SimplePsych

Disruptive, Impulsive, Control & Conduct Disorders

Slides: B Chow
Edits: L Jia

Updated 2021

SimplePsych

Disruptive, Impulse, Control & Conduct Disorders

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Pyromania
- Kleptomania
- Other specified DICCD
- Unspecified DICCD

SimplePsych

Introduction

- Problems with self-control of emotions + behaviors
  - Behaviors that **violate rights of others** (aggression, destruction)
  - Conflict with **societal norms or authority figures**

- Relative emphasis between emotional + behavioral regulation
  - Conduct disorder → poorly controlled behaviors
  - Intermittent explosive disorder → poorly controlled emotions
  - Pyromania, kleptomania → more evenly distributed

- Development & course
  - More common in **males** → degree varies with specific disorder, age
  - Usually **first onset in C&A** → very rare for CD/ODD to emerge as adult

- Most CD would have previously met criteria for ODD
  - But most ODD **do NOT develop CD**
  - ODD at risk of developing **anxiety, depressive disorders**

SimplePsych

Introduction

- May occur in typically developing individuals
  - Consider frequency, persistence, pervasiveness
  - Consider age, gender, culture

- Common externalizing spectrum of personality dimensions:
  - **Disinhibition vs constraint**
  - **Negative emotionality**

- High level of comorbidity with:
  - **Other DICCD**
  - **Substance use disorder**
  - **Antisocial personality disorder**

Oppositional Defiant Disorder

Oppositional Defiant Disorder – Diagnostic Criteria

A. Frequent behaviors lasting ≥6 months, exhibited during interactions with at least 1 non-sibling individual, (4+/8):

Angry/Irritable Mood

1. Loses **temper**
2. Easily **annoyed**, touchy
3. **Angry**, resentful

Argumentative/Defiant Behavior

4. **Argues** with authority figures/adults
5. **Actively defies** requests from authority figures/rules
6. **Deliberately annoys** others
7. **Blames others** for mistakes

Vindictiveness

8. **Vindictive/spiteful** (at least twice in past 6 months)

B. Sig distress (in individual or others) or impairment

C. Not exclusively during psychotic, depressive, bipolar or SUD. Does **not** meet criteria for DMDD

DSM5

Oppositional Defiant Disorder – Specifiers

- *Specify current severity:*
  - **Mild:** 1 setting
  - **Moderate:** 2 settings
  - **Severe:** 3+ settings

Oppositional Defiant Disorder – Diagnostic Features

- Frequent persistent pattern (mood, behavior, vindictiveness)
  - May show behavioral features WITHOUT negative mood
  - May be confined to one setting **(usually home)**
  - **Pervasiveness** → indicator of severity
    - Assess across multiple settings + relationships
    - Oppositional behavior may be common among siblings
    - Typically more evident with adults or peers
- Symptoms can occur to some degree without disorder
  - Preschool children may show weekly temper tantrums (normal)
  - Consider frequency, assoc symptoms, impairment
- Problematic interactions with others → ?relative contribution
  - Do not regard themselves as problematic, justify behaviour as a response
  - Cause/effect of **hostile parenting, poor conditions** → can still make DX

Oppositional Defiant Disorder – Associated Features

- More prevalent in families with:
  - **Disrupted child care**, by succession of different caregivers
  - **Harsh, inconsistent or neglectful child-rearing** practices

- Most common comorbidities
  - **ADHD**
  - **Conduct disorder**

- Increased risk for **suicide attempts** (controlled for comorbidities)

Oppositional Defiant Disorder – Prevalence

- Prevalence = **1 – 11%** (average = 3%)
  - May vary by age, gender
  - Prior to adolescence → more prevalent in **MALES (1.4x)**
  - Adolescence, adults → NO DIFFERENCE

Oppositional Defiant Disorder – Development & Course

- First ODD sx usually appear during **preschool years**
  - Rarely after early adolescence
  - Oppositional behaviors incr during preschool and adolescence → important to compare to normative levels before ODD dx

- ODD often precedes conduct disorder
  - Esp for **childhood-onset conduct disorder**
  - But most C&A with ODD do NOT develop conduct disorder
  - **Defiant, argumentative, vindictive sx** → most of risk for conduct disorder
  - **Angry-irritable mood sx** → most of risk for emotional disorders
    - At risk for anxiety, depressive disorders (without conduct disorder)

