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Disruptive, Impulse-Control, and Conduct Disorders

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"He just explodes."

"It seems he always has to do exactly the opposite of what I tell him."

The disruptive, impulse-control, and conduct disorders, previously listed across a variety of diagnostic classes in DSM-IV, are now grouped together in DSM-5 and include the following: oppositional defiant disorder; intermittent explosive disorder; conduct disorder; antisocial personality disorder; pyromania; kleptomania; other specified disruptive, impulse-control, and conduct disorder; and unspecified disruptive, impulse-control, and conduct disorder. The core feature of these conditions is persistent dissocial patterns of individuals apparent across a variety of developmental stages. Although the disorders are placed in a new location within DSM-5, the diagnostic criteria have undergone only relatively minor changes with regard to time and age requirements of certain diagnoses.

In assessing individuals to clarify the presence of a diagnosis, a thorough history, including details about symptoms, timing, and age, are highly important. In addition, collateral historical information is imperative to fully grasp the nature of the symptoms, their presentation, and the contribution of the symptoms to the level of dysfunction for the individual.

In DSM-IV, antisocial personality disorder was included only in the personality disorders diagnostic class. In DSM-5, this diagnosis occurs both in personality disorders and in disruptive, impulse-control, and conduct disorders. Overall, this diagnosis manifests with significant disruptions in self and interpersonal functioning, resulting from a focus on primary gain to self and lack of empathy or desired emotional attachment with others. Please see Chapter 21 later in this volume for a discussion of personality disorders.

This chapter focuses in-depth on two disorders: oppositional defiant disorder and intermittent explosive disorder:

- Oppositional defiant disorder involves a persistent pattern of aggression, irritability, and anger, coupled with defiant and vindictive behaviors. This disorder typically manifests before adolescence but in some cases can manifest later. One of the keys to this disorder is the presence of symptoms that exceed what is normative for the age range. In the approach to a possible diagnosis of oppositional defiant disorder, taking a thorough history—including gathering of collateral information—is of uppermost importance. Clinicians assessing for this diagnosis should inquire about symptoms that are pervasive across multiple settings and environments, although symptoms need only occur in one setting to meet criteria for the diagnosis.
- Intermittent explosive disorder is characterized by recurrent behavioral outbursts during which the individual does not control his or her aggressive impulses. These recurrent behavioral outbursts are beyond what might be expected for the stimulus.

IN-DEPTH DIAGNOSIS

Oppositional Defiant Disorder

The mother of Adam, a 7-year-old boy, brings him to a suburban outpatient clinic for evaluation and possible treatment because of disruptive behavior at school. His mother, a single mother of four children (ages 2–15), works full time outside the home and reports that she is seeking help because she feels as though Adam's behavior has become unmanageable at home and is beginning to manifest at school. His mother reports excessive arguments at home between Adam and his siblings, both younger and older; Adam often talks back and does not follow rules at home or school. His mother recalls that he has been the most challenging to manage of her children, starting when he was between ages 3 and 4. She felt the immediate need to seek assistance when the school notified her because security guards had been called for the second time in 3 weeks in response to Adam's behavior. The most recent incident involved Adam climbing onto the roof of one of the school buildings and taunting the teachers and security guard as they tried to get him to come down safely. He reports that he climbed up there because he thought hiding from his teacher was fun and because she deserved it, and he did not care if he got in trouble.

Adam's case is a very common presentation of oppositional defiant disorder: a young child with long-standing behavioral concerns noted across multiple settings. It is most typical that the child's behavior is tolerated by the parent(s) at home from a

very young age and is met with discord when the child attends school and has difficulty with peers, figures of authority, and following the rules. In addition to better understanding Adam's home environment, it is also important to screen for any other disorders that may have a similar presentation or have high risk of comorbidity, such as mood disorders or attention-deficit/hyperactivity disorder (ADHD).

Approach to the Diagnosis

When approaching the diagnosis of oppositional defiant disorder, the clinician needs to consider the criteria for this and other disorders very carefully. As demonstrated in the vignette, one of the most critical parts of the oppositional defiant disorder diagnosis is ruling out other diagnoses such as a mood disorder or ADHD. A clinician should understand the age of the child and his or her current developmental stage, consider the complaint from the parents, and corroborate the information in a collaborative approach, working with the parents to contact other caregivers, teachers, and school officials if possible. Outside information may provide insight into recent environmental or relationship changes for the child.

