Clinical Perspectives

Childhood Irritability Disorder: A Proposal for DSM Conditions for Further Study

Aderonke Oyetunji, MD[1]

[1] psychiatry, University of Kansas Medical Center

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Childhood irritability, characterized by a persistently low threshold for frustration and pervasive angry mood, is among the most common reasons for psychiatric referral yet remains diagnostically marginalized. Current *Diagnostic and Statistical Manual of Mental Disorders* (*DSM)* categories—disruptive mood dysregulation disorder, oppositional defiant disorder, and intermittent explosive disorder—do not adequately capture children with persistent irritability who lack recurrent explosive outbursts or defiance. This Clinical Perspective proposes including childhood irritability disorder (CID) in the *DSM* "Conditions for Further Study" section. CID would be defined by chronic irritability present across settings for at least 6 months, onset before age 10, and associated functional impairment, with optional specifiers for temper outbursts and defiance. Dimensional thresholds, such as the Affective Reactivity Index, provide anchors for clinical severity. Recognition of CID would enhance diagnostic clarity, reduce treatment variability, and yield more homogeneous research cohorts. Field trials are needed to establish reliability and validity, but formal inclusion represents a necessary step toward addressing this under-recognized and impairing presentation.

Chronic irritability in childhood is characterized by a persistently low threshold for frustration, sustained angry mood, and emotional dysregulation. It is among the most common reasons for child psychiatric referral. Despite mounting evidence of its clinical significance, longitudinal impact, and focused advocacy by child psychiatry researchers, chronic irritability remains diagnostically marginalized.[1,2] This Clinical Perspective proposes consideration of childhood irritability disorder (CID) for inclusion in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* "Conditions for Further Study" section, with evaluation of its potential as a standalone diagnosis contingent on future empirical findings.

Previous literature has examined how best to classify chronic irritability, particularly whether 1) irritability and temper outbursts constitute a unified construct or separable phenomena and 2) irritability should be conceptualized as a core mood disturbance or as a transdiagnostic dimension. Carlson and colleagues questioned whether irritability and outbursts should "hang together or hang separately,"[1] while Leibenluft et al emphasized irritability's longitudinal continuity and predictive validity.[2] Recent *International Classification of Diseases* field studies and accompanying commentaries further reflect disagreement about whether irritability warrants diagnostic independence or should remain embedded within existing categories.[3,4]

This perspective builds on that dialogue by synthesizing these viewpoints and advocating that chronic irritability, which is already recognized as clinically and biologically distinct, be considered for inclusion in "Conditions for Further Study" as a discrete mood-anchored syndrome. Herein, irritability refers to a persistently low threshold for frustration/anger, distinct from broader "mood dysregulation." Currently, attempts to classify irritability remain fragmented. *DSM-5* introduced disruptive mood dysregulation disorder (DMDD) to address concerns over pediatric bipolar misdiagnosis.[5] However, DMDD requires frequent, severe temper outbursts alongside chronic mood irritability, criteria that many functionally impaired children do not meet. This perspective does not aim to lower DMDD thresholds but rather to delineate a mood-anchored syndrome characterized by persistent irritability, without requiring severe, recurrent outbursts. CID is, therefore, proposed as a candidate for the *DSM* "Conditions for Further Study" section, with an optional "with temper outbursts" specifier. The proposed diagnostic criteria for CID are summarized in Table 1.

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Table 1. Proposed Diagnostic Criteria for Childhood Irritability Disorder