- As adults, incr risk of:
  - Antisocial behavior, impulse-control problems
  - Substance abuse, anxiety, depression

Oppositional Defiant Disorder – Risk & Prognostic Factors

- Temperamental
  - **Emotional regulation** (emotional reactivity, frustration tolerance)
- Environmental
  - **Harsh, inconsistent or neglectful child-rearing practices**
- Genetic & Physiological
  - **Neurobiological markers assoc with ODD+CD**
    - Lower HR, skin conductance reactivity
    - Decr basal cortisol reactivity
    - Abnormalities in prefrontal cortex, amygdala
  - Unclear if specific to ODD

Oppositional Defiant Disorder – Culture-Related Issues

- Prevalence
  - **Relatively consistent** (across countries with different race/ethnicity)

Oppositional Defiant Disorder – Functional Consequences

- Sig impairment (emotional, social, academic, occupational)
  - Frequent conflicts with parents, teachers, supervisors, peers, romantic

Oppositional Defiant Disorder – Differential Diagnosis

- Conduct disorder
  - Both → conflict with adults, authority figures
  - ODD → less severe, no aggression to people/animals, **no destruction of property, no pattern of theft/deceit**
  - Conduct disorder → does not include emotional dysregulation

- ADHD → often comorbid
  - Ensure ODD sx not solely in ADHD situations

- Depressive, bipolar disorders → if only during mood episodes

DSM5

Oppositional Defiant Disorder – Differential Diagnosis

- Disruptive mood dysregulation disorder → trumps ODD dx
  - Both → chronic negative mood + temper outbursts
  - More severe in DMDD → only minority meeting ODD will have DMDD
- Intermittent explosive disorder
  - Both → high rates of anger
  - ODD → no serious aggression
- Language disorder → impaired language comprehension
- Social anxiety disorder → fear of negative evaluation

Oppositional Defiant Disorder – Comorbidity

- ADHD
  - Higher rates of ODD → ?shared temperamental risk factors
- Conduct disorder
  - ODD often precedes CD → esp childhood-onset subtype
- Anxiety, major depressive disorder
  - Largely attributable to presence of **angry-irritable mood sx**
- Higher rates of SUD
  - Unclear if dependent on comorbidity with conduct disorder

Intermittent Explosive Disorder

Intermittent Explosive Disorder – Diagnostic Criteria

A. Behavioral outbursts (failure to control aggressive impulses):
   1. Aggression **NOT resulting in damage/injury**, **twice weekly for 3 mos**
      OR
   2. Aggression **resulting in DAMAGE/INJURY**, **3 times in past year**

B. Aggressiveness **grossly out of proportion** to stressor

C. **Not premeditated or to achieve tangible objective**

D. Sig distress, impairment, financial/legal consequences

E. **At least age 6** (or equivalent developmental level)

F. Not better explained by AMD, not due to substance/AMC, not part of adjustment disorder for age 6-18

- *Can be dx in addition to ADHD, conduct disorder, ODD, ASD if in excess + warrants independent clinical attention*

DSM5

Intermittent Explosive Disorder – Diagnostic Features

- Failure to control impulsive aggressive behavior
  - Response to **minor provocation** by **close intimate/associate**
    - Typically wouldn't result in aggression
  - **Rapid onset, minimal prodromal period, typically <30 mins**
  - **Impulsive, anger-based** (not premeditated or instrumental)

- A1) Aggression (verbal/physical) without damage/injury
  - **Twice weekly, for 3 months** → often between damaging aggression
  - Temper tantrums, tirades, verbal arguments, assaulting animals, others

- A2) Aggression causing damage/injury
  - **Three times in past year** → with non-damaging aggression between
  - Destroying property/objects, physical injury to animals, other individuals

Intermittent Explosive Disorder – Associated Features

- Associated with:
  - **Unipolar mood disorders**
  - **Anxiety disorders**
  - **Substance use disorders**
  - Onset of these disorders → typically LATER than IED

Intermittent Explosive Disorder – Prevalence

- 12-month prevalence = **3%**
  - More prevalent among **younger** (age <40 vs age >50)
  - More prevalence if **high school education or less**

Intermittent Explosive Disorder – Development & Course

- Onset most commonly → **late C&A**
  - Rarely after age 40
- Typically chronic + persistent course
  - May be episodic + recurrent
- Quite common regardless of presence of ADHD, other DICCD