Once the child's context is clearly understood, the clinician can begin to align confirmed symptoms with assigned criteria to determine if they corroborate the diagnosis. Isolating the single diagnosis of oppositional defiant disorder can be difficult, given that this diagnosis is often accompanied by what are referred to as "internalizing" and "externalizing." DSM-5 has attempted to address this difficulty by outlining categories under Criterion A to guide clinicians in assessing the presence of angry/irritable mood, argumentative/defiant behavior, and level of vindictiveness, if appropriate.

The DSM-5 criteria are specific in that the pattern of behavior needs to be persistent and have a particular frequency, based on whether the child is under age 5, or age 5 or older. If the child is under age 5, the behavior is required to be persistent on "most days" for at least 6 months. If the child is age 5 or older, the behavior must occur at least once per week for at least 6 months. Thorough understanding of the nature and number of settings where the behavior is observed will provide severity classification of the disorder as mild, moderate, or severe.

As stated in DSM-5, "Oppositional defiant disorder has been associated with increased risk for suicide attempts, even after comorbid disorders are controlled for" (p. 464).

Getting the History

A mother comes to the clinic with Michael, her 9-year-old son, just before the New Year's holiday, concerned that he will not behave well and "will ruin everybody's vacation by being bad." She goes on to report that she has done some of her own research online at home, and she found some Web sites about children who have oppositional defiant disorder who "sound exactly like him." The interviewer then asks the mother to share more about what she has read that fits what she has experienced with her son. The mother reports that since his third birthday, Michael "has broken every rule possible." She describes symptoms such as irritability, teasing others ("to the point where it really is awful and he won't stop!"), blaming his sister "for everything," being "cranky all the time," and not going to bed in the evenings even when reminded several times.

The interviewer then attempts to obtain an accurate time frame of the symptoms: "You mentioned that you feel as if this difficulty started around his third birthday. Do you feel as if these symptoms that you just mentioned have happened since before the start of this school year, perhaps in the summer?" The mother replies, "Absolutely!" The interviewer then asks for data regarding frequency: "How often does he get in trouble because of not following the rules? Is it every day after school? Is it mostly on the weekends? What do you think?" The mother replies, "I feel as if I'm taking his video games away almost every day now." The examiner continues, "How often do you hear feedback from the teacher?" The mother responds, "Well, now the teacher has taken to sending me a weekly e-mail about Michael's behavior, because it is so frequent that he is arguing with one of his friends or getting a referral to the principal's office."

The interviewer continues to determine if any recent environmental or social changes have occurred for Michael and also elicits his academic and medical history.

Michael's case represents a very typical presentation of oppositional defiant disorder, when the parent has observed a child's defiant behaviors from a very young age and is prompted to seek assistance when the child's academic and social function has become impaired. It is very common for a parent to present having previously "diagnosed" the child via Web sites. It is the interviewer's responsibility to clarify the symptoms and take a thorough history. The interviewer clarifies symptoms, determining that Michael has more than the required number (four) from Criterion A. The interviewer then verifies the temporal pattern. Parents often feel as though their child has "always been like this" and have difficulty specifying exact time intervals. Typically, providing a timeframe for parents and/or children as benchmarks in their memory can help elicit a more distinctive temporal history. To further understand the frequency, the interviewer asks about the number of times the child has been disciplined not only at home but also at school. This line of inquiry provides salient information, covering more than just frequency. Additional information to acquire is whether this behavior is observed by others at school, affects the child socially, and ultimately occurs at least once weekly. As always, the context of the child should be examined, and any medical diagnosis that may be contributing to the child's presentation should be ruled out.

Tips for Clarifying the Diagnosis

- Clarify that the child has at least four symptoms from these three categories: angry/irritable mood, argumentative/defiant behavior, and vindictiveness.
- Be very clear on the persistence and frequency based on the age of the child (i.e., younger than age 5, or age 5 or older).
- Understand the level of dysfunction and disruption for the child that is causing impairment.
- Consider whether the behavior may be accounted for by any other disorder, and verify that it does not occur exclusively during the course of another disorder.

