ICD-11 DIAGNOSTIC GUIDELINES

Disruptive Behaviour or Dissocial Disorders

Note: This document contains a pre-publication version of the ICD-11 diagnostic guidelines for Disruptive Behaviour or Dissocial Disorders. There may be further edits to these guidelines prior to their publication.

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DISRUPTIVE BEHAVIOUR OR DISSOCIAL DISORDERS

Disruptive Behaviour or Dissocial Disorders are characterized by persistent behaviour problems across multiple settings with onset commonly, though not exclusively, during childhood. When present, these problems often persist into adulthood. These disorders are characterized by behaviours that range from those described as disruptive—that is, markedly and persistently defiant, disobedient, provocative or spiteful—to behaviours that are considered dissocial because they persistently violate the basic rights of others or major age-appropriate societal norms, rules, or laws.

A majority of individuals commit isolated acts of aggression or rule violation at some point in their lives, and this does not warrant the diagnosis of a Disruptive Behaviour or Dissocial Disorder. In all cases, the behaviours characteristic of the disorders in this grouping must clearly depart from the normal range for the individual's age and gender given his or her socio-cultural context.

Disruptive Behaviour or Dissocial Disorders may co-occur with other Mental, Behavioural, or Neurodevelopmental Disorders. However, a separate diagnosis of a Disruptive Behaviour or Dissocial Disorder is not warranted if the disruptive behaviour is limited to symptomatic episodes of another mental disorder (e.g., defiant and noncompliant behaviour during a Depressive Episode), or if the behaviour is due to the effects of a substance or to another medical condition.

Disruptive Behaviour or Dissocial Disorders are frequently associated with psychosocial environments that include family dysfunction, problems with peers, coworkers, and romantic partners; and failure at school or work. Other psychosocial risk factors are common, such as peer rejection, deviant peer group influences, and parental mental disorder. Behaviours that are adaptive given the individual's environmental circumstances (e.g., running away from an abusive home; stealing in order to survive) should not be used as the sole basis for these diagnoses.

Disruptive Behaviour or Dissocial Disorders include the following:

6C90 Oppositional Defiant Disorder
- 6C90.0 Oppositional Defiant Disorder, with chronic irritability-anger
- 6C90.1 Oppositional Defiant Disorder, without chronic irritability-anger

6C91 Conduct-Dissocial Disorder
- 6C91.0 Conduct-Dissocial Disorder, childhood onset
- 6C91.1 Conduct-Dissocial Disorder, adolescent onset

6C9Y Other Specified Disruptive Behaviour or Dissocial Disorders

In addition, the following qualifiers may be applied to all disorders in the Disruptive Behaviour or Dissocial Disorders grouping:

6C9x.x0 with limited prosocial emotions
6C9x.x1 with typical prosocial emotions

6C90 Oppositional Defiant Disorder

Essential (Required) Features:

- A pattern of markedly noncompliant, defiant, and disobedient behaviour that is atypical for individuals of comparable age, developmental level, gender, and sociocultural context. The pattern of behaviour may include:
    - Persistent difficulty getting along with others (e.g., arguing with authority figures, actively defying or refusing to comply with requests, directives, or rules, deliberately annoying others, blaming peers or co-workers for mistakes or misbehaviour).
    - Provocative, spiteful, or vindictive behaviour (e.g., antagonizing others; using social media to attack or mock others).
    - Extreme irritability or anger (e.g., being touchy or easily annoyed, losing temper, angry outbursts, being angry and resentful).
- The behaviour pattern has persisted for an extended period of time (e.g., 6 months or more).
- The oppositional behaviours are not better accounted for by relational problems between the individual and a particular authority figure toward whom the individual is behaving in a defiant manner. Examples may include parents, teachers, or supervisors who act antagonistically or place unreasonable demands on the individual.
- The behaviour pattern results in significant impairment in personal, family, social, educational or other important areas of functioning.

Qualifiers for Oppositional Defiant Disorder:

Two qualifiers indicating the presence or absence of chronic irritability-anger can be assigned to the diagnosis of Oppositional Defiant Disorder.

