BEEN CAUGHT STEALING: AN OVERVIEW OF THE ASSESSMENT AND MANAGEMENT OF DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

E. JO MASON, MD
CHILD AND ADOLESCENT PSYCHIATRY
PRISMA HEALTH- UPSTATE

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OBJECTIVES

- **To familiarize yourself with Disruptive, Impulse-Control, and Conduct Disorders in the DSM-5**
- **To understand the prevalence and demographics of these disorders**
- **To discuss diagnostic features, associated features, and development and course of these disorders**
- **To discuss risk and prognostic factors of each disorder**
- **To discuss differential diagnosis and comorbidities of each disorder**
- **To discuss psychopharmacology and psychotherapies for each disorder**

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CATEGORIZING IMPULSE-CONTROL DISORDERS THE DSM-5 WAY

- **DSM-5 created a new chapter : Disruptive, Impulse-Control, and Conduct Disorders.**
- **Brought together disorders previously classified as disorders usually first diagnosed in infancy, childhood, or adolescence (ODD and CD) and impulse-control disorders NOS.**
- **Disorders are unified by presence of difficult, disruptive, aggressive, or antisocial behavior.**
- **Often associated with physical or verbal injury to self, others, or objects or with violation of the rights of others.**
- **Behaviors can be defensive, premeditated, or impulsive.**

Grant JE, Leppink EW. Choosing a treatment for disruptive, impulse control, and conduct disorders: limited evidence, no approved drugs to guide treatment. Current Psychiatry. 2015;14(1):29-36.

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PREVALENCE

- **More common in males than females**
- **Have first onset in childhood or adolescence**
- **Lifetime prevalence :**
  - ODD 8.5%
  - CD 9.5%
  - IED 5.2%
  - Any ICD 24.8%
- **Despite a high prevalence in the general population, these disorders have been relatively understudied**
- **There are no FDA-approved medications for any of these disorders**

Kessler RC, Berglund P, Demler O, et al. Lifetime Prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005; 62(6): 593-602.

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DISRUPTIVE BEHAVIORS

- **The founding of juvenile court clinics in 1899 to deal with delinquents directly resulted in the creation of the child guidance movement and the establishment of child and adolescent psychiatry as a subspecialty.**
- **Disruptive Behavior Disorders are the most frequent referral problems for child and adolescent psychiatrists!**
- **Account for 1/3 to 1/2 of all cases seen in mental health clinics**
- ***Adult sociopathy is almost always preceded by disruptive behavior in childhood***

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DSM-5 DISORDERS

- **Oppositional Defiant Disorder (ODD)**
- **Intermittent Explosive Disorder (IED)**
- **Conduct Disorder (CD)**
- **Antisocial Personality Disorder**
- **Pyromania**
- **Kleptomania**
- **Other Specified Disruptive, Impulse-Control, and Conduct Disorder**
- **Unspecified Disruptive, Impulse-Control, and Conduct Disorder**

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OPPOSITIONAL DEFIANT DISORDER

"CONFLICT WITH AUTHORITY"

A. A pattern of angry or 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 touch or easily annoyed

3. Is often angry or 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

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: **DSM-5**. Washington, D.C: American Psychiatric Association.

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OPPOSITIONAL DEFIANT DISORDER

Vindictiveness

8. Has been spiteful or vindictive at least twice within the past 6 months

- **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.**

B. The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context, or it impacts negatively on social, education, 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, Moderate, Severe

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American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: **DSM-5**. Washington, D.C: American Psychiatric Association.

OPPOSITIONAL DEFIANT DISORDER

Diagnostic Features:

- **Conflict with authority**
- **A frequent and persistent pattern of angry/irritable mood**
- **Argumentative/defiant behavior**
- **Vindictiveness**

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: **DSM-5**. Washington, D.C: American Psychiatric Association.

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OPPOSITIONAL DEFIANT DISORDER

- **Symptoms may be confined to one setting (home)**
- **In more severe cases, there are symptoms in multiple settings**
- **Symptoms may not be apparent during clinical exam**
- **The persistence and frequency of the symptoms should exceed what is normative for an individual's age, gender, and culture.**
    - For example, it is not unusual for preschool children to show temper tantrums on a weekly basis.