Consider the Case

Tina is a 5-year-old girl whose parents have brought her to the clinic for assistance with her behavior at home. Her mother, father, and stepfather report that they have recently

caught her lying more, cheating at family board games, and fighting and arguing with her older sister. Her teachers have sent reports home about similar behavior happening at school and during her after-school program. Tina has a few friends at school, but her parents have witnessed her threatening and bullying her friends when they do not play games she wants to play or play according to her rules. Her mother recalls noticing this behavior worsening since Tina was age 3, when Tina had difficulty following directions. She recently has become more irritable. She has always been known to be fidgety and has never been known to remain seated to complete homework or leisure activities at home. Tina refuses to do her homework, among other tasks that she is asked to complete both at home and at school, and feels as though she is always getting in trouble for situations that are not her fault.

Tina's parents are bringing her in for care at a younger age than would typically be expected. Tina is apparently experiencing complex symptoms that relate to two diagnoses, oppositional defiant disorder and ADHD. At times, children who have difficulty following instructions or seem as though they are not listening may appear to be defiant. In Tina's case, she has displayed symptoms across diverse settings—that is, at home, school, and after-school care. Tina has been defiant despite identifying that she has heard and understands instructions, and she frequently blames her behavior on others. In addition, she has had difficulties with friendships, not only blaming her friends for her argumentative behavior, but also forcing them to play in certain ways, cheating on games, and planning schemes with ill outcomes toward her friends and sister. Tina's history is also suggestive of ADHD, given that she is described as fidgety, having difficulty sitting still, impulsive, and appearing to not listen at times. Questions that might confirm a comorbid diagnosis of ADHD include whether Tina frequently loses things, forgets instructions and activities, and/or has difficulty waiting for her turn.

Differential Diagnosis

The differential diagnosis for oppositional defiant disorder includes conditions such as conduct disorder, ADHD, depressive and bipolar disorders, disruptive mood dysregulation disorder, intermittent explosive disorder, intellectual disability (intellectual developmental disorder), language disorder, or social anxiety disorder (social phobia). Oppositional defiant disorder and ADHD often co-occur. Clinicians should rely on the characterization of symptoms, including the timing and setting, to establish whether criteria have been met. It is important to define the age at onset of symptoms, contextual presence of the symptoms, and the temporal relationship, including examination of a continual nature versus intermittent symptoms. Disruptive behavior noted with ADHD is a result of the inattention and impulsivity of the disorder, and thus should not be considered a diagnosis of co-occurring oppositional defiant disorder unless it is clear that the criteria for both diagnoses have been met. Furthermore, if an individual resists completing tasks, it should be made clear that the tasks do not demand sustained attention and effort, which would be more indicative of an ADHD diagnosis.

Oppositional defiant disorder is best differentiated from conduct disorder by the impulsivity of mood and irritability that is characteristic of oppositional defiant disorder. Conduct disorder is more severe in that it also includes the criteria of aggres-

sion toward people or animals, destruction of property, or a pattern of theft or deceit. It is also possible to observe the manifestation of aggression and/or irritability in the context of a depressive disorder or episode. The time frame of disruptive behavior may help in discerning the correct diagnosis or diagnoses. Furthermore, the irritability manifested in oppositional defiant disorder is characterized by defiant behavior and possible vindictive behavior. To further identify the presence of a distinct mood episode or mood disorder, a clinician would rely on the required neurovegetative criteria met for a mood episode, in addition to the differences in required time intervals.

See DSM-5 for additional disorders to consider in the differential diagnosis. Also refer to the discussions of comorbidity and differential diagnosis in their respective sections of DSM-5.

Summary

- Oppositional defiant disorder is characterized by the presence of persistent, nonepisodic patterns of angry/irritable mood, defiant behavior, or vindictiveness for at least 6 months.
- The presence of oppositional behavior creates a significant disruption in a variety of settings, such as school and/or home.
- The severity of oppositional defiant disorder can be specified as mild, moderate, or severe, depending on the number of settings.
- The diagnosis of oppositional defiant disorder requires that other diagnoses in this class be ruled out, as well as medical and neurodevelopmental disorders.