6C90.0 Oppositional Defiant Disorder, with chronic irritability-anger

- All diagnostic requirements for Oppositional Defiant Disorder are met.
- Prevailing, persistent irritable mood or anger that is atypical for individuals of comparable age, developmental level, gender, and sociocultural context, including most of the following features:
    - Often feeling angry or resentful; showing bitterness toward others, or feeling as if things are unfair.
    - Often being touchy or easily annoyed; exhibiting oversensitivity or irritation to minimal or perceived provocations.
    - Often losing temper; exhibiting angry verbal or behavioural outbursts, which may include tantrums, destructive behaviours, or other forms of severe mood dysregulation.
- The anger or resentment, touchiness or annoyance, and loss of temper is out of proportion in intensity or duration to any provocation, and may be present independent of any apparent provocation.
- Chronic irritability and anger are characteristic of the individual's functioning nearly every day and are not limited to discrete periods, are observable across multiple

settings or domains of functioning (e.g., home, school, social relationships), and are not restricted to the individual's relationship with their parents or guardians.
- The pattern of chronic irritability and anger is not better accounted for by another mental disorder (e.g., irritable mood in the context of Manic or Depressive Episodes).
- Individuals with this subtype usually also display other characteristic features of Oppositional Defiant Disorder, including defiant, headstrong, or vindictive behaviours.

6C90.1 Oppositional Defiant Disorder, without chronic irritability-anger

- All diagnostic requirements for Oppositional Defiant Disorder are met.
- Absence of prevailing, persistently angry or irritable mood. In these individuals, anger and irritability occur less frequently, and tend to be transitory, less severe, and less often out of proportion to the provocation as compared to individuals with chronic irritability-anger.

Additional Clinical Features:

- Although often identified through parental report of noncompliant behaviour, the negative and antagonistic aspects of Oppositional Defiant Disorder also exert a broader negative influence on interactions with others outside the family. Oppositional Defiant Disorder is associated with peer rejection and interpersonal discord through the school years and into adulthood.
- Frequently, the oppositional defiant features have a provocative quality such that individuals initiate confrontations and may be seen as excessively rude and uncooperative.
- Younger children (e.g., 3 to 5 years of age), are typically more closely supervised and receive frequent instructions and limits imposed on them by authority figures (e.g., parents or other guardians, caregivers, teachers). As children grow older, direct demands by authority figures typically become less frequent. Moreover, others interacting with children or adolescents with Oppositional Defiant Disorder may come to avoid placing demands on them due to their negative response. Therefore, a diagnosis is not precluded because oppositional or defiant behaviours occur relatively infrequently, as long as they characterize most interactions with authority figures.
- Adults with Oppositional Defiant Disorder continue to experience conflictual relationships with parents and family members and have generally poorer social support networks. This affects the number and quality of their friendships and romantic relationships. They typically struggle to function in the workplace due to difficulties in their interactions with supervisors and co-workers.
- Features of irritability and anger (e.g., being touchy or easily annoyed, losing temper, being angry and resentful) are sometimes the predominant characteristics of the clinical presentation. However, irritability and anger alone are neither necessary nor sufficient for the diagnosis. These symptoms must be accompanied by a pattern of markedly noncompliant, defiant, and disobedient behaviour that is atypical for individuals of comparable age and developmental level. The presence of chronic irritability and anger is indicated by using the corresponding qualifier.

- Oppositional Defiant Disorder with chronic irritability-anger is not necessarily more severe or rare than Oppositional Defiant Disorder without chronic irritability-anger. Rather, Oppositional Defiant Disorder with chronic irritability-anger identifies a pattern of mood dysregulation that can range in severity from frequent and impairing tantrums to extreme presentations of the mood dysregulation.
- Individuals with Oppositional Defiant Disorder may present with limited prosocial emotions. When assessing for Oppositional Defiant Disorder, the clinician should also assess for limited prosocial emotions, and, if present, assign the appropriate qualifier (see p. X). Individuals with Oppositional Defiant Disorder with limited prosocial emotions are more likely to exhibit a more persistent and severe pattern of antisocial behaviour that may subsequently meet the diagnostic requirements for Conduct-Dissocial Disorder.
- Oppositional Defiant Disorder in childhood frequently co-occurs with Attention Deficit Hyperactivity Disorder, Conduct-Dissocial Disorder, and internalizing disorders such as Depressive Disorders or Anxiety or Fear-Related Disorders.