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OPPOSITIONAL DEFIANT DISORDER

- **Temper tantrums for a preschool child would only be considered a symptom of ODD if :**
  - they occurred on most days for the preceding 6 months
  - they occurred with at least 3 others symptoms of the disorder
  - if the outbursts contributed to the significant impairment associated with the disorder
    - property destruction
    - child being asked to leave preschool

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IN THE NEWS – JANUARY 26, 2019

Plexus - GHS Intranet | 50,000 preschoolers are suspend

https://www.nbcnews.com/news/us-news/50-000-preschoolers-are-suspended-each-year-can-mental-health-n962691?fbclid=IwAR1YhQ_cLMKFsz7L1...

Apps | CITI | Inbox (285) | BCBS | AACAP | APA | JAACAP | Prescriptions | epocrates | Honda | Pelham Road | GHS Applications | FSA | Tuition Express

NEWS

POLITICS | U.S. NEWS | BUSINESS | WORLD | TECH & MEDIA | THINK | SPORTS

U.S. NEWS

50,000 preschoolers are suspended each year. Can mental health training for teachers make a difference?

Mental health consultants aim to equip early childhood teachers with the tools they need to curb suspension and expulsion rates in preschools.

4:11 PM
1/27/2019

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OPPOSITIONAL DEFIANT DISORDER

More prevalent :

- in families where child care is disrupted by a succession of different caregivers
- In families in which harsh, inconsistent, or neglectful child-rearing practices are common

Prevalence:

- Ranges from 1%-11%, which an average prevalence estimate of around 3.3%
- Somewhat more prevalent in males than in females (1.4:1)

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: **DSM**-**5**. Washington, D.C: American Psychiatric Association.

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OPPOSITIONAL DEFIANT DISORDER

Development and Course:

- **First symptoms usually appear during preschool years**
- **Rarely appear later than early adolescence**
- **Often precedes the development of conduct disorder**
- ***However, many children with ODD do not develop CD***
- **Children with ODD are at increased risk for problems in adjustment as adults, including:**
  - Antisocial behavior
  - Impulse-control problems
  - Substance abuse
  - Anxiety
  - Depression

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: **DSM-5**. Washington, D.C: American Psychiatric Association.

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OPPOSITIONAL DEFIANT DISORDER

Risk Factors

- **High levels of emotional reactivity**
- **Poor frustration tolerance**
- **Harsh, inconsistent, or neglectful child-rearing practices**

Functional Consequences of the Disorder

- **Frequent conflict with parents, teachers, supervisor, peers, and romantic partners**
- **Significant impairments in the individual's emotional, social, academic, and occupational adjustment**

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

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OPPOSITIONAL DEFIANT DISORDER

Comorbidity

- **ADHD (30-50% of children with ADHD are likely to have a disruptive behavior disorder)**
- **Often precedes CD**
- **Anxiety (Separation Anxiety, OCD)**
- **Depression**
- **Substance Use Disorders**

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PHARMACOTHERAPY FOR ODD

- **No medications are FDA-approved**
- **Stimulants are commonly used because of the high comorbidity with ADHD**
- Methylphenidate and d-amphetamine have shown some efficacy in trials of ODD and CD
- Improvement in oppositional symptoms may be secondary to improvement in ADHD symptoms

Grant JE, Leppink EW. Choosing a treatment for disruptive, impulse control, and conduct disorders: limited evidence, no approved drugs to guide treatment. Current Psychiatry. 2015;14(1):29-36.

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PHARMACOTHERAPY

- **Alpha-2 agonists have shown some efficacy in treating ODD**
  - Clonidine
  - Guanfacine (Tenex)

- **Atomoxetine (Strattera) has been studied for ODD, but its efficacy is limited.**
  - Improvement in oppositional symptoms may be secondary to improvement in ADHD symptoms

- **Antipsychotics have also been used, with the largest body of research suggesting that Risperdal has some efficacy**

  Risperdal is 2nd or 3rd line because of the adverse SE

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PSYCHOLOGICAL TREATMENTS

- **Behavior modification therapy**
- **Parent-Child Interaction therapy**
  - Emphasize skills to manage outbursts and erratic emotionality
- **Emotion regulation , behavior, and social skills training**
- **Family/teacher training programs**
  - Helping the Noncompliant Child
  - **Triple P**
    - These programs focus on ways to manage oppositional behavior at home and in the classroom
    - Focus on strategies to limit positive reinforcement for problem behaviors
- **Group Programs**
  - "Incredible Years" program
  - Community Parent Education Program

