The Wiley Handbook of Disruptive and Impulse-Control Disorders
The Wiley Handbook of Disruptive and Impulse-Control Disorders

Edited by

John E. Lochman

and

Walter Matthys

WILEY Blackwell
To Linda and Paula and to our children and grandchildren:
Lisa, Kara, Bryan, Garrett, Audrey, Jonathan, Lori, Ine, Joost, 
Bram, Ellen, and Dorien
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Part 1

Introduction to the Handbook
In this introductory chapter, we will provide a general description of the diagnostic conditions that are the focus of this book—Disruptive Behavior Disorders (DBDs; namely Oppositional Defiant Disorder and Conduct Disorder), Intermittent Explosive Disorder (IED), and Impulse-Control Disorders (Pyromania and Kleptomania), see Chapters 2, 3, and 6 for full descriptions of them. Although there are some obvious behavioral links across these disorders, they also, as will become apparent in subsequent chapters, have some important differences. DSM-5, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 2013), included this set of disorders within one chapter, and we have decided to follow that convention for the The Wiley Handbook of Disruptive and Impulse-Control Disorders. This chapter will also include a brief background to the history of diagnostic classification and its purposes, explain our key assumptions, which are the basis for how the Handbook addresses these forms of psychopathology, and provide an overview of how the chapters are structured into the book’s main sections.

The Handbook is designed to survey and integrate the most important and the most recent scholarship and research on these disruptive and impulse-control disorders in children and adolescents. Each chapter will contain a synthetic overview of the accumulated research in the area in question and identify important next directions for research. The chapters will thus serve as a stimulant for new advances in our understanding of the source, course, and treatment of these disorders. Key researchers have authored the chapters in this volume, and comment on the research methods being employed in each area, as well as the outcomes and implications of the findings. An overriding emphasis throughout the book is to comment on the applied “real-world” value of the accumulated research findings, and in that sense, the Handbook is expected to spur policy implications and recommendations.
**DBDs, IED, and Impulse-Control Disorders**

This set of disorders is primarily characterized by behaviors that adversely affect the well-being and safety of others. The three main types of behavioral problems evident in the criteria for the disorders are: (a) markedly defiant, disobedient, provocative behavior; (b) major violations of either the basic rights of others or of age-appropriate societal norms and rules, and (c) explosive episodes of aggression. Explosive aggressive behavior may involve violence toward people or animals, destruction of property, or overtly threatening behavior that is markedly out of proportion to any stressor, frustration, or provocation that might have preceded the episode. Many youth commit an isolated illegal act at some point, but this does not warrant the designation “conduct disorder.”

Although the disorders (DBDs, IED, Impulse-Control Disorders) addressed in this *Handbook* involve problems in behavioral and emotional regulation, the disorders vary in the degree of these two areas of dysregulation. Conduct Disorder is defined by criteria that primarily address poorly controlled behaviors that violate societal norms, although some of the behavioral symptoms may be due to poor emotional control of anger. IED represents the other extreme, as the IED criteria primarily involve poorly controlled emotion, and Oppositional Defiant Disorder (ODD) lies in between, as the criteria are more evenly distributed between emotional and behavioral dysregulation. Pyromania and Kleptomania are relatively rare disorders that are diagnosed as poor impulse control that leads to the periodic behaviors (fire setting and stealing) that serve to relieve internal tension when expressed. This set of disorders tends to have first onset in childhood or adolescence. Many of the symptoms defining these disorders can occur in some degree in typically developing individuals, so a critically important step in diagnosis is to determine that the frequency, persistence, pervasiveness across situations, and impairment resulting from the behaviors is substantially different than what would be expected normatively for a child of the same age, gender, and culture.

The disorders described in this book have been linked to a common externalizing spectrum (e.g., Krueger & South, 2009; Witkiewitz et al., 2013) related to a disinhibited personality dimension (see Chapter 6 of this *Handbook* for a discussion of personality disorders), and to a lesser extent to negative emotionality. These personality dimensions may partially cause the high rates of comorbidity between these disorders and other conditions such as substance abuse (see Chapter 5 for a full discussion of this comorbidity). Disruptive behavior disorders may arise in individuals with some other serious underlying mental disorder; in those cases both should be diagnosed if the diagnostic criteria are met. However, a separate diagnosis of a DBD, IED or impulse-control disorder is not warranted if the disruptive behavior is limited to episodes of some other mental disorder (such as mania or depression) and where the other mental disorder can reasonably be viewed as primary.

**Background on Diagnostic Classification and its Purposes**

Before we embark on the description and treatment of the disruptive behavior disorders and their close relatives (IED and impulse-control disorders) throughout this *Handbook*, it is useful to think about the history and issues involved in psychiatric diagnoses in general (Fabrega, 1996, 2001; Pincus & McQueen, 2002). Early efforts to classify human problems started as human civilizations became more established, and people became attentive to the types of physical and emotional difficulties that were evident in themselves and their peers. The earliest known efforts by humans to classify mental disorders as they perceived them among their fellow humans included Egyptian and Sumarian references to senile dementia, melancholia, and hysteria evident in writings prior to 2000 B.C. In the fifth century
before Christ, Hippocrates and his followers developed what could be regarded as the first classification system for mental illnesses. This system included classification of melancholia, paranoia, phobias, phrenitis, mania, epilepsy, and Scythian disease (transvestism). These disorders were presumed to be due to different imbalances of the four humors. Hippocrates’ system placed these disorders within the medical domain, and was based on observation of patients, in contrast to the logical approach to categorization of mental disorders used by Plato, which distinguished between rational and irrational forms of madness that were created when the rational and irrational souls were separated.