Boundaries with Normality (Threshold):

- Transient noncompliance, defiance, and disobedience including irritability or anger can occur within the normal range of behaviour as a part of typical development or in response to increased demands on the developing child, changes in the child's environment (e.g., transition to a new school or city), or as a manifestation of normative anxiety in the context of specific tasks or situations (e.g., going to school and separating from parents for the first time). The presence of such behaviours should not be taken as evidence for a presumptive diagnosis of Oppositional-Defiant Disorder. Oppositional-Defiant Disorder should only be diagnosed when there is a persistent pattern of markedly noncompliant, defiant, and disobedient behaviour that is atypical considering the individual's age, gender, and social-cultural context.

Course Features:

- The heterogeneity of presentations in Oppositional Defiant Disorder has meaningful clinical and prognostic implications. Oppositional Defiant Disorder can be a developmental precursor for the development of Conduct-Dissocial Disorder, especially when the presentation of Oppositional Defiant Disorder includes severely defiant or spiteful/vindictive behaviours. However, many children with Oppositional Defiant Disorder do not subsequently develop Conduct-Dissocial Disorder.
- A diagnosis of Oppositional Defiant Disorder with chronic irritability and anger is associated with the subsequent development of Depressive Disorders and Anxiety or Fear-Related Disorders.

Developmental Presentations:

- Typical age of onset of Oppositional Defiant Disorder is in middle childhood with initial symptoms typically appearing at preschool age. Symptoms rarely emerge for the first time later than early adolescence.
- Prevalence rates of Oppositional Defiant Disorder are estimated at 3.3% among children and adolescents (aged 6 – 18). Although rates are equivalent among preschool-aged boys and girls as well as adolescents and adults, higher rates are observed among school-aged

boys (ratio of 1.4:1). Some evidence suggests that the overall prevalence of Oppositional Defiant Disorder decreases beginning in adolescence and young adulthood.
- Oppositional Defiant Disorder is more common among children and adolescents whose families have experienced substantial disruptions in care-giving relationships or in which parenting practices tend to be harsh, inconsistent, or neglectful.
- Although oppositional and argumentative behaviours are common in typically developing children, unlike in Oppositional Defiant Disorder, these behaviours tend to be transient and do not consistently negatively impact the child's functioning and development.
- Oppositional Defiant Disorder has been associated with greater peer rejection, heightened interpersonal conflict, and increased risk for co-occurring and subsequent difficulties in adjustment throughout childhood and adulthood.

Culture-Related Features:

- There is substantial variation in the prevalence of Oppositional Defiant Disorder across cultures. These differences may be related to cultural norms regarding uncooperative or defiant behaviour in children. For example, cultures that value obedience highly may have a lower threshold for considering a child's behaviour to be noncompliant, defiant, or disobedient. The behaviours relevant to assigning a diagnosis of Oppositional Defiant Disorder should be evaluated in relation to social, cultural and subgroup norms.
- Variation in the prevalence of Oppositional Defiant Disorder and Conduct-Dissocial Disorder across cultural groups may be related to differences in family structure and behaviour. Lower prevalence may be associated with stricter disciplinary practices at home, strong emphasis on educational or occupational attainment, and cultural values that disapprove of an antisocial lifestyle.

Gender-Related Features:

- Prevalence of Oppositional Defiant Disorder is higher among school-aged boys than school-aged girls, but does not appear to differ by gender at other points across the lifespan.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Conduct-Dissocial Disorder:*** The behaviour problems associated with Oppositional Defiant Disorder are largely characterized by interpersonal conflict with authority figures and difficulty getting along with others. In contrast, Conduct-Dissocial Disorder is characterized by a repetitive and persistent pattern of more severe and dissocial behaviour in which the basic rights of others or major age-appropriate social or cultural norms, rules, or laws are violated (e.g., aggression toward people or animals, destruction of property, deceitfulness or theft, serious violations of rules). However, individuals with Conduct-Dissocial Disorder often demonstrate a range or history of behaviour problems that may include the interpersonal difficulties characteristic of Oppositional Defiant Disorder. Both diagnoses may be given if the full diagnostic requirements are met for each.
- ***Boundary with Attention Deficit Hyperactivity Disorder:*** Individuals with Attention Deficit Hyperactivity Disorder often have difficulty following directions, complying

with rules, and getting along with others. When these disruptive behaviours are better accounted for by inattention or hyperactivity-impulsivity (e.g., failure to follow long and complicated directions, difficulty remaining seated or staying on-task when asked), Oppositional Defiant Disorder should not be diagnosed. In Oppositional Defiant Disorder, the pattern of noncompliance is characterized by disobedience, beyond problems with attention and behavioural inhibition. However, Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder commonly co-occur and both diagnoses may be given if the full diagnostic requirements are met for both disorders.