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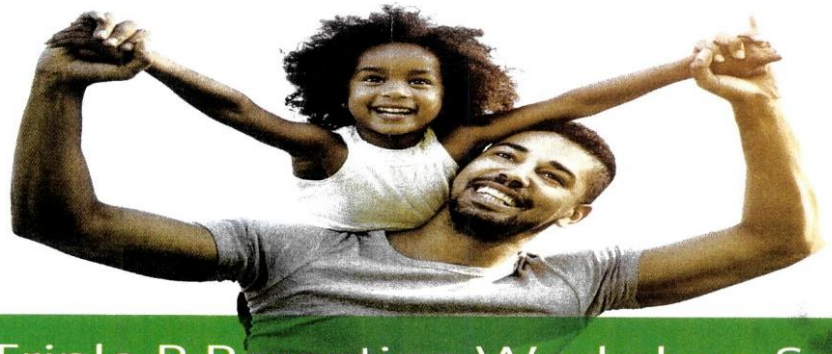

Triple P Parenting Workshop Series

Happier Families. Better Relationships. Successful Kids.

JULIE VALENTINE center

Triple P Postive Parenting Program is a parenting program, but it doesn't tell you how to be a parent. It's more like a toolbox of ideas. You choose the strategies you need. You choose the way you want to use them.

Group discussion sessions led by a trained parent advocate provide parents with a flexible, practical way to develop skills, strategies and confidence to handle any parenting situation.

Triple P helps you:

- Raise happy, confident kids
- Manage misbehavior so the whole family enjoys life more
- Set rules and routines that everyone respects and follows
- Encourage behavior you like
- Take care of yourself as a parent
- Feel confident you're doing the right thing

FREE group sessions take place at the West Greenville Community Center, 8 Rochester St., Greenville. On-site childcare is available.

To register, call Jessica Herron at **(864) 331-0560, ext. 231**.

GHS Children's Hospital
Greenville Health System
Bradshaw Institute for Community Child Health & Advocacy

ghs.org

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INTERMITTENT EXPLOSIVE DISORDER

A. Recurrent behavioral outbursts representing a failure to control aggressive impulses as manifested by either of the following:

1. Verbal aggression 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 results 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 outbursts are not premeditated and are not committed to achieve some tangible objective.

D. The outbursts cause either marked distress in the individual or impairment in occupational or interpersonal function, or are associated with financial or legal consequences.

E. Chronological age is at least 6 years (or equivalent developmental level).

F. The outbursts are not better explained by another mental disorder.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: **DSM-5**. Washington, D.C: American Psychiatric Association.

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INTERMITTENT EXPLOSIVE DISORDER

Prevalence:

- One-year prevalence in the US is about 2.7%.
- Lifetime prevalence of 7%.
- 6.3% of a community sample met criteria for lifetime IED*
- More prevalent among younger individuals (younger than 35-40 years)
- More prevalent in individuals with a HS education or less
- Men account for 80% of the cases

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: **DSM-5**. Washington, D.C: American Psychiatric Association.

*Coccaro EF, Schmidt CA, Samuels JF, et al. Lifetime and 1-month prevalence rates of intermittent explosive disorder in a community sample. J Clin Psychiatry. 2004;65(6):820-824.

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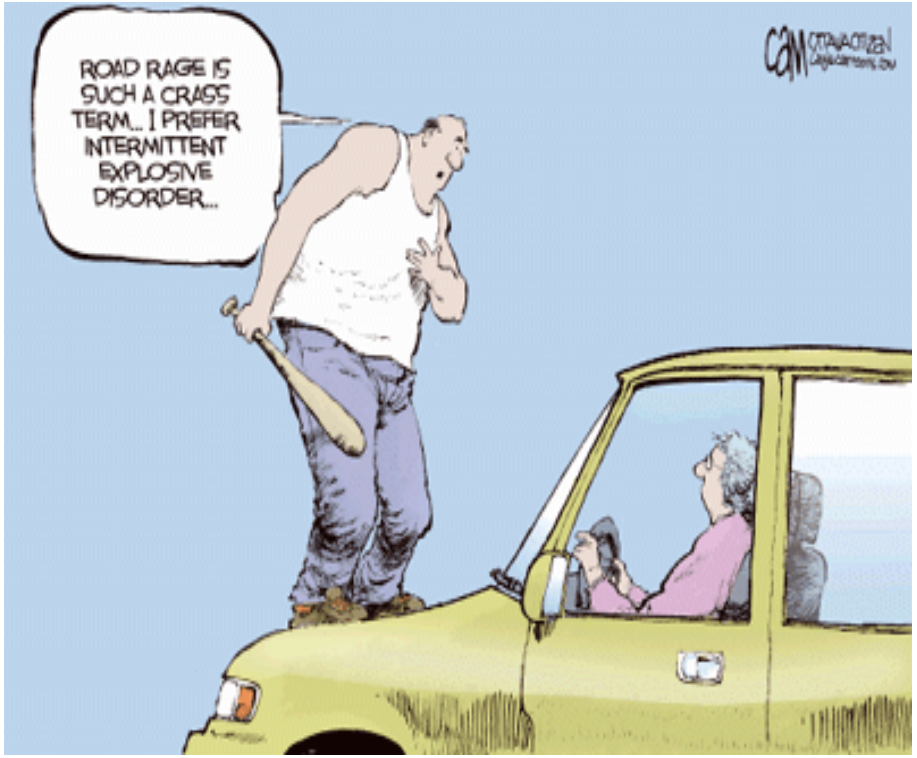
DIFFERENTIAL DIAGNOSIS

