serious concern only if it is extreme when compared to children of similar age and developmental level, and if it affects the child's social, family, and academic life. Impulse-control occurs when an inability to regulate internal experiences (like emotions or sensations) triggers disruptive behaviors. Defiant and oppositional behavior can manifest itself as oppositional defiant disorder (ODD), the more severe conduct disorder (CD), or intermittent explosive disorder (IED). Other disorders included in this category are pyromania and kleptomania.

While some characteristics of ODD and CD overlap, there are important distinctions. Youth with ODD may not display significant physical aggression and may be less likely to have problems with the law. Moreover, because ODD is seen as a disorder of noncompliance and CD involves the violation of another's rights, it is helpful to view these mental health disorders as two points on a continuum, rather than as two separate mental health disorders.

Increases in oppositional and antagonistic behaviors are somewhat typical at the onset of adolescence. Youth with autism spectrum disorder, ADHD, anxiety, or depression may also be more likely to exhibit these symptoms. Clinicians, therefore, should give careful consideration to determining whether oppositional behaviors are manifestations of typical development or of a primary mental health disorder.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) criteria for disruptive, impulse-control, and conduct disorders are outlined in the paragraphs that follow.

## Oppositional Defiant Disorder (ODD)

ODD manifests as a pattern of hostile and oppositional behavior, including but not limited to:

- Frequent temper tantrums
- Excessive arguing with adults

## KEY POINTS

- Characterized by extreme oppositional behavior that affects a child's social, family, and academic life.
- Risk factors include living in dysfunctional or violent environments, child abuse and neglect, deviant peer associations, and genetic influences.
- Parent behavior management training is the primary intervention.
- Multisystemic therapy and cognitive behavioral therapy are also evidence-based treatments.

- Active defiance and refusal to comply with adult requests and rules
- Deliberate attempts to annoy or upset people
- Blaming others for his or her mistakes or misbehavior
- Often being touchy or easily annoyed by others
- Frequent anger and resentment
- Aggressive behavior
- Mean and hateful talking when upset
- Vindictiveness —spiteful attitude and revenge seeking

Oppositional behaviors often manifest in the home setting and with familiar adults. Behaviors may or may not be present in the school and/or community settings, and thus may not be present in the mental health professional's office. To be diagnosed with ODD, the behaviors must occur with at least one individual who is not the person's sibling. The severity of the disorder is indicated by the number of settings in which the symptoms are present. Significant distress or impairment in functioning must also be present in order to make a diagnosis of ODD.

### Conduct Disorder (CD)

Children and adolescents with CD exhibit persistent and critical patterns of misbehavior. Like children with ODD, youth with CD may have an issue with controlling their tempers; however, these youth also violate the rights of others and/or major societal norms. Following an episode, they may lack remorse or empathy.

The symptoms of CD include, but are not limited to, the following:

- Bullies, threatens, or intimidates others
- Deceitfulness and lying to obtain goods or favors or to avoid obligations
- Stealing from others, sometimes while confronting the victim
- Serious violations of rules (truant, runs away, etc.)
- Often initiates physical fights
- Deliberate destruction of property
- Aggression and/or physical cruelty to people and animals
- Use of a dangerous weapon on others with the intent to harm
- Forces someone into sexual activity

These disturbances must cause clinically significant impairment in social, academic, or occupational functioning. Children and adolescents diagnosed with CD have more difficulty in areas of academic achievement, interpersonal relationships, drugs, and alcohol use. They also are often exposed to the juvenile justice system because of their delinquent or disorderly behaviors. Some will develop adult antisocial personality disorder later in life.

### Intermittent Explosive Disorder (IED)

IED involves impulsive or anger-based aggressive outbursts that begin rapidly. The outbursts often last fewer than 30 minutes and are provoked by minor actions of someone close, often a family member or friend. The aggressive episodes are generally impulsive and/or based in anger rather than premeditated.

Aggressiveness must be “grossly out of proportion” to the provocation and accompanying psychosocial stressors. The recurrent outbursts are neither premeditated, nor are they to achieve an outcome. Thus, outbursts are impulsive or based in anger, and are not meant to intimidate or to seek money or power. Finally, the outbursts must cause the individual considerable distress, impair his or her occupational or interpersonal functioning, or be associated with financial or legal consequences.

Children diagnosed with IED display:

- Verbal or physical aggression that occurs, on average, twice per week for three months but does not result in damage or injury to people or animals, **or**
- Behavioral outbursts that occur three or more times a year that do result in damage or injury to people or animals

### Pyromania

The essential feature of pyromania is the deliberate and purposeful setting of fires. It involves multiple episodes.