- ***Boundary with Autism Spectrum Disorder:*** Noncompliant and other disruptive behaviours characteristic of Oppositional Defiant Disorder should be distinguished from behaviour problems that are common among individuals with Autism Spectrum Disorder. The key difference is that, in Autism Spectrum Disorder, disruptive behaviours are often associated with specific environmental factors (e.g., sudden change in routine, aversive sensory stimulation), or the noncompliance is a consequence of the core symptoms of that disorder (e.g., social communication deficits, restricted, repetitive, inflexible patterns of behaviour, sensory sensitivities) rather than reflecting an intention to be provocative or spiteful. Individuals with Oppositional Defiant Disorder do not typically exhibit the social communication deficits and restricted, repetitive, and inflexible patterns of behaviour, interests, or activities that are characteristic of Autism Spectrum Disorder.
- ***Boundary with Mood Disorders:*** It is common, particularly in children and adolescents, for patterns of noncompliance and symptoms of irritability/anger to occur as a feature of a Mood Episode. Specifically, noncompliance may result from a number of depressive symptoms (e.g., diminished interest or pleasure in activities, difficulty concentrating, hopelessness, psychomotor retardation, reduced energy). During Manic, Mixed or Hypomanic Episodes, individuals are less likely to follow rules and comply with directions. Moreover, in children and adolescents, depressive, manic, or hypomanic mood can manifest as irritability. When the behaviour problems occur entirely in the context of Mood Episodes, a separate diagnosis of Oppositional Defiant Disorder should not be assigned.
- ***Boundary with Anxiety or Fear-Related Disorders:*** In children and adolescents, symptoms of Anxiety or Fear-Related Disorders can sometimes manifest as noncompliance, defiance, and disobedience including irritability or anger. For example, children may exhibit angry outbursts and refuse to comply with requests when presented with a task or a situation that makes them feel anxious (e.g., when a child with Social Anxiety Disorder is asked to make a presentation in class). These behaviours are typically a manifestation of a desire on the part of the child or adolescent to avoid the feared situation or stimulus. Furthermore, children and adolescents with Anxiety or Fear-Related Disorders do not typically exhibit provocative, spiteful, or vindictive behaviour. If the defiant behaviour occurs only in response to situations or stimuli that elicit anxiety, fear, or panic, Oppositional Defiant Disorder should not be diagnosed.
- ***Boundary with Intermittent Explosive Disorder:*** Regularly occurring severe temper outbursts that are grossly out of proportion in intensity or duration to the provocation are the core symptom of Intermittent Explosive Disorder but may also occur in the context of Oppositional Defiant Disorder with chronic irritability-anger. Individuals with Oppositional Defiant Disorder with chronic irritability-anger typically display other features of Oppositional Defiant Disorder, including defiant, headstrong, or vindictive behaviours, which are not characteristic of Intermittent Explosive Disorder. In addition,

individuals with Intermittent Explosive Disorder are more likely to exhibit significant physical aggression.

6C91 Conduct-Dissocial Disorder

Essential (Required) Features:

- A repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate social or cultural norms, rules, or laws are violated. Typically, there are multiple behaviours involved, including one or more of the following:
    - *Aggression towards people or animals,* such as bullying, threatening or intimidating others, instigating physical fights, using weapons that can cause serious physical harm to others (such as a brick, broken bottle, knife or gun), physical cruelty to people, physical cruelty to animals, aggressive forms of stealing (e.g., mugging, purse snatching, extortion), or forcing someone into sexual activity.
    - *Destruction of property,* such as deliberate fire setting with the intention of causing serious damage or deliberate destruction of others' property (e.g., purposely breaking other children's toys, breaking windows, scratching cars, slashing tires).
    - *Deceitfulness or theft,* such as stealing items of value (e.g., shoplifting, forgery), lying to obtain goods or favours or to avoid obligations (e.g., 'conning' others), or breaking into someone's house, building or car.
    - *Serious violations of rules,* such as children or adolescents repeatedly staying out all night despite parental prohibitions, repeatedly running away from home, or often skipping school or work without permission.
- The pattern of behaviour must be persistent and recurrent, including multiple incidents of the types of behaviours described above over an extended period of time (e.g., at least 1 year). The mere commission of one or more delinquent acts is not sufficient for the diagnosis.
- The behaviour pattern results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Qualifiers for Conduct-Dissocial Disorder:

Two subtypes related to age of onset can be specified in individuals who meet the diagnostic requirements for Conduct-Dissocial Disorder.