- **General medical conditions: Dementia, Delirium, Personality change due to medical condition**
- **Substance intoxication or withdrawal**
- **Delusion-Driven Behavior: Schizophrenia, Schizoaffective, Depression with psychotic features, Delusional Disorder**
- **Elevated Mood: Mania, Schizoaffective Disorder**
- **Depressed Mood: Depression, Bipolar, Schizoaffective Disorder**
- **Pattern of Antisocial Behavior: ASPD or Conduct Disorder**
- **Pattern of Impulsivity by Early Adulthood: BLPD, DMDD, ODD, Inattention, ADHD**
- **Other Conditions: Paraphilias, Autism, Eating Disorders, Adjustment Disorders, Other Impulse Control Disorders**



INTERMITTENT EXPLOSIVE DISORDER

Development and Course:

- Onset most common in late childhood or adolescence (mean onset 13-21 years)
- Rarely begins for the first time after age 40
- IED carries significant morbidity – 180 related injuries per 100 lifetime cases

Risk and Prognostic Factors:

- History of physical and emotional trauma during first 2 decades of life
- First-degree relatives of individuals with IED are at increased risk
- Twin studies have shown a substantial genetic influence
- Neurobiological support for the presence of serotonergic abnormalities, specifically in the areas of the limbic system (anterior cingulate) and orbitofrontal cortex
- Amygdala responses to anger stimuli, during MRI, are greater in individuals with IED

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PHARMACOTHERAPY

Data comes from a small set of double-blind studies shown in this table →

- **Prozac – produced a sustained reduction in aggression and irritability as early as the second week**
- Trileptal/Oxcarbazepine – significant improvements in symptoms – especially impulsive aggression
- Depakote – no significant difference from placebo