Criterion	Description
A. Core mood disturbance	A persistent irritable or angry mood present most of the day, nearly every day, for ≥6 months; observable by multiple informants (eg, caregiver, teacher) across 2 or more settings, producing clinically significant impairment.
B. Dimensional threshold	Severity may be indexed using validated measures such as the Affective Reactivity Index, Clinician Affective Reactivity Index, or Child Behavior Checklist (CBCL) irritability items. Scores in the clinically elevated range (ie, well above age- and sex-normed expectations) guide (but do not determine) the clinical threshold, which is ultimately established by the presence of persistent mood disturbance, cross-setting impairment, and developmental atypicality, consistent with *DSM* conventions.
C. Age of onset	Onset before age 10, distinguishing childhood irritability disorder from normative adolescent mood fluctuation.
D. Specifiers	•**With temper outbursts:** Recurrent verbal or behavioral outbursts grossly out of proportion to provocation and inconsistent with developmental level; when present, severity and frequency are assessed dimensionally rather than by a fixed categorical threshold (eg, caregiver report or CBCL items). •**With defiance:** Persistent argumentative or oppositional behavior toward authority figures exceeding developmentally normative levels (eg, frequent arguing, deliberate noncompliance, spiteful acts), evident across settings and measurable with validated behavioral scales. *Note:* The presence of either specifier does not replace the required persistent irritable mood.
E. Exclusion criteria	•**Bipolar spectrum:** Exclude if distinct episodes of elevated or expansive mood occur. •**Major depressive disorder (MDD):** If irritability appears only during depressive episodes, diagnose MDD. •**Neurodevelopmental or trauma-related disorders (ASD/ADHD/anxiety/trauma):** If irritability is secondary to the primary condition and not pervasively mood-anchored, code the primary disorder. •**Oppositional defiant disorder (ODD):** If oppositional behaviors predominate (≥4 ODD symptoms beyond irritable mood), ODD is the better fit. •**Intermittent explosive disorder:** Exclude when recurrent, discrete aggressive outbursts occur without a persistent irritable mood between episodes.
F. Duration and impairment	Symptoms persist for ≥6 months and cause clinically significant impairment in social, academic, or family functioning.
G. Classification note	Conceptually aligned with mood disorders, given its sustained affective disturbance rather than episodic behavioral dyscontrol; proposed for inclusion in the *DSM* "Conditions for Further Study" section.

As summarized in Table 1, CID is defined by a persistent irritable mood with optional specifiers for temper outbursts or defiance. The proposed criteria intentionally reflect points of convergence in the existing literature, including an emphasis on persistent mood disturbance rather than episodic behavior, developmental onset in childhood, cross-setting impairment, and the separation of irritability from temper outbursts, a distinction repeatedly highlighted in prior nosological debates. Although the "with temper outbursts" specifier resembles DMDD criteria, CID differs in that the persistent irritable mood is required, while temper outbursts are not required for diagnosis and, when present, are characterized by their frequency and severity rather than a fixed categorical threshold. DMDD, by contrast, requires ⩾3 severe outbursts per week in addition to chronic irritability; thus, CID captures youth whose irritability is impairing yet subthreshold for meeting the frequency or intensity criteria for DMDD.

Similarly, oppositional defiant disorder (ODD) includes an irritable mood cluster. Still, the diagnosis organizes symptoms into oppositional/defiant and vindictive behaviors, where irritability is a subcluster rather than the organizing construct. While some youths with irritability also meet ODD criteria, many do not present sufficient oppositional symptoms; CID centers the affective disturbance and resultant impairment.[6] Also, unlike intermittent explosive disorder (IED)—which centers on discrete, impulsive, aggressive outbursts—CID requires a persistent irritable mood between episodes, and if aggressive outbursts occur, they are optional and captured as a specifier. The existing framework overlooks children with persistent irritability who do not exhibit explosive behavior or defiance. Table 2 compares the proposed CID with *DSM-5* conditions most frequently used to describe chronic irritability.