6C91.0 Conduct-Dissocial Disorder, childhood onset

- All diagnostic requirements for Conduct-Dissocial Disorder are met.
- One or more features of the disorder have clearly been present and persistent during childhood prior to adolescence (e.g., before 10 years of age).

6C91.1 Conduct-Dissocial Disorder, adolescent onset

- All diagnostic requirements for Conduct-Dissocial Disorder are met.
- None of the features of the disorder were present prior to adolescence (e.g., before 10 years of age).

Additional Clinical Features:

- Individuals with Conduct-Dissocial Disorder may be part of a delinquent peer group where delinquent activities are often conducted in association with peers. This may be particularly common among those with adolescent onset.
- The relationship between Conduct-Dissocial Disorder and Oppositional Defiant Disorder has historically been conceptualized as hierarchical and developmental in nature, with Conduct-Dissocial Disorder being generally considered as more severe than, and commonly preceded by, Oppositional Defiant Disorder. However, Conduct-Dissocial Disorder frequently co-occurs and can be diagnosed with Oppositional Defiant Disorder, particularly among individuals with a more persistent history of behaviour problems.
- Individuals with Conduct-Dissocial Disorder with limited prosocial emotions (see p.) and individuals with Conduct-Dissocial Disorder, childhood onset are at greater risk for exhibiting a more persistent and severe pattern of antisocial behaviour over time. However, the subtypes for age of onset and the qualifier for prosocial emotions are distinct characteristics that should be considered separately. In particular, childhood onset does not necessarily indicate that the individual will exhibit limited prosocial emotions.
- Conduct-Dissocial Disorder frequently co-occurs with Attention Deficit Hyperactivity Disorder, Developmental Learning Disorder, Anxiety or Fear-Related Disorders, Mood Disorders, and Disorders Due to Substance Use.

Boundaries with Normality (Threshold):

- Engaging in political protests should not be regarded as indicating the presence of Conduct-Dissocial Disorder.
- The behaviours that contribute to a diagnosis of Conduct-Dissocial Disorder can include criminal offenses and may entail legal or disciplinary repercussions, particularly for adolescents and adults. At the same time, many individuals who commit such criminal offenses do not exhibit a persistent and recurrent pattern of antisocial behaviour in which the basic rights of others or major age-appropriate social or cultural norms, rules, or laws are violated. Criminal behaviours may occur impulsively or opportunistically, or in relation to substance use or intoxication. Clinical assessment and diagnosis should focus on the broader pattern of behaviour rather than solely on the criminality of specific behaviours or incidents.

Course Features:

- Earlier age of onset and greater symptom severity are predictive of worse prognosis with these individuals being more likely to engage in criminal behaviour and substance abuse as well as experience additional co-occurring mental and behavioural disorder diagnoses during adulthood.

- The course of Conduct-Dissocial Disorder is highly variable with some individuals experiencing a full remission of symptoms by adulthood. Initial symptoms of Conduct-Dissocial Disorder are typically less severe in form (e.g., lying) but may progress in their severity over time (e.g., assault). There are significant individual differences in course features and progression of symptoms over time.
- When Conduct-Dissocial Disorder is present in adulthood it has generally been preceded by a history of serious behaviour problems during childhood and adolescence.
- The persistence of Conduct-Dissocial Disorder into adulthood is often marked by continuity in types of behaviour problems (e.g., property violations in contrast to theft). Individuals with Conduct-Dissocial Disorder who are violent during adolescence typically continue to engage in more frequent violence than their peers in adulthood. Status offenses (e.g., running away, truancy) are less relevant in adulthood but are a risk factor for continuing rule-breaking behaviour and criminal arrest.

Developmental Presentations:

- Although onset of Conduct-Dissocial Disorder can occur in early childhood during the preschool years, typical age of onset is during early to middle adolescence. Onset of Conduct-Dissocial Disorder is rare after the age of 16.

Culture-Related Features:

- Assessment of conduct problems should account for contextual factors to determine whether a diagnosis is appropriate. In some cultural settings, for example, school-age children may be away from school for long periods of seasonal employment, rather than for conduct reasons. Alternatively, in communities with high levels of organized violence (e.g., gangs) or in the midst of civil conflict or war (e.g., where children as recruited as soldiers), children may be coerced into participating in interpersonal violence or property theft, which they may carry out for their own survival. A diagnosis of Conduct-Dissocial Disorder should not be assigned in such cases.
- Conduct Disorder in adolescents often co-occurs with Disorders Due to Substance Use, especially those associated with use of alcohol. The rates of co-occurrence are influenced by sociocultural variation in availability of substances.