IN-DEPTH DIAGNOSIS

Intermittent Explosive Disorder

Mr. Peters is a 28-year-old software engineer who presents at the request of a recent court order for mandatory anger management treatment. He reports that he was charged with domestic violence after a physical altercation with his wife of 2 years. He endorses a distant history of school expulsion on two separate occasions in middle school and high school, each for a physical fight. He reports that as a young boy he witnessed a significant degree of domestic violence between his parents, who both had alcoholism. He feels that over the years he has been able to control his anger and his rage, except every now and then when it has become more difficult and resulted in mild to moderate destruction of his own property. On further examination, Mr. Peters expresses an overwhelming amount of guilt and shame about his outbursts, reporting that he knows his anger is often not warranted. He says he loves his wife more than himself, and he recognizes that the punishment he inflicts on her does not fit the "crime." He is now fearful of the dissolution of his marriage and the loss of his job and benefits.

Intermittent explosive disorder is characterized by repeated serious outbursts and aggressiveness that are grossly out of proportion to the situation or to known precipitants. The outbursts are impulsive and not calculating or premeditated. They are very upsetting to the individual and to others who are affected or witness to them. Intermittent explosive disorder is not due to another disorder or condition; for exam-

ple, the expansiveness or irritability seen in bipolar disorder or the behavioral dysregulation after head injury.

It is not uncommon for an individual with intermittent explosive disorder to present for treatment long after symptoms have started and as the consequences of behavioral problems have accumulated. Intermittent explosive disorder often is most evident at a stage in life when social, vocational, and/or occupational demands are placed on an individual. For Mr. Peters, the disorder manifested itself most distinctly and jarringly in the threat of dissolution of his marriage and occupation. Mr. Peters's report regarding his childhood is relevant to the diagnosis. He recalls school expulsion on more than one occasion spanning between middle and high school, indicating a likely adolescent onset. He identifies that his symptoms have been a chronic problem for him, resulting in physical damage to objects and people and, ultimately, causing extreme dysfunction in a variety of areas. Most important, he is able to identify that his reactions to certain minor provocations are also greater than what others might expect. As with all disruptive, impulse-control, and conduct disorders, it is important to understand the temporal relationship of his symptoms, to rule out any episodic nature of them that might be more indicative of a mood disorder diagnosis. Intermittent explosive disorder can be diagnosed in children over age 6 years and in adolescents, as well as adults.

Approach to the Diagnosis

Making the diagnosis of intermittent explosive disorder can be difficult, given the strict criteria outlined and the symptoms of other disorders that may appear to manifest as intermittent explosive disorder. A thorough history will reveal whether the specific time requirements for the diagnosis have been met. In addition, the quality of the outbursts must be accurately assessed to determine whether criteria are met. Parents and families will often present clear descriptions of a specific tantrum or outburst. It is important to determine whether the outburst is outside the realm of what might be a typical or expected response to an environmental provocation.

One key indication that an outburst response is out of proportion to the stimulus is destruction of property. If the nature of the outbursts tends to include destruction of property, investigating the frequency of outbursts is appropriate, determining whether there has been one in the recent 3 months and how many have occurred in the past 12 months. The quality of the outburst can be more difficult to assess when it consists of verbal altercation or assault, without destruction of property or physical assault. Even in this case, it is appropriate to screen for additional qualifiers, such as cruelty toward an animal or another human being or physical aggression.

Age at onset is critical to the diagnosis of intermittent explosive disorder. Symptoms can begin at any time throughout the lifespan, with onset often found to be within childhood (at least age 6) or adolescence, but rarely after age 40. Once the age at onset is understood, it is important to understand that the course of symptoms may be episodic in nature, following a chronic and persistent course.

Intermittent explosive disorder outbursts can be triggered by what appear to be very small matters, producing unexpected results. Regardless of the provocation, the outbursts are generally frequent with rapid onset, lasting less than 30 minutes. The

character of the outbursts may be either in the form of low-intensity verbal or physical aggression without resulting damage or destruction, averaging twice weekly for 3 months, or in the form of high-intensity physical aggression with physical injury or destruction of property three times within 1 year.

Care should be taken during historical and diagnostic interview to clarify and confirm the presence or absence of a major mood disorder, episode of psychosis, direct physiological effects of a substance, or a general medical condition. In the context of these disorders, the diagnosis of intermittent explosive disorder should not be made. The presence of a childhood history of a disruptive behavior disorder of childhood is not uncommon (i.e., ADHD, oppositional defiant disorder, conduct disorder).