The symptoms of this disorder include:

- Deliberately and purposefully setting a fire more than one time.
- Tension or emotional arousal being present before the act of setting the fire.
- Having a fascination with, interest in, curiosity about, or attraction to fire and its uses and consequences.
- Feeling pleasure, relief, or gratification when setting fires or when seeing the aftermath of a fire or the damage it caused.
- The fires are not set for monetary gain, to cover up criminal activity, to express anger or vengeance, in response to any hallucinations or delusions, or as a result of impaired judgment (from another disorder or substance).
- The firesetting is not better explained by CD, a manic disorder, or antisocial personality disorder.

Pyromania as a primary diagnosis appears to be very rare. In people incarcerated for repeated firesetting, only about three percent meet all the symptoms for pyromania. For more information on this disorder, please refer to the “Juvenile Firesetting” section of the *Collection*.

### Kleptomania

Kleptomania is distinct from theft in that it involves the impulsive and unnecessary stealing of often useless things. Individuals may hoard the things they steal, give them away, or even return them to the store. The disorder is not about the objects stolen; it is about the compulsion to steal and the lack of self-control over this compulsion. Females with kleptomania outnumber males at a ratio of three to one.

Kleptomania typically follows one of three patterns of stealing: 1) brief episodes of stealing with intermittent and long periods of remission, 2) longer periods of stealing with brief periods of remission, or 3) chronic and continuous episodes of stealing with only minor fluctuation in frequency. Kleptomania is very rare, with a prevalence rate of 0.3 to 0.6 percent in the general population. Accordingly, it will not be discussed in this section of the *Collection*.

## CAUSES AND RISK FACTORS

As with most psychiatric disorders, there is no single cause of these disorders. Rather, they arise out of a complex combination of risk and protective factors related to biological and environmental/social influences.

Researchers agree that there is a strong genetic and biological influence on the development of disruptive, impulse-control, and conduct disorders. These and related behavioral disorders (e.g., ADHD, substance use disorders, and mood disorders) tend to cluster in families. Parents of children with ODD often have mood disorders, while parents of children with CD are more likely to have depression, substance use disorders, schizophrenia, ADHD, and/or antisocial personality traits or behaviors.

Several social factors may also present a risk, including poverty, lack of structure, community violence, and dysfunctional family environment. Youth who are neglected through lack of parental supervision and positive parenting behaviors and/or who experience harsh treatment, including child abuse, are at higher risk. Those with deviant peer associations are also more likely to meet the criteria for these disorders. This may be because youth can learn deviant behaviors from others and can have their negative behavior patterns reinforced in deviant relationships.

Characteristics of the coronavirus pandemic may exacerbate impulse-control disorders. For more information, see the “COVID-19 Pandemic and Lockdown” section of the *Collection*.

## EVIDENCE-BASED TREATMENTS

Although ODD, CD, and IED are considered separate diagnoses, the treatment principles for these disorders are very similar. Individualized treatment plans should be developed to address the particular problems and severity of each child and family situation.

A summary of treatments is outlined in Table 1.

Parent behavior management training is the primary intervention for disruptive, impulse-control, and conduct disorders. The key strategies of these approaches include the following:

- Identification and reduction of positive reinforcement of structured behavior
- Increased reinforcement of prosocial and compliant behavior
- Utilization of nonviolent and consistent discipline for disruptive behaviors
- Emphasis on predictability and immediacy of parental contingencies

Multisystemic therapy (MST) is an individualized case management program that incorporates many aspects of parent management and child social skills training for youth with serious behavior disorders who are at risk for out-of-home placement. MST attempts to intervene with the multiple factors that can contribute to antisocial behavior at the individual, family, and broader social levels, including peer, school, and neighborhood factors. Trained clinicians identify strengths in each youth’s social network and capitalize on these to promote positive change. By helping both parents and youth to manage their lives more effectively, the need for out-of-home placement may be eliminated.

No medications have been formally approved for impulse-control disorders, so medications are directed at specific symptoms to improve quality of life. Medication is not sufficient treatment by itself.