Gender-Related Features:

- Conduct-Dissocial Disorder is more common among males.
- Males with Conduct-Dissocial Disorder are more likely to exhibit symptoms of stealing, vandalism, fighting, and school discipline problems, whereas females are more likely to exhibit lying, truancy, substance abuse, absconding, and prostitution.
- Males with Conduct-Dissocial Disorder more commonly exhibit both physical and relational aggression, whereas females are more likely to exclusively exhibit relational aggression.

Boundaries with Other Disorders and Conditions (Differential Diagnosis):

- ***Boundary with Oppositional Defiant Disorder:*** For a diagnosis of Conduct-Dissocial Disorder to be assigned, the pattern of behaviour must be severe and dissocial (i.e.,

violating major rules, norms, or the rights of others), such that it extends beyond the noncompliant and defiant behaviours that are characteristic of Oppositional Defiant Disorder. However, Oppositional Defiant Disorder and Conduct-Dissocial Disorder frequently co-occur, particularly among adolescents and individuals with a more persistent history of behaviour problems, and may be diagnosed together if the full diagnostic requirements for both disorders are met.

- ***Boundary with Attention Deficit Hyperactivity Disorder:*** Individuals with Attention Deficit Hyperactivity Disorder may exhibit disruptive behaviours as a result of their impulsivity or hyperactivity; however, these disruptive behaviours are not typically severe and dissocial in nature (i.e., they do not violate major rules, norms, or the rights of others), and therefore would not warrant an additional diagnosis of Conduct-Dissocial Disorder. However, Conduct-Dissocial Disorder and Attention Deficit Hyperactivity Disorder can co-occur, and both may be diagnosed if the full diagnostic requirements for both disorders are met.
- ***Boundary with Mood Disorders:*** Conduct problems, aggressive behaviours, risky behaviours, and irritability/anger can occur in the context of Mood Episodes (Depressive, Manic, Mixed, or Hypomanic). Moreover, in children and adolescents, depressive, manic, or hypomanic mood can manifest as irritability. When the behaviour problems occur entirely in the context of Mood Episodes, a separate diagnosis of Conduct-Dissocial Disorder is generally not warranted.
- ***Boundary with Intermittent Explosive Disorder:*** Individuals with Intermittent Explosive Disorder may come into conflict with other people and the law because of their explosive outbursts, but these episodes do not constitute a more general pattern of antisocial behaviour characteristic of Conduct-Dissocial Disorder (e.g., rule violations, lying, theft). In addition, Intermittent Explosive Disorder is characterized by impulsive aggression, while aggression in Conduct-Dissocial Disorder is often premeditated and instrumental.
- ***Boundary with Personality Disorder:*** Conduct-Dissocial Disorder is not a Personality Disorder, although it is related to specific Personality Disorder categories in the clinical and research nomenclature (i.e., Dissocial Personality Disorder, Antisocial Personality Disorder). Personality Disorder is characterized by a relatively enduring and pervasive disturbance in how individuals experience and interpret themselves, others, and the world that results in maladaptive patterns of cognition, emotional experience, emotional expression, and behaviour. These maladaptive patterns lead to significant problems in psychosocial functioning that are particularly evident in interpersonal relationships, manifested across a range of personal and social situations (i.e., not limited to specific relationships or situations). Individuals with Personality Disorder may have prominent dissocial features as an aspect of personality traits. The diagnosis of Conduct-Dissocial Disorder is made based on a recurrent pattern of antisocial behaviour that may range in duration from a discrete period lasting a number of months to a pattern that persists across the lifespan. Conduct-Dissocial Disorder and Personality Disorder can co-occur, and both may be diagnosed if the full diagnostic requirements for both disorders are met.
- ***Boundary with Disorders Due to Substance Use:*** If the pattern of dissocial behaviour is limited to obtaining or using illicit substances, or if the behaviour is exclusively related to the effects of intoxication, dependence, or withdrawal, Conduct-Dissocial Disorder should not be diagnosed and a Disorder Due to Substance Use should be considered instead. At the same time, co-occurrence of episodes of dissocial behaviour and substance use is common among individuals with Conduct-Dissocial Disorder. This

distinction may therefore depend on a complex clinical judgment that takes into account the onset, sequencing, and context of the relevant behaviours. However, Conduct-Dissocial Disorder and Disorders Due to Substance Use frequently co-occur, and both may be diagnosed if the full diagnostic requirements are met.