Getting the History

Mr. Fields, age 42 years, presents to a clinician's office reporting that he needs help with anger management. The clinician proceeds by asking about his most recent complaints and why he feels he needs to manage his anger. Mr. Fields reports a story from the previous week, when he became enraged at his coworker who interrupted him in a meeting, which prompted Mr. Fields to abruptly end the meeting by yelling and storming out. The clinician asks Mr. Fields to consider how many times these "enraged" moments happen to him in a given week. Mr. Fields replies that some weeks it does not happen, but other weeks it may happen nearly every day, so "on average three to four times each week." The interviewer then investigates the quality of the outbursts: "Does that enraged feeling you get ever become so great that you end up physically throwing things, damaging property, or hurting others?" Mr. Fields reports that although he feels as if the outbursts could get to that point, he somehow has been able to refrain from hurting anyone and breaking things.

The interviewer then asks, "Do you remember when you first started noticing feeling like your anger was out of control?" In an effort to clarify the amount of functional impairment Mr. Fields currently experiences, the interviewer asks, "How long have you been at your current job?" The man reports that he started at his current company 3 months ago, after having been terminated from his previous company the year prior. He continues on to say that this is his third job in 3 years, with the common feedback that he is "difficult to work with." Mr. Fields recalls that he felt "these anger impulses" during college. He stopped drinking and started "working out" more and going to church regularly. He felt that these efforts helped, and he has continued these "good habits" to help him manage his outbursts—"but still it's such a problem for me!" The clinician is prompted to delve further into Mr. Fields's childhood history, asking, "Did either of your parents or anyone in your family ever complain about your anger when you were in, say, middle school or high school?" The man reports that he rarely got in trouble during his school years and often made the honor roll.

The interviewer allows Mr. Fields to lead with his initial broad complaint before targeting specifics of the described symptoms. The interviewer makes sure to elicit the time of onset of symptoms, investigates whether the symptoms occurred earlier in childhood, and seeks to determine the presence of other disorders during childhood. The interviewer further investigates the quality of Mr. Fields's outbursts by highlighting the presence or absence of property destruction and the frequency of the outbursts. To qualify for the diagnosis of intermittent explosive disorder, verbal aggression should occur approximately twice per week, on average, for at least 3 months. The in-

terviewer would also want to investigate very carefully the presence of other disorders, such as major mood or psychotic disorders, a general medical condition, or substance intoxication or withdrawal.

Tips for Clarifying the Diagnosis

- Question when the symptoms began.
- Determine the time course of the symptoms.
- Establish the intensity of the symptoms. Learn whether there is damage or destruction to people or property.
- Find out whether the outbursts are provoked and in what situation(s).
- Determine whether it is possible to predict when an outburst is going to occur.

Consider the Case

> Gary is a 15-year-old boy whose grandmother is concerned about his behavior at home and school. She reports that he recently spent one night at the juvenile detention center after the police were called to his school for verbal threats he was making toward his teacher. Gary and his grandmother report that his outbursts have been an increasing problem since he was in first grade; however, this is the first time the police have been called to a public place for his behavior. Gary migrated to the United States with his father and grandparents approximately 6 months ago. Gary's grandmother reports that since age 6, Gary has had extreme temper tantrums on numerous occasions, throwing his toys and often destroying his small handheld electronics. Recently, he has begun breaking objects in his room, such as a lamp and his dresser drawer. Once he punched a hole in his wall. She recalls that since he was 12 years old, not a month has gone by when she hasn't seen a serious tantrum resulting in property destruction in some way.

Gary's case shows an onset of symptoms dating back to at least age 6, as documented by his grandmother's history. To qualify for the diagnosis of intermittent explosive disorder, an individual must be at least age 6 years. Gary meets criteria on the basis of the degree of his symptoms and their frequency, in that his grandmother notes a history of property destruction during his tantrums, occurring on a monthly basis over several years. Most recently his outburst was at school and resulted in verbal assault of his teacher and involvement of law enforcement. His symptoms demonstrate reactions that are outside of the expected social norm, with excessive consequence severity. Given the timing of Gary's presentation for care, not long after coming to a new country, an element of adjustment may be playing a role. Because Gary is now presenting 6 months after his immigration, the diagnosis of intermittent explosive disorder is appropriate. In addition, he has a history of symptoms documented back to an early age, supporting the diagnosis.