Table

Trials[a] of medication for disruptive, impulse-control, and conduct disorders

Impulse-control disorder[b]	Medication	Design, duration	Subjects	Mean daily dosage (±SD)	Outcome
Intermittent explosive disorder (IED)					
Coccaro et al, 2009[23]	Fluoxetine	Parallel design, 12 weeks	100 enrolled, 55 completers	29.8 (± 12.6) mg for responders	Fluoxetine group showed sustained reduction in symptoms
Hollander et al, 2003[24]	Divalproex	Parallel design, 12 weeks	109 subjects, No data on % completers (IED)	1,567 mg	Similar improvement in IED and placebo
Mattes, 2005[25]	Oxcarbazepine	Parallel design, 10 weeks	48 enrolled, 24 completers (45 with at least 4 weeks)	1500 (± 630) mg	Oxcarbazepine group showed significant reduction in symptoms
Mattes, 2008[27]	Levetiracetam	Parallel design, 10 weeks	40 enrolled, 19 completers (34 with adequate trial)	2313 (± 854) mg	No improvement compared with placebo
Conduct disorder					
Campbell et al, 1984[28]	Lithium vs haloperidol vs placebo	Parallel design, 6 weeks	82 enrolled, 61 completers	Lithium: 500 to 2,000 mg; Haloperidol: 1.0 to 6.0 mg	Both active groups showed improvement across measures
Campbell et al, 1995[30]	Lithium vs placebo	Parallel design, 10 weeks	79 enrolled, 50 completers	600 to 1,800 mg	Lithium showed improvements in aggression symptoms
Malone et al, 1998[31]	Lithium vs placebo	Parallel design, 6 weeks	40 enrolled, 40 completers	1425 (± 321) mg	Explosive aggression showed greater response vs predatory aggression
Malone et al, 2000[32]	Lithium vs placebo	Parallel design, 6 weeks	86 enrolled, 40 completers	1,425 (± 321) mg	Lithium group had greater reduction of aggression symptoms
Platt et al, 1981[33]	Lithium vs haloperidol vs placebo	Parallel design, 6 weeks	30 enrolled, 27 completers	1.5 to 6 mg	Both active groups showed some cognitive deficits
Platt et al, 1984[34]	Lithium vs haloperidol vs placebo	Parallel design, 6 weeks	82 enrolled, 61 completers	Lithium: 1,000 to 2,000 mg; Haloperidol: 1.0 to 6.0 mg	Both active groups showed some cognitive deficits
Rifkin et al, 1997[35]	Lithium vs placebo	Parallel design, 2 weeks	33 enrolled, 26 completers	0.6 to 1.0 mmol/L	No significant change on aggression measure
Cueva et al, 1996[36]	Carbamazepine vs placebo	Parallel design, 6 weeks	24 enrolled, 22 completers	400 to 800 mg	No significant differences by group in regard to aggression
Findling et al, 2003[37]	Risperidone vs placebo	Parallel design, 10 weeks	20 enrolled, 9 completers (4 lost from active group)	0.75 to 1.50 mg	Active group improved across measures
Connor et al, 2008[38]	Quetiapine vs placebo	Parallel design, 7 weeks	19 enrolled, 8 completers (1 lost from active group)	294 ± 78 mg	Active group improved across measures
Greenhill, 1985[39]	Molindone vs thioridazine	Parallel design, 9 weeks	31 enrolled	Molindone: 27 mg; Thioridazine: 170 mg	Aggressive symptoms improved in both groups
Khanzode et al, 2006[40]	High-dose divalproex vs low-dose	Parallel design, 7 weeks	71 enrolled; intent to treat analysis	500 to 1500 mg or ≥250	Depression and impulse control improved in high-dosage group
Padhy et al, 2011[41]	High-dose divalproex vs low-dose	Parallel design, 7 weeks	70 enrolled, 61 completers	500 to 1500 mg or ≥250	High-dosage group showed greater improvement
Steiner et al, 2003[42]	High-dose divalproex vs low-dose	Parallel design, 7 weeks	71 enrolled; intent-to-treat analysis	500 to 1500 mg or ≥250	Moderate improvements on impulse control
Klein et al, 1997[43]	Methylphenidate vs placebo	Parallel design, 5 weeks	83 enrolled, 74 completers	41.3 mg (no SD provided)	Active group improved across measures
Kleptomania					
Grant et al, 2009[20]	Naltrexone	Parallel design, 8 weeks	25 enrolled, 23 completers	116.7 (± 44.4) mg	Naltrexone significantly superior to placebo
Koran et al, 2007[21]	Escitalopram	Mixed method	15 assigned to blinded termination	20 mg	No improvement compared with placebo for preventing relapse

[a]Double-blind, placebo-controlled
[b]No controlled studies have assessed treatment of pyromania or oppositional defiant disorder independent of comorbid diagnoses
SD: standard deviation

Grant JE, Leppink EW. Choosing a treatment for disruptive, impulse control, and conduct disorders: limited evidence, no approved drugs to guide treatment. Current Psychiatry. 2015;14(1):29-36.

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PSYCHOLOGICAL TREATMENTS

- **CBT**
- **Group Therapy**
  - Significant improvements spanning several target symptoms of IED
  - Reduces symptom severity

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CONDUCT DISORDER

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 3 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:

<u>Aggression to People and Animals</u>

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**
4. **Has been physically cruel to people**
5. **Has been physically cruel to animals**
6. **Has stolen while confronting a victim**
7. **Has forced someone into sexual activity**

<u>Destruction of Property</u>

8. **Has deliberately engaged in fire setting with the intention of causing serious damage**
9. **Has deliberately destroyed others' property (other than fire setting)**

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

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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**
12. **Has stolen items of nontrivial value without confronting a victim**

Serious Violations of Rules

13. **Often stays out at night despite parental prohibitions, beginning before age 13**
14. **Has run away from home overnight at least twice while living in the parental home, or once without returning for a lengthy period**
15. **Is often truant from school, beginning before age 13**

B. **The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.**

C. **If the individual is age 18 or older, criteria are not met for antisocial personality disorder.**

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

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CONDUCT DISORDER

Prevalence:

