DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

Conduct Disorder

CD

DSM-5-TR 312.81-312.89 | ICD-10-CM F91.1, F91.2, F91.9

Repetitive violation of the basic rights of others or of major age-appropriate societal norms, rules, and laws.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~2-10% (median ~4%)	Childhood or adolescent onset	~2-3:1 male:female	~40% develop antisocial PD

CLINICAL PICTURE

- Aggression toward people and animals including bullying, fighting, weapon use, cruelty, robbery, and forced sexual activity.
- Deliberate property destruction through fire setting or vandalism intended to cause substantial damage or loss to others.
- Deceitfulness and theft, including breaking and entering, conning others for goods or favors, and shoplifting without confrontation.
- Serious rule violations such as staying out at night before age 13, running away overnight, and chronic truancy from school.
- The limited prosocial emotions phenotype shows shallow affect, absent remorse, callous use of others, and unconcern about performance.
- Presentation commonly includes early substance use, early sexual activity, school exclusion, and juvenile justice system contact.

DIAGNOSTIC CRITERIA AT A GLANCE

- Requires three or more of fifteen criteria within the past 12 months, with at least one criterion present in the past 6 months.
- Criteria span four clusters: aggression to people and animals, destruction of property, deceitfulness or theft, and serious rule violations.
- Specify childhood-onset type when a criterion is present before age 10, adolescent-onset type, or unspecified onset when timing is unknown.
- Specify with limited prosocial emotions when two or more callous-unemotional features persist across settings for at least 12 months.
- Severity is rated mild, moderate, or severe based on the number of symptoms and the degree of harm caused to other people.

NEUROBIOLOGY & PHYSIOLOGY

- Reduced amygdala reactivity to fearful faces and impaired fear conditioning characterize the callous-unemotional subtype.
- Reduced gray matter in ventromedial prefrontal cortex, orbitofrontal cortex, and anterior insula tracks antisocial behavior severity.
- Low resting heart rate is among the best-replicated biological correlates of antisocial and aggressive behavior in youth.
- A hypoactive HPA axis with blunted cortisol reactivity and altered serotonergic function is linked to impulsive aggression.
- Heritability is roughly **50%** and higher for callous-unemotional traits, with strong gene-by-environment interplay throughout development.
- Childhood maltreatment, prenatal substance exposure, and lead exposure interact with genotype, including MAOA variants, to raise risk.

PSYCHOLOGICAL MECHANISMS

- Social information processing biases include hostile attributions, limited response generation, and positive outcome expectancies for aggression.
- Coercive family process combined with deviant peer affiliation supplies both the training and the reinforcement for antisocial acts.
- Callous-unemotional youth show reward-dominant responding and poor punishment learning, which blunts standard consequence-based discipline.
- Reactive aggression follows perceived threat and provocation, whereas proactive aggression is planned, goal-directed, and instrumental.
- Group treatment that aggregates delinquent peers risks deviancy training and iatrogenic worsening of antisocial behavior.

DIFFERENTIAL & COMORBIDITY

- **ODD** lacks aggression, destruction, deceit, and serious rule violations, while intermittent explosive disorder lacks the nonaggressive criteria.
- Bipolar disorder, psychosis, PTSD, and substance intoxication can produce aggression without the chronic pervasive antisocial pattern.
- **ADHD** co-occurs in 30-50%, substance use disorders rise sharply in adolescence, and depression is common and raises suicide risk.
- Screen for trauma exposure, exploitation, gang involvement, firearm access, and fire setting at every assessment contact.
- Suicide attempts, homicide, serious injury, and premature mortality are all elevated well above general population rates.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No agent is approved for conduct disorder itself; medication targets comorbidity and severe aggression rather than the diagnosis.
- **Risperidone 0.5-3 mg/day** has the strongest evidence for severe aggression; monitor weight, lipids, glucose, and prolactin.
- Stimulants for comorbid **ADHD** reduce aggression with moderate to large effect and should be optimized before any antipsychotic.
- **Lithium** and **valproate** have limited support for impulsive aggression and require serum levels and hepatic or renal monitoring.
- Treat substance use disorders directly, since ongoing use undermines essentially every psychosocial intervention attempted.

PSYCHOTHERAPY

- **Multisystemic therapy**, delivered in home over 3-5 months with low caseloads, reduces reoffending and out-of-home placement.
- **Functional family therapy** across 12-16 sessions targets family communication and reduces recidivism in justice-involved adolescents.
- **Multidimensional Treatment Foster Care** outperforms group residential care for severe, chronically offending adolescents.
- **Parent management training** and **PCIT** remain first line for childhood-onset cases in children under about age 12.
- Avoid aggregating antisocial youth in unsupervised groups, boot camps, and scared-straight programs, which can worsen outcomes.

ADJUNCT & SUPPORTIVE

- Assess with the **CBCL**, callous-unemotional measures such as the **ICU**, and structured violence risk tools such as the **SAVRY**.
- Coordinate care across school, juvenile justice, and child welfare systems, since fragmented plans reliably predict treatment failure.
- Educational placement, vocational training, and sustained mentoring build alternatives to antisocial sources of reinforcement.
- Restrict firearm access, address neighborhood violence exposure, and structure unsupervised after-school and evening hours.
- Reserve residential care for imminent safety risk, prioritizing family-based and community-based alternatives whenever feasible.

CLINICAL PEARLS

- Childhood onset with callous-unemotional traits predicts the worst trajectory.
- Family- and community-based care beats group residential care for antisocial youth.
- Treat ADHD and substance use; both amplify aggression and undermine therapy.

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NOTE

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