Intermittent Explosive Disorder – Risk & Prognostic Features

- Environmental
  - Hx of **physical + emotional trauma,** in **first 20 years of life**

- Genetic & Physiological
  - **First degree relatives** of IED → incr risk of IED
  - Twin studies → sig genetic influence for impulse-aggression

  - **Serotonergic abnormalities**
    - Globally, limbic system (anterior cingulate), orbitofrontal cortex
    - Incr amygdala response to anger stimuli (vs healthy control)

Intermittent Explosive Disorder – Culture-Related Issues

- Lower prevalence in some regions
  - Asia, Middle East, Romania, Nigeria (vs US)
  - May not be elicited or present due to cultural factors

SimplePsych

Intermittent Explosive Disorder – Gender-Related Issues

- Varies by studies
  - Some → greater in **MALES (OR 1.4-2.3)**
  - Some → no gender difference

Intermittent Explosive Disorder – Functional Consequences

- Social → loss of friends/family, marital instability
- Occupational → demotion, loss of employment
- Financial → value of destroyed objects
- Legal → civil suits, criminal charges

Intermittent Explosive Disorder – Differential Diagnosis

- DMDD → **mutually exclusive dx**
  - Persistent negative mood state, onset before age 10, don't dx after age 18

- ADHD, conduct disorder, ODD, autism spectrum disorder
  - Conduct disorder → outbursts proactive + predatory
  - ODD → temper tantrums, verbal arguments with authority
  - **LOWER levels of impulsive aggression** (vs IED)
  - If severity warrants independent clinical attention → can give both dx

- Antisocial or borderline PD
  - Impulsive aggressive outbursts → **LOWER level** (vs IED)

DSM5

Intermittent Explosive Disorder – Differential Diagnosis

- Substance intoxication/withdrawal
  - Alcohol, PCP, cocaine, stimulants, barbiturates, inhalants
- Not exclusively during episode of AMD
- Delirium, major NCD, personality change due AMC
  - Direct physiological effect
- Not exclusively during adjustment disorder if age 6-18

Intermittent Explosive Disorder – Comorbidity

- Most common comorbidities
  - **Depressive disorder**
  - **Anxiety disorders**
  - **SUDs**

- Greater risk of IED if history of:
  - Antisocial PD, borderline PD
  - Other disorders with disruptive behavior (ADHD, CD, ODD)

Conduct Disorder

Conduct Disorder – Diagnostic Criteria

A. Repetitive and persistent pattern of behaviour
   Violation of basic rights of others or societal norms/rules
   Presence of **3+/15 for past 12 months**
   (with **1+/15 for past 6 months):**
   1. **Aggression to people + animals (7)**
   2. **Destruction of property (2)**
   3. **Deceitfulness or theft (3)**
   4. **Serious violations of rules (3)**

B. Sig functional impairment

C. If age >18, does NOT meet antisocial PD

SimplePsych

Conduct Disorder – Diagnostic Criteria

A) 3+/15 for past 12 months, 1+/15 for past 6 months	
Aggression to People + Animals	**Destruction of Property**
1. Often **bullies**, threatens, intimidates 2. Often initiates **physical fights** 3. Has used a **weapon** 4. Physically **cruel to people** 5. Physically **cruel to animals** **6. Stolen while confronting** a victim 7. Forced someone to **sexual activity**	8. **Fire setting** with intention to cause serious damage 9. Destruction of **others' property**
Deceitfulness or Theft	**Serious Violations of Rules**
10. **Broken into** someone else's house, building, car 11. Often **lies for gain** 12. **Stolen without confronting** victim	13. Often **stays out at night** (age <13) **14. Ran away from home overnight** (twice, or once for long duration) 15. Often **school truancy** (age <13)

DSM5

Conduct Disorder – Specifiers

- *Specify subtype:*
  - **Childhood-onset type:** at least one sx before age 10
  - **Adolescent-onset type:** no sx until after age 10
  - **Unspecified onset:** insufficient information to determine age of onset

- *Specify if:*
  - **With limited prosocial emotions:** 2+/4, past 12 months
    - **Lack of remorse/guilt:** lack of concern about negative consequences
    - **Callous/lack of empathy:** cold, uncaring, self-centered
    - **Unconcerned about performance:** school, work, limited effort, blames
    - **Shallow/deficient affect:** shallow, insincere, superficial, no expression