- **One-year population prevalence estimates range from 2% to more than 10%, with a median of 4%.**
- **Prevalence rates rise from childhood to adolescence**
- **Prevalence rates are higher among males than females**
- **Few children with impairing conduct disorder receive treatment**

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

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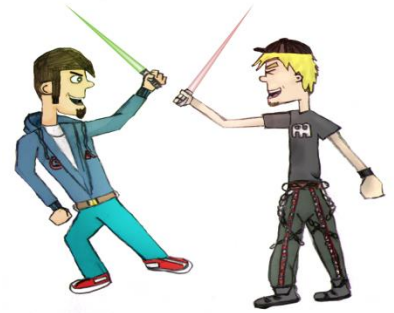
CONDUCT DISORDER



Development and Course:

- **Onset may occur as early as the preschool years**
- **First symptoms usually occur from middle childhood – middle adolescence**
- **ODD is a common precursor**
- **Onset is rare after the age of 16**
- **In a majority of individuals, the disorder remits by adulthood**
- **More favorable outcome in adolescent-onset CD**
- **Worse prognosis in early-onset → increased risk of criminal behavior, conduct disorder, and substance use disorders in adulthood**

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CONDUCT DISORDER

RISK AND PROGNOSTIC FACTORS:

- **Difficult, under-controlled infant temperament**
- **Lower-than-average intelligence, particularly verbal IQ**
- **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**
- **Peer rejection**
- **Association with a delinquent peer group**
- **Neighborhood exposure to violence**
- **Genetic and environmental factors**
  - Slower resting heart rate
  - Reduced autonomic fear conditioning
- **Children with a biological or adoptive parent or a sibling with conduct disorder**
- **Biological parents with:**
  - Severe alcohol use disorder
  - Depressive and bipolar disorders
  - Schizophrenia
  - History of ADHD or conduct disorder

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

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PHARMACOTHERAPY

- **No medication is FDA-approved**
- **7 studies have shown efficacy with lithium**
  - A number of trials assessing lithium also included a treatment condition with Haldol, which showed significant improvement.
  - Both lithium and haloperidol were associate with cognitive deficits
- **Preliminary double-blind results have indicated that these meds might be effective in treating CD, <u>but evidence is limited and additional studies are needed:</u>**
  - Methylphenidate
  - Risperidone
  - Quetiapine
  - Carbamzepine
- **3 studies of Depakote have shown some efficacy**

  These studies did not include a placebo group, so additional studies are necessary to corroborate these findings.

Grant JE, Leppink EW. Choosing a treatment for disruptive, impulse control, and conduct disorders: limited evidence, no approved drugs to guide treatment. Current Psychiatry. 2015;14(1):29-36.

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PSYCHOLOGICAL TREATMENTS

- **Behavioral Therapy**
- **Family-Based Therapy**
- **School-Based Therapy**
- **Parental skills training**
  - To focus on parents' skill acquisition to help manage outbursts and aggressive behavior.

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KLEPTOMANIA

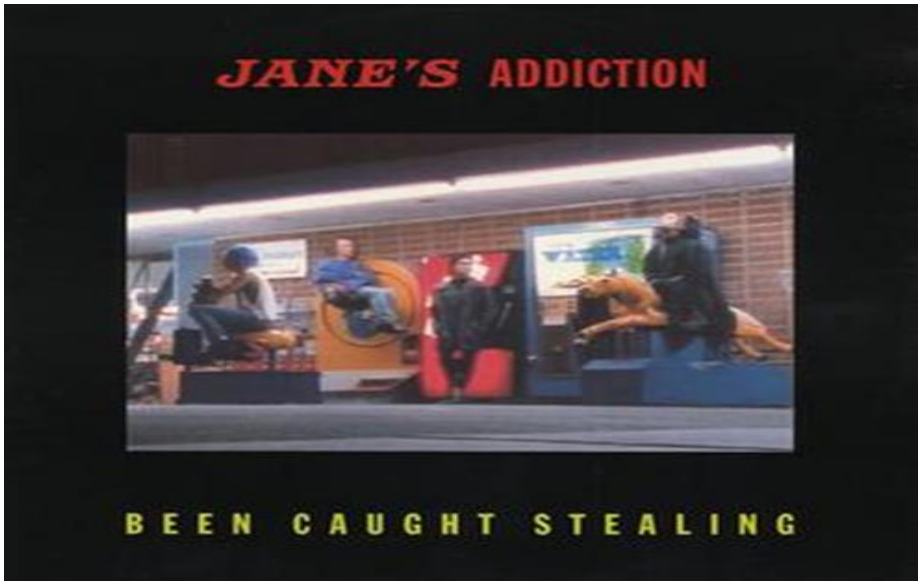
A. **Recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value.**