6C9Y Other Specified Disruptive Behaviour or Dissocial Disorders

Essential (Required) Features:

- The presentation is characterized by disruptive or dissocial symptoms that share primary clinical features with other Disruptive Behaviour or Dissocial Disorders (i.e., persistent behaviour problems across multiple settings that range from markedly and persistently defiant, disobedient, provocative or spiteful to those that persistently violate the basic rights of others or major age-appropriate societal norms, rules, or laws).
- The disruptive or dissocial symptoms do not fulfil the diagnostic requirements for Oppositional Defiant Disorder or Conduct-Dissocial Disorder.
- The symptoms are not better accounted for by another Mental, Behavioural, or Neurodevelopmental Disorder (e.g., Attention Deficit Hyperactivity Disorder, a Mood Disorder, an Anxiety or Fear-Related Disorder).
- The behaviour pattern has persisted for an extended period of time (e.g., 6 months or more).
- The symptoms and behaviours are not developmentally appropriate or culturally sanctioned.
- The symptoms and behaviours are not a manifestation of another medical condition and are not due to the effects of a substance of medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Qualifiers Applicable to Disruptive Behaviour or Dissocial Disorders

Qualifiers for limited or typical prosocial emotions:

The qualifier ‘with limited prosocial emotions’ may be applied to individuals who meet the diagnostic requirements for Disruptive Behaviour or Dissocial Disorders and also exhibit a pattern of limited prosocial emotions sometimes referred to as ‘callous and unemotional traits.’ Individuals with these characteristics represent a minority of those with Disruptive Behaviour and Dissocial Disorders diagnoses. The ‘with limited prosocial emotions’ qualifier represents a relatively more severe and less common presentation of Disruptive Behaviour or Dissocial Disorders, compared to those with these diagnoses and typical prosocial emotions.

In evaluating prosocial emotions, it is important to obtain information from others who have known the individual for an extended period of time, in addition to the individual’s self-report of their own behaviours and experience.

Limited or typical prosocial emotions in individuals with Oppositional Defiant Disorder or Conduct-Dissocial Disorder can be specified as follows:

6C9x.x0 with limited prosocial emotions

- In the context of a diagnosis of Disruptive Behaviour or Dissocial Disorders, the presence of a characteristic social-emotional pattern in which several of the following features are repeatedly manifested:
  - *Limited or absent empathy or sensitivity* to others' feelings or concern for their distress; the individual is more concerned with how behaviours affect himself/herself rather than how they affect others, even if they cause harm.
  - *Limited or absent remorse, shame, or guilt* over one's own behaviour (unless prompted by being apprehended); lack of concern about the consequences of his/her actions on others and relative indifference toward the probability of punishment.
  - *Limited or absent concern over poor/problematic performance* in school, work, or other important activities; may put forth little effort and blame others for his/her poor performance.
  - *Limited or shallow expression of emotions,* particularly positive or loving feelings toward others; emotional expression may appear shallow, superficial, insincere, or instrumental.
- This pattern is pervasive across situations and relationships (i.e., the qualifier should not be applied based on a single characteristic, a single relationship, or a single instance of behaviour).
- The pattern is persistent over time (e.g., at least 1 year).
- Among individuals with Oppositional Defiant Disorder, those with limited prosocial emotions tend to display a particularly extreme and stable pattern of oppositional behaviours. Among those with Conduct-Dissocial Disorder, those with limited prosocial emotions tend to display a particularly severe, aggressive and stable pattern of antisocial behaviours.

6C9x.x1 with typical prosocial emotions

- In the context of a diagnosis of Disruptive Behaviour or Dissocial Disorders, this qualifier represents a more common pattern of Oppositional Defiant Disorder or Conduct-Dissocial Disorder that is not characterized by the features of limited prosocial emotions.
- Although some features similar to limited prosocial emotions (e.g., low concern, limited remorse) may be evident at times, they are generally infrequent, transitory, and less pronounced and do not represent a persistent pervasive pattern of social-emotional deficits.
- Most individuals with Disruptive Behaviour or Dissocial Disorders exhibit typical prosocial emotions.