- *Specify current severity:*
  - **Mild:** relatively minor harm
  - **Moderate:** between mild and severe
  - **Severe:** considerable harm

SimplePsych

Conduct Disorder – Subtypes

- Estimated age of onset often **2 years later** than actual onset

Childhood-onset (1 symptom before age 10)	**Adolescent-onset (No symptoms before age 10)**
• Usually **MALE** • More freq **physical aggression** • Disturbed **peer relationships** • **Preceding ODD** • Full CD criteria **before puberty** • Concurrent **ADHD**, other neurodev difficulties • More likely **persist into adult**	• **Balanced gender ratio** • Less likely aggressive behaviors • More normative peer relationships • Less likely to persist into adulthood

Conduct Disorder – Specifiers

- "With limited prosocial emotions"
  - Reflects typical pattern of **interpersonal + emotional functioning**
    - Callous, unemotional traits
    - Thrill seeking, fearlessness, insensitivity to punishment
  - **More likely to engage in planned aggression for instrumental gains**
  - Can occur with any subtype or severity
    - More likely to have **childhood-onset type + severe level**
  - Requires multiple information sources

Conduct Disorder – Diagnostic Features

- A1) Bullying, threatening, intimidating (messaging, social media)
- A2) Initiate frequent physical fights
- A3) Uses weapons that can cause physical harm
- A4) Physically cruel to people
- A5) Physically cruel to animals
- A6) Steal while confronting a victim (mugging, robbery)
- A7) Force someone into sexual activity

- A8) Deliberate fire setting
- A9) Deliberate destruction of other's property

- A10) Breaking into someone else's house, building, car
- A11) Conning others, lying for gain
- A12) Stealing without confronting (shoplifting, fraud)

- A13) Staying out at night (age <13) (despite parental rules)
- A14) Running away overnight (twice, once if long duration)
- A15) Often truant from school (age <13)

Conduct Disorder – Associated Features

- Freq misperception of intentions of others
  - As **more hostile/threatening** than actually
  - Respond with **aggression** that they feel is **reasonable/justified**

- Personality features common with conduct disorder
  - Negative emotionality, poor self-control, poor frustration tolerance
  - Irritability, temper outbursts, suspiciousness
  - Insensitivity to punishment, thrill-seeking, recklessness

- Substance use → esp in **adolescent females**

- Suicidality (SI, SA, completed suicides) → **higher rates**

Conduct Disorder – Prevalence

- 12-month prevalence = **2-10%** (median 4%)
  - Consistent across countries with difference race/ethnicity
- Prevalence RISES from **childhood to adolescence**
- More common among **MALES**

Conduct Disorder – Development & Course

- Onset → usually **middle childhood through adolescence**
  - Can occur as early as preschool years, rare after age 16

- Course is variable
  - **Majority REMIT by adulthood**
  - If **adolescent-onset type**, or fewer/milder symptoms
    - Many have adequate adjustment as adults
  - If **childhood-onset type** → worse prognosis
    - Incr risk of criminal behavior, conduct disorder, SUD in adulthood
  - Risk of later disorders as adults (mood, anxiety, PTSD, impulse-control, psychotic, somatic symptom, SUD)

- Varies with age (incr strength, cognitive, sexual maturity)
  - First sx tend to be less serious → last sx tend to be more severe
  - If more damaging behaviors early → worse prognosis
  - If conduct behaviors as adult at work/home → consider antisocial PD

Conduct Disorder – Risk & Prognostic Factors

- Temperamental
  - Difficult under-controlled infant temperament
  - **Below average intelligence** (esp verbal IQ)

- Environmental
  - ***Family-level risk factors***
    - Parental rejection, neglect, inconsistent child-rearing practice
    - Harsh discipline, physical or sexual abuse
    - **Lack of supervision**, early institutional living
    - Frequent changes of caregivers, **large family size**
    - Parental criminality, familial psychopathology (SUD)
  - ***Community-level risk factors***
    - Peer rejection, delinquent peer group, **neighborhood violence**
  - Both types of risk factors → more common/severe in **childhood-onset**

SimplePsych

Conduct Disorder – Risk & Prognostic Factors

- Genetic
  - Incr risk if **family hx of conduct disorder** (bio/adoptive parents, siblings)
    - Esp for childhood-onset subtype
  - More common if parent has:
    - Severe AUD, depressive, bipolar disorder, schizophrenia, hx ADHD