On the other side of the world, the early history of the Mayan culture in the Americas also indicates that they identified several psychiatric syndromes in the period 500–100 B.C. Our understanding of the classification of mental disorders within the later Incan culture largely comes from Spanish chronicles, but suggests that differentiations were being made between anxiety, insanity (e.g., Utek cay), melancholy (e.g., Putirayay), and hysteria (Elferink, 1999). As with modern classification systems, these early descriptions of emotional and mental maladies led to intervention efforts, including efforts by Mayan priests to intervene with gods such as Ixchel, the patroness of medicine. A number of plants were used by Incans and pre-Incans to treat depression, including the seeds of the vilca tree, which has hallucinogenic properties, and the china root, which is still used in folk medicine today.

Mental disorders were thought in the ancient world to be the result of supernatural phenomena, and the mentally ill were scorned and feared. Children with mental or physical handicaps were viewed as sources of economic burden and embarrassment, and were often abandoned and sometimes put to death. In the Western world, advances in classification of mental illnesses were slow in the millennia after the Greek and Roman philosophers. Innovations in classification did not substantially develop until the seventeenth century. A function of these evolving classification systems was to move from assuming that causes of disorders were supernatural to determining the natural causes of diseases.

Thomas Sydenham (1624–1663), who has been characterized as the “English Hippocrates” and “father of modern medical thinking,” emphasized careful clinical observation and diagnosis of patients, and pioneered the idea of syndromes in which associated symptoms would have a common course (Dewhurst, 1966). Sydenham described how different individuals with the same disease would have similar symptom presentations, and that there were different causes for different disorders. Sydenham’s approach suggested that classification of mental disorders could be approached best through systematic observation and description of symptom patterns. This descriptive approach to classification became increasingly accepted by professional groups, as evident in Jean Columbier and Francois Doublet’s publication of Instruction sur la manière de gouverner les insensés . . . in psychiatry in 1785, which involved information compiled from, and sanctioned by, a group of French physicians who were treating the mentally ill. The categories of mental illness described in this book included ones that were, in fact, similar to categories suggested by Hippocrates thousands of years earlier (mania, melancholy, frenzy, stupidity). Subsequent descriptive classification systems by Pinel and Jean-Etienne Esquirol identified finer distinctions within disorders, and were the first to use terms like “remission” to describe the course of mental illness.

However, this taxonomic system, which had evolved from the botanical sciences, was largely abandoned in the nineteenth century in favor of an anatomical-clinical approach which described the course of diseases and the accompanying brain lesions. The work of Bale, and especially of Greisinger, was particularly important in this effort to develop a classification system that incorporated then prevalent understandings of the cause of the disease. They believed that all mental disorders had an underlying physical cause that originated in the brain. Emil Kraepelin took the next step at the end of the nineteenth century and proposed that a classification system could be developed on the basis of etiology,
symptomatology, and course of disorder. Contemporary classification systems have evolved from these predecessors, and the ICD and DSM are generally compatible systems of classification of mental disorders.

International Classification of Diseases (ICD)

After World War II, the US Army and the US Navy developed a more comprehensive diagnostic system which could also address less severe mental disorders evident in veterans. The system used by the armed forces and the ICD-6 (International Classification of Diseases – Revision 6) played a major role in serving as the foundation for the first edition of the Diagnostic and Statistical Manual of Disorders (DSM) published by the American Psychiatric Association in 1952. The ICD actually predates the DSM by nearly 100 years, and is the standard used throughout the world. The ICD developed out of efforts to statistically record and classify causes of death, such as the Bills of Mortality in London, and were not originally aimed to standardize medical diagnosis and treatment. A major change in the ICD classification occurred with ICD-6 in 1948, as it was expanded to classify morbidity as well as mortality information, and included for the first time a section on mental, psychoneurotic, and personality disorders. The ICD-6 and its successive revisions through ICD-10 proved to be adaptable enough to be extended for use in diagnosing illnesses and for classifying health statistics in hospitals (Goodheart, 2014). All 193 World Health Organization (WHO) member countries, including the United States, are required by international treaty to collect and report health statistics to the WHO using the ICD as a framework.

The next revision of the ICD, ICD-11, is undergoing field trials, and will appear in 2018. The WHO’s priorities for the development of the classification of mental and behavioral disorders in ICD-11 include increasing its clinical utility in global mental health settings (Reed, 2010) and improving the identification and diagnosis of mental disorders among children and adolescents (Lochman et al., 2015; Rutter, 2012). The disruptive behaviors will appear in a section titled Disruptive Behavior and Dissocial Disorder. The inclusion of mental and behavioral disorders alongside all other diagnostic categories is an important advantage for ICD, as it can facilitate research on related mechanisms of etiology and comorbidity of disease processes across psychopathology and other medical conditions, and can increase the clinical use of the classification by all specialties and general health care workers all over the world (International Advisory Group, 2011).

Diagnostic and Statistical Manual (DSM)

The American Psychiatric Association published a predecessor to the DSM prior to the American Civil War, in 1844, as a way to develop a statistical classification of institutionalized mental patients. This pre-DSM was meant to improve communication about the types of patients in hospitals (APA, 2013), certainly a familiar aim today. Following efforts to address veterans’ mental disorders after World War II, the American Psychiatric Association published the first edition of the DSM in 1952. This manual was heavily based on the diagnostic system used by the armed forces in World War II, and was published in collaboration with the roll-out of ICD-6. There were three major categories of dysfunction in DSM-I: organic brain syndromes, functional disorder, and mental deficiency, which then comprised 106 categories (the number of categories increased sharply in subsequent editions; there were 407 in DSM-IV). DSM-II followed in 1968, but these first two DSM versions experienced only limited success among mental health professionals, largely because of their