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 explained by conduct disorder, a manic episode, or antisocial personality disorder.**



I've been caught stealing

Once when I was 5

I enjoy stealing

It's just as simple as that

Well, it's just a simple fact

When I want something,

I don't want to pay for it

I walk right through the door

Walk right through the door

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

DIFFERENTIAL DIAGNOSIS

- **Criminal acts of shoplifting/stealing**
- **Malingering to avoid prosecution**
- **Antisocial Personality Disorder**
- **Conduct Disorder**
- **A manic episode**
- **Schizophrenia**
- **Dementia**

PRISMA HEALTH

KLEPTOMANIA

Prevalence:

- **Occurs in only about 4%-24% of individuals arrested for shoplifting**
- **Prevalence in the general populations is very rare – 0.3% -0.6%**
- **Females > males at a ratio of 3:1**

Development and Course:

- **Often begins in adolescence**
- **May continue with intermittent episodes of stealing for years**
- **64%-84% have been arrested for stealing ***
- **15%-23% have been incarcerated ****

- *McElroy SL, Pope HG Jr, Hudson JI, et al. Kleptomania: a report of 20 cases. Am J Psychiatry. 1991; 148(5): 652-657.
- **Grant JE, Kim SW. Clinical characteristics and associated psychopathology of 22 patients with kleptomania. Compr Psychiatry. 2002; 43(5): 378-384.

Grant JE. Leppink EW. Choosing a treatment for disruptive, impulse control, and conduct disorders: limited evidence, no approved drugs to guide treatment. Current Psychiatry. 2015;14(1):29-36.

PRISMA HEALTH

KLEPTOMANIA

Risk and Prognostic Factors:

- **First –degree relatives of individuals with kleptomania may have higher rates of OCD than the general population**
- **Higher rates of substance use disorders in relatives of individuals with kleptomania**

Comorbidity:

- **Compulsive buying**
- **Depressive and Bipolar disorders**
- **Anxiety Disorders**
- **Eating Disorders**
- **Personality Disorders**
- **Substance use disorders (EtOH)**
- **Other disruptive, impulse-control, and conduct disorders**

PRISMA HEALTH

PHARMACOTHERAPY

- **Most of the literature is based on case series and anecdotal reports**
- **Show benefit in some patients**
  - Tricyclic antidepressants
  - SSRIs
  - Anticonvulsants (topiramate)
  - Anxiolytics

- **Only 1 randomized, placebo-controlled study of pharmacotherapy for kleptomania**
  - Used oral naltrexone 50mg -150mg/day
  - Naltrexone significantly superior to placebo
  - Reduces stealing **urges** and **behaviors**

- **Lexapro showed no improvement compared to placebo for preventing relapse**
- **Pilot study using the NMDA receptor antagonist memantine has positive results in reducing stealing behaviors and improving mood and functioning***
- **One treatment resistant case showed complete remission using the catechol-O-methyltransferase (COMT) inhibitor, tolcapone**
  - Thought to improve executive functioning

***Grant JE et al. Assessment and treatment of kleptomania. *The Oxford handbook of impulse control disorders,* New York, 2012, Oxford University Press.**

Grant JE, Leppink EW. Choosing a treatment for disruptive, impulse control, and conduct disorders: limited evidence, no approved drugs to guide treatment. Current Psychiatry. 2015;14(1):29-36.

PRISMA HEALTH

PHARMACOTHERAPY

- **No controlled studies, only case reports**
- **Case reports suggest that insight-oriented psychotherapy and cognitive and behavioral therapies might be effective.**

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 circumstance, in response to a delusion or 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.**

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

PRISMA HEALTH

PYROMANIA

Prevalence:

- **Lifetime prevalence of fire setting, was reported as 1.13% in a populations sample**
- **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:

- **Insufficient data to establish a typical age of onset**
- **Mean age of onset is usually late adolescence**
- **Course is chronic if untreated**
- **Fire-setting incidents are episodic and may wax and wane in frequency**
- **Occurs much more often in males – especially those with poorer social skills and learning difficulties**

Grant JE, Leppink EW. Choosing a treatment for disruptive, impulse control, and conduct disorders: limited evidence, no approved drugs to guide treatment. Current Psychiatry. 2015;14(1):29-36.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

PHARMACOTHERAPY AND PSYCHOLOGICAL TREATMENTS

- **No FDA-approved medications**
- **No randomized, controlled clinical trials examining pharmacotherapy**
- **In case reports, meds that have shown benefit include:**
  - Topiramate
  - Escitalopram
  - Sertraline
  - Fluoxetine
  - Lithium
  - Combination of olanzapine and sodium valproate
- **A case report of an 18yo male with pyromania described successfully using a combination of topiramate and CBT to achieve significant symptom improvement.**

Grant JE, Leppink EW. Choosing a treatment for disruptive, impulse control, and conduct disorders: limited evidence, no approved drugs to guide treatment. Current Psychiatry. 2015;14(1):29-36.