- Physiological (none are diagnostic)
  - Slower **resting heart rate** (not seen in any other mental disorder)
  - Decr autonomic fear conditioning, low **skin conductance**
  - Structural/functional differences in areas for **affect regulation/processing**
    - Frontotemporal-limbic connections → **prefrontal cortex, amygdala**

- Course modifiers
  - Persistence more likely if:
    - **Childhood-onset, "with limited prosocial emotions", ADHD, SUD**

Conduct Disorder – Culture-Related Issues

- Disruptive behavior may viewed as near-normative
  - Very threatening, high-crime areas/war zones

Conduct Disorder – Gender-Related Issues

Males	Females
• Fighting • Stealing • Vandalism • School discipline	• Lying • Truancy • Running away • Substance use • Prostitution
• Physical aggression • Relational aggression	• **More relational aggression**

Conduct Disorder – Functional Consequences

- Social consequences
  - School suspension/expulsions, work adjustment, legal difficulties
  - May preclude attending normal school, living in parental/foster home

- Medical consequences
  - **Early onset of sexual behavior**, STDs, unplanned pregnancies
  - Substance use (tobacco, alcohol, illegal drugs)
  - Reckless/risky acts, physical injuries, **more accidents**
  - Predicts **midlife health difficulties**

- Common reason for treatment referral
  - Freq diagnosed in mental health facilities for children (esp forensics)
  - More severe/chronic impairment that other disorders

Conduct Disorder – Differential Diagnosis

- Oppositional defiant disorder (can give both dx)
  - Both → conflict with adults, other authority figures
  - ODD → less severe, no aggression, no destruction, no theft/deceit
    - Requires emotional **dys**regulation
- ADHD (can give both dx)
  - Disruptive behavior → usually not violating social norms/rights of others
- Depressive, bipolar disorders (can give both dx)
  - Mood disturbance, episodic
- Intermittent explosive disorder (can give both dx)
  - High rates of aggression → IED dx if warrants independent attention
  - IED → not premeditated, not for gain, no non-aggressive sx
- Adjustment disorders (with disturbance of conduct, mixed)
  - Onset of psychosocial stressor, resolve within 6 months

Conduct Disorder – Comorbidity

- ADHD, ODD → both common, predict worse outcomes
- Antisocial personality disorder
  - Often meets criteria for conduct disorder
- Other mental disorders
  - Anxiety, depressive, bipolar disorders
  - SUDs
  - Specific learning disorder, communication disorders
    - May have lower than expected academic achievement
    - Esp reading, verbal skills

Antisocial Personality Disorder

Antisocial Personality Disorder

- See Personality Disorders

Pyromania

Pyromania – Diagnostic Criteria

A. **Deliberate fire setting,** multiple episodes
B. **Tension/affective arousal** before the act
C. **Fascination + attraction to fire** (and situational context)
D. **Pleasure/relief when setting fires** (or with aftermath)

E. Not due to other objective or impairment
F. Not better explained by **conduct disorder, antisocial PD, mania**

Pyromania – Diagnostic Features

- C) Fascination, interest, curiosity, attraction to fire
  - Situational contexts → **paraphernalia, uses, consequences**
  - Often regular watches of fires, may set off false alarms
  - Pleasure from institutions, equipment, personnel assoc with fire
    - May spend time at local fire department
    - Set fires to be affiliated with the fire department
    - Even become firefighter

- D) Pleasure, gratification, relief when setting fire
  - Also witnessing its effects, participating in its aftermath

- **E) NOT due to other objective or impairment**
  - Monetary gain, sociopolitical expression, concealing crimes
  - Expressing **anger/vengeance**, improve living circumstances
  - Response to delusion or hallucination, major NCD, intellectual disability

Pyromania – Associated Features

- May make considerable advance preparation
  - May lead to property damage, legal consequences, injury, loss of life
  - May be **indifferent to consequences** caused by fire
  - May derive **satisfaction** from resulting destruction

- Individuals who impulsively set fires (may have pyromania)
  - Often have current or past history of **AUD**

Pyromania – Prevalence

- Population prevalence = UNKNOWN
  - Pyromania as primary dx likely **very rare**
  - In criminal system, those with repeated fire setting → 3% met pyromania
- Fire setting lifetime prevalence = 1.1%
  - Just one component of pyromania (not sufficient for dx)
  - More common comorbidities
    - Antisocial PD, SUD, bipolar, gambling disorder