Differential Diagnosis

Because of the low prevalence of intermittent explosive disorder, the clinician should consider the presence of another mental disorder during assessment. Irritable and aggressive behavior that is thought to be related to intermittent explosive disorder may,

in fact, be a manifestation of a general medical condition, substance abuse/intoxication, mood disorder, personality disorder, or psychotic disorder, among other possibilities. It is important for clinicians to understand the temporal relationship of symptoms and to rule out any episodic quality of the symptoms that may be more characteristic of a mood disorder, as well as the presence of a substance or medication or withdrawal from a substance that may be causing a direct psychological effect on the individual. This evaluation occurs by a thorough clinical interview and examination, as well as, when indicated, a blood or urine toxicology screen. The presence of a general medical condition precludes the diagnosis of intermittent explosive disorder. Ruling out other mental disorders or general medical conditions is best accomplished by a thorough psychiatric and neurological exam.

Aggression that is well thought out, motivated, or vindictive in nature does not meet criteria for intermittent explosive disorder. The presence of a personality disorder, such as borderline personality disorder or antisocial personality disorder, does not rule out the presence of intermittent explosive disorder. The disorders should each be carefully considered, including the symptom and temporal pattern of each, and both diagnoses may be made if criteria are met. Most often, the personality disorder is an established diagnosis, with a new persistent change in the quality of intermittent impulsive aggression.

See DSM-5 for additional disorders to consider in the differential diagnosis. Also refer to the discussions of comorbidity and differential diagnosis in their respective sections of DSM-5.

Summary

- Intermittent explosive disorder is a diagnosis that may be considered when clinically significant aggression is present.
- Before making the diagnosis of intermittent explosive disorder, it is important for the clinician to rule out a general medical condition, substance intoxication or withdrawal, or another mental disorder that may account for the symptoms.
- A thorough clinical and neurological examination should be completed as part of the symptom assessment.
- Symptom severity should be assessed on the basis of the functional impairment that the symptoms are causing.

SUMMARY

Disruptive, Impulse-Control, and Conduct Disorders

The disruptive, impulse-control, and conduct disorders are among the most frequent disorders seen by child and adolescent mental health professionals. The underlying symptom that brings all of these disorders together under one diagnostic umbrella is the nature of self and interpersonal dysfunction that occurs. Oppositional defiant disorder initially manifests within the family, disrupting those relationships, and is most

often brought to clinical attention once the child reaches school age and is beginning to demonstrate difficulties at school with peers and authority figures. Intermittent explosive disorder often begins in adolescence but is most likely to present to clinical attention when dysfunction affects a young adult's peer relationships and occupational endeavors.

Behavioral dysregulation is an underlying commonality in this diagnostic class. Nevertheless, each diagnosis is distinct and has specific diagnostic criteria. It is important to understand the temporal relationship of symptoms, in addition to understanding when the symptoms may have first manifested in a person's history and how consistent or persistent the symptoms have remained. With intermittent explosive disorder, for example, the timing of explosive behaviors, including the length of time and the frequency, is imperative information to glean in arriving at the correct diagnosis or diagnoses. As always, for each of these disorders, keeping the individual's appropriate expected developmental stage in the forefront is essential for clarity in understanding the diagnosis.

Diagnostic Pearls

- Across this diagnostic class, all disorders involve the violation of some aspect of social norms and individual rights.
- The disruptive, impulse-control, and conduct disorders create clinically significant disturbance and impairment in social, educational, and vocational activities, as well as in interpersonal and intrapersonal relationships.
- All diagnoses (except kleptomania) included in the disruptive, impulse-control, and conduct disorders diagnostic class share, but do not require, the common symptom of increased rate of anger.
- Although high rates of aggression are commonalities across all diagnoses in this class (except kleptomania), the types of aggression are distinctly different across the diagnoses, specifically regarding premeditated aggression for secondary gain versus impulsive aggression.
- When evaluating for these diagnoses, it is imperative to be mindful of psychosocial context, because certain environments, such as impoverished backgrounds or war-laden areas, may make the presentation normative.

Self-Assessment

Key Concepts: Double-Check Your Knowledge

What is the relevance of the following concepts to the various disruptive, impulse-control, and conduct disorders?