**Table 1**  
**Treatments for Disruptive, Impulse-Control, and Conduct Disorders**

What Works	
Parent management training (PMT)	<p>PMT programs focus on teaching and practicing parenting skills with parents or caregivers. Program models include:</p> <ul style="list-style-type: none"> <li>• Helping the Noncompliant Child</li> <li>• Incredible Years</li> <li>• Parent-child interaction therapy</li> <li>• Parent MT to Oregon model</li> </ul>
Multisystemic therapy (MST)	<p>MST is an intensive family- and community- based treatment that addresses the multiple determinants of serious antisocial behavior. MST clinicians use empirically validated approaches, such as cognitive-behavioral therapy and pragmatic family therapies, and typically provide individual and family counseling and 24-hour crisis management.</p>
Cognitive behavioral therapy (CBT)	<p>CBT emphasizes problem-solving skills and anger control/coping strategies.</p>
CBT & PMT	<p>Combines CBT and PMT.</p>
What Seems to Work	
Multidimensional treatment foster care	<p>Community-based program alternative to institutional, residential, and group care placements for use with severe chronic delinquent behavior; foster parents receive training and provide intensive supported treatment within the home.</p>
Not Adequately Tested	
Brief Strategic Family Therapy	<p>Counselors establish relationships with the family, then coach to reshape patterns of interpersonal interactions.</p>
Atypical antipsychotics medications	<p>Risperidone (Risperdal), quetiapine (Seroquel), olanzapine (Zyprexa), and aripiprazole (Abilify); limited evidence for effectiveness in youth with ID or ASD; primarily short-term use recommended.</p>
Stimulant or atomoxetine	<p>Methylphenidate, d-Amphetamine, atomoxetine; limited evidence when comorbid with primary diagnosis of ADHD.</p>
Mood stabilizers	<p>Divalproex sodium, lithium carbonate; limited evidence when comorbid with primary diagnosis of bipolar disorder.</p>
Selective serotonin reuptake inhibitors (SSRIs)	<p>Limited evidence when comorbid with primary diagnosis of depressive disorder; may also address aggression.</p>

What Does Not Work	
Boot camps, “military schools,” shock incarcerations	Ineffective at best; can lead to worsening of symptoms.
Dramatic, short-term, or talk therapy	Little to no effect as currently studied.

Severe and persistent cases of ODD that develop into CD may require an alternative placement when the safety of the youth and/or those around him or her are in jeopardy. Youth may require out-of-home placement when they require crisis management services or when their family is unable or unwilling to collaborate with treatment. When considering day treatment, residential treatment, or hospitalization, the least restrictive setting should be selected for the shortest possible time to ensure safety and progress. Other placements that may be considered are therapeutic foster care or respite care.

## RESOURCES AND ORGANIZATIONS

### American Academy of Child & Adolescent Psychiatry (AACAP)

Conduct Disorder Resource Center

[http://www.aacap.org/aacap/Families\\_and\\_Youth/Resource\\_Centers/Conduct\\_Disorder\\_Resource\\_Center/Home.aspx](http://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Conduct_Disorder_Resource_Center/Home.aspx)

Oppositional Defiant Disorder Resource Center

[http://www.aacap.org/aacap/Families\\_and\\_Youth/Resource\\_Centers/Oppositional\\_Defiant\\_Disorder\\_Resource\\_Center/Home.aspx](http://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Oppositional_Defiant_Disorder_Resource_Center/Home.aspx)

### American Psychiatric Association (APA)

<https://www.psychiatry.org/>

### American Psychological Association (APA)

<http://www.apa.org/>

### Association for Behavioral and Cognitive Therapies

<http://www.abct.org/Home/>

### Johns Hopkins Medicine

Conduct Disorder

<https://www.hopkinsmedicine.org/health/conditions-and-diseases/conduct-disorder>

### Mental Health America (MHA)

Fact Sheet on Conduct Disorder

<https://www.mhanational.org/conditions/conduct-disorder>

### Society of Clinical Child and Adolescent Psychology

<https://sccap53.org>

### Title IV-E Prevention Sources Clearinghouse

<https://preventionservices.acf.hhs.gov/>

## VIRGINIA RESOURCES AND ORGANIZATIONS

### Virginia Commonwealth University Health System

Department of Psychiatry

<https://psych.vcu.edu/>

Virginia Treatment Center for Children (VTCC)

<https://www.chrichmond.org/services/mental-health/virginia-treatment-center-for-children>

### Virginia Tech

Child Study Center

<http://childstudycenter.wixsite.com/childstudycenter>

Psychological Services Center

<https://support.psyc.vt.edu/centers/psc>

***The Collection of Evidence-based Practices for Children and Adolescents with  
Mental Health Treatment Needs, 9<sup>th</sup> Edition***  
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