Pyromania – Development & Course

- Insufficient data → typical onset, course unknown
  - Relationship of childhood fire setting + adulthood pyromania unknown
  - Fire-setting incidents → episodic, may wax/wane in frequency
- Arson offenses → **>40% are younger than age 18** (C&A)
  - Pyromania in childhood still rare
- Juvenile fire setting
  - Usually assoc with conduct disorder, ADHD, adjustment disorder

Pyromania – Gender-Related Issues

- More common in **MALES**
  - Esp if poorer social skills, learning difficulties

Pyromania – Differential Diagnosis

- Other causes of intentional fire setting
  - Profit, sabotage, revenge, concealing crime, political statement
  - Attract attention/recognition
  - Developmental experimentation in childhood

- Other mental disorders
  - Exclusion if conduct disorder, antisocial PD, manic episode
  - Not due to delusion/hallucination
  - Not due to AMC
  - Not due to impairment judgement (major NCD, intellectual disability, drugs)

Pyromania – Comorbidity

- High co-occurrence
  - Depressive, bipolar disorders
  - Substance use disorders
  - Gambling disorder
  - Other DICCD

Kleptomania

Kleptomania – Diagnostic Criteria

A. **Failures to resist impulses to steal** unneeded objects
B. **Increasing tension**, immediately before theft
C. **Pleasure, gratification, relief** at time of theft

D. Not done to express anger/vengeance, or due to psychosis
E. Not better explained by **conduct disorder, antisocial PD, mania**

DSM5

Kleptomania – Diagnostic Features

- Objects stolen despite little value to individual
  - Could have afforded to pay for them
  - Often gives them away or discards them
  - May hoard stolen objects, or secretly return term
- Generally avoid stealing if immediate arrest probable
  - Usually do not preplan thefts or fully consider chances of apprehension
- Stealing done withOUT assistance/collaboration with others

Kleptomania – Associated Features

- Typically attempt to resist the impulse to steal
  - Aware act is **wrong + senseless**
  - **Fears being apprehended**
  - Often feels **depressed or guilty** about thefts

- Associated behavioral addictions neurotransmitter pathways
  - Serotonin, dopamine, opioid systems

Kleptomania – Prevalence

- In individuals arrested for shoplifting → **4 – 24% kleptomania**
- Prevalence in general population = **0.3 – 0.6% (very rare)**
- Much more common in **FEMALES (3x)**

Kleptomania – Development & Course

- Age of onset → variable
  - Often begins in **adolescence**
  - May begin in childhood, adolescence, adulthood
  - Rarely in late adulthood

- Three typical courses
  - **1) Sporadic** → brief episodes, long periods of remission
  - **2) Episodic** → protracted periods of stealing, periods of remission
  - **3) Chronic** → some degree of fluctuation

- May continue for years, despite multiple convictions

Kleptomania – Risk & Prognostic Factors

- Genetic & Physiological
  - No controlled family history studies
  - In first degree relatives of kleptomania, higher rates of
    - **OCD, SUD, AUD**

Kleptomania – Functional Consequences

- Legal, family, career, personal difficulties

Kleptomania – Differential Diagnosis

- Ordinary theft or shoplifting
  - Deliberate, motivated by value of object or act
  - May steal on dare, act of rebellion, rite of passage
  - No other characteristic features
  - **Shoplifting relatively common** (kleptomania very rare)
- Malingering → to avoid criminal prosecution
- Antisocial PD, conduct disorder
- Manic episodes, psychotic episodes, major NCD
  - Delusions, hallucinations, impaired judgement

Kleptomania – Comorbidity

- Compulsive buying
- Depressive, bipolar disorders (esp MDD)
- Anxiety disorders
- Eating disorders (esp bulimia nervosa)
- Personality disorders
- Substance use disorders (esp AUD)
- Other DICCD

Other Specified Disruptive, Impulse-Control & Conduct Disorder

Other Specified DICCD

- Does not meet full criteria
- Clinician choose to specify reason

- Recurrent behavioral outbursts of insufficient frequency

Unspecified Disruptive, Impulse-Control & Conduct Disorder

Unspecified DICCD

- Does not meet full criteria
- Clinician choose NOT to specify reason