- Social norms
- Sequelae of behavioral disruption
- Consequence severity

- Interpersonal functioning
- Expected developmental stage
- Irritability
- Comorbid diagnoses
- Severity of aggression

Questions to Discuss With Colleagues and Mentors

1. What is the core concept that ties this diagnostic class together?
2. How much do you, or can you, rely on the collateral data from sources such as teachers, parents, employers, and spouse to inform your diagnostic approach when you are evaluating a new patient with a disruptive, impulse-control, or conduct disorder?
3. Given the common co-occurrence of other disorders, how do you clarify the diagnoses in this diagnostic class?
4. How do you think about gender and cultural considerations in this diagnostic class?
5. When a person presents with symptoms of intermittent explosive disorder, what laboratory or other testing is appropriate?

Case-Based Questions

PART A

> Mr. Hill is a 42-year-old man who reports a history of being "moody" since he was in college. He reports that he has been so moody at times in the past that he has lost a few friends and been divorced three times. His occupational history has been one of instability, and he wonders if he'll ever be able to hold a job longer than a year. He reports that when he was about age 35, he began using alcohol to help him calm down in the evenings, because he was afraid he would just absolutely explode on somebody. He denies any other substance use or abuse, and his medical workup is negative.

What is the most striking aspect of Mr. Hill's history with which a clinician should be first concerned? Mr. Hill is describing significantly impaired self-control and interpersonal functioning, a hallmark for disruptive, impulse-control, and conduct disorders.

PART B

> Mr. Hill mentions that most days he is "fine" and can remain calm, but he has always lived in fear that he is going to explode on anyone at any moment. He says he never has a stretch of days when he is "moody" or "down," but rather that "it is just kind of unpredictable, and so random. Things that should only make me a little upset or cranky make me lose my mind it seems!"

Could Mr. Hill possibly have a mood disorder? Given that Mr. Hill says his symptoms are random, not episodic, and do not last for a significant period of time, a mood disorder diagnosis is less likely.

PART C

> Mr. Hill, given the opportunity to talk about his childhood, reports that in retrospect "I wasn't necessarily moody as a kid, but I had a couple of times when I got in trouble at school and got in a few fights in middle school."

Which diagnosis should most likely remain at the top of the differential for Mr. Hill?
Mr. Hill is describing symptoms that are most consistent with intermittent explosive disorder, with a slight history of disruptive behavior dating back to childhood. The level of dysfunction is concerning, especially because it has persisted for quite some time, in that he has been through three marriages and multiple jobs.

Short-Answer Questions

1. For a child under age 5 to be diagnosed with oppositional defiant disorder, how often must the symptoms occur?
2. For a child age 5 or older to be diagnosed with oppositional defiant disorder, how often must the symptoms occur?
3. What are the key categorical components of oppositional defiant disorder behavior that must be evidenced for diagnostic qualification?
4. How often must vindictive or spiteful behavior occur for oppositional defiant disorder?
5. What is the required time criterion for an individual to manifest aggressive impulses for the diagnosis of intermittent explosive disorder?
6. What is the youngest age for which intermittent explosive disorder may be diagnosed?
7. What is the typical age at onset for intermittent explosive disorder?

Answers

1. Generally, symptoms must occur on most days for a period of at least 6 months for a child under age 5 to be diagnosed with oppositional defiant disorder.
2. Generally, symptoms must occur at least once per week for at least 6 months for a child age 5 or older to be diagnosed with oppositional defiant disorder.
3. The key categorical components of oppositional defiant disorder behavior that must be evidenced for diagnostic qualification are angry/irritable mood, argumentative/defiant behavior, and vindictiveness.
4. Vindictive or spiteful behavior must occur at least twice within the past 6 months for oppositional defiant disorder.
5. For the diagnosis of intermittent explosive disorder, the individual must manifest verbal or physical aggression twice weekly, on average, for the past 3 months (without damage or destruction to property or physical injury to animals or other individuals), *or* three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury to animals or other individuals within a 12-month period.
6. The youngest chronological age for which intermittent explosive disorder may be diagnosed is 6 years (or equivalent developmental level).
7. The typical age at onset for intermittent explosive disorder is childhood or adolescence.

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