ANTISOCIAL PERSONALITY DISORDER

A. Disregard for and violation of others rights since age 15, as indicated by one of the seven sub features:

- **Failure to obey laws and norms by engaging in behavior which results in criminal arrest, or would warrant criminal arrest**
- **Lying, deception, and manipulation, for profit or self-amusement,**
- **Impulsive behavior**
- **Irritability and aggression, manifested as frequently assaults others, or engages in fighting**
- **Blatantly disregards safety of self and others,**
- **A pattern of irresponsibility and**
- **Lack of remorse for actions**

The other diagnostic Criterion are:

B. The person is at least age 18

C. Conduct disorder was present by history before age 15

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ANTISOCIAL PERSONALITY DISORDER VERSUS CONDUCT DISORDER

- **In contrast to the diagnosis of adult antisocial personality disorder, all of the diagnostic criteria for CD are observable, objective behaviors rather than inferred, internal constructs, such as lack of remorse.**
- **Repeated studies have found the CD behaviors to be reliable and valid criteria in identifying those youth at *greatest risk for continued antisocial behavior***
- **When CD does appear in children with ADHD, the antisocial behaviors are more severe and appear earlier than in children without ADHD.**
- **About 40% of those diagnosed with CD go on to have antisocial personality disorder.**

PRISMA HEALTH

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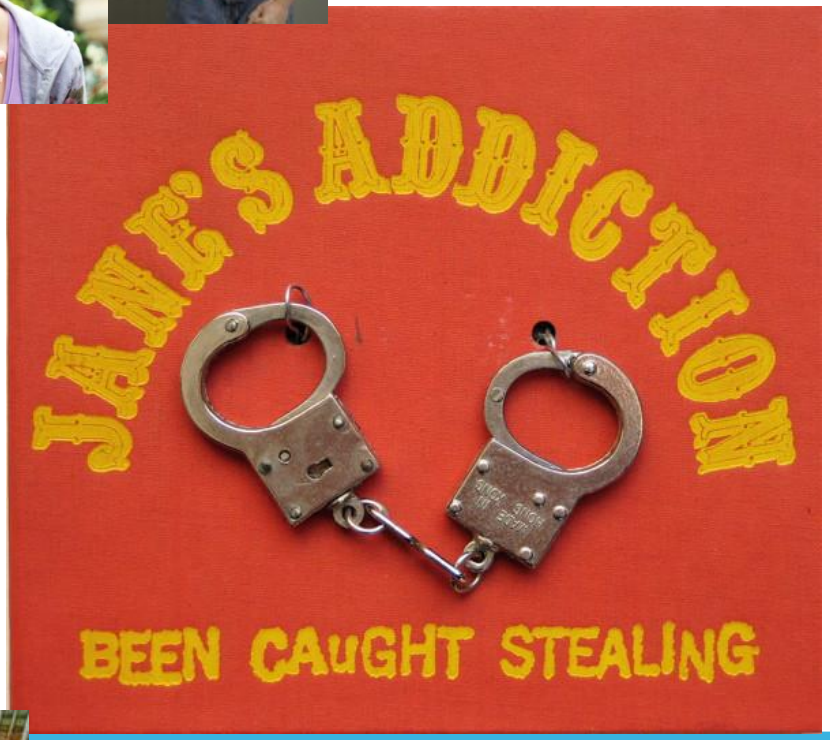
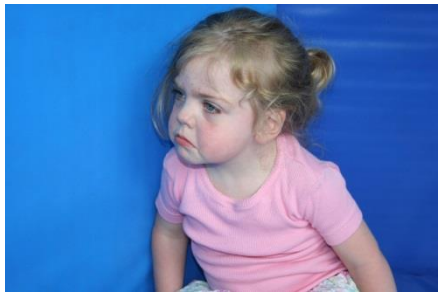
QUESTIONS?





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