Children with chronic irritability often receive disparate diagnoses or fall into diagnostic gray areas, leading to inconsistent treatment and limited access to tailored interventions. If CID is included in "Conditions for Further Study," guidance may be provided on adding specific "R codes," such as R45.5 or R45.89, to comorbid diagnoses, as suggested in the literature, to improve diagnostic accuracy.[1] This will enable field trials, reliability testing, and threshold calibration before considering full diagnostic inclusion. Ultimately, establishing CID as a diagnostic entity could promote early detection, reduce heterogeneity by using testable hypotheses derived from field trials within clinical trials, and support the development of specific treatment guidelines. While existing literature has laid the scientific groundwork, no unified proposal for *DSM* inclusion has yet gained consensus.[5] CID offers greater flexibil-

Table 2. Comparison of Childhood Irritability Disorder With Existing *DSM* Diagnoses

Feature	Childhood irritability disorder (proposed)	Disruptive mood dysregulation disorder	Oppositional defiant disorder (irritable subtype)
Core mood	Chronic irritability or angry mood	Chronic irritability + frequent outbursts	Irritable mood (1 of 3 domains)
Outbursts required	No	Yes (≥3/wk)	No
Age of onset	Before age 10	Before age 10	Before age 12
Functional impairment	Required	Required	Required
Duration	≥6 mo	≥12 mo	≥6 mo
Setting requirement	Multiple settings[a]	Multiple settings[a]	At least 1 setting[a]
Focus	Affective dysregulation	Mood + behavioral dysregulation	Defiance, anger, vindictiveness
Intended use	Standalone mood dysregulation diagnosis	Replaces misdiagnosed bipolar disorder	Behaviorally driven oppositionality

[a]Multiple = 2 or more settings (home and school); at least 1 = symptoms present in any single context.

ity than DMDD in its behavioral criteria and departs from ODD/IED by focusing on affective, rather than oppositional, mood dysregulation.

Conceptually, CID aligns most closely with mood disorders, given its sustained affective disturbance rather than episodic behavioral dyscontrol. However, future empirical work will determine whether it bridges affective and disruptive spectra.

Dimensional tools like the Affective Reactivity Index and its clinician-administered counterpart, the CL-ARI, have demonstrated high reliability and predictive validity, providing practical anchors for determining when irritability is clinically significant.[7] Pending further study, subtypes of CID with or without outbursts could be defined. By anchoring the diagnosis in persistent irritable mood (rather than behavioral composites) and using dimensional thresholds to define severity, CID may yield more phenotypically coherent research cohorts. Field trials and comparative validity studies could support the conclusion that chronic irritability is neurobiologically distinct, thereby supporting the inclusion of CID in the *DSM*. Emerging neuroimaging and genetic studies suggest that chronic irritability may have partially distinct neurodevelopmental correlates while still overlapping with broader mood dimensions, raising the possibility that CID could represent a more neurobiologically coherent phenotype, a hypothesis to be tested in future field trials.[2] These findings, together with twin heritability data, further support the presence of partially distinct developmental pathways underlying chronic irritability.[8] Irritability also demonstrates strong longitudinal continuity, predicting adult depression, anxiety, and functional impairment across multiple large-scale studies.[9] CID would also address a real-world clinical need given the absence of a diagnosis that “fits” the irritable child whose behavior does not meet criteria for existing disorders but whose chronic irritability is impairing.

Future work, including field trials, is needed to assess the reliability and prevalence of CID and build consensus among researchers, clinicians, and families. Clinical intervention studies targeting this phenotype are also needed to inform evidence-based treatment approaches. Consideration of CID as a distinct diagnostic construct would reflect current evidence on persistent irritability and provide a framework for systematic evaluation, including refinement of diagnostic thresholds and boundaries. By centering sustained affective disturbance as the organizing construct, rather than episodic outbursts or oppositional behavior, CID offers a parsimonious approach to studying a clinically impairing presentation that is currently distributed across multiple diagnostic categories. Placement within the *DSM* “Conditions for Further Study” would allow this construct to be empirically tested while addressing concerns about diagnostic proliferation by consolidating rather than expanding the diagnostic system.

PLAIN LANGUAGE SUMMARY

This article looks at how persistent irritability in children is common, impairing, and often overlooked by current *Diagnostic and Statistical Manual of Mental Disorders* diagnoses. Many children with chronic irritability do not meet criteria for existing disorders, which leaves families with confusing diagnoses and inconsistent care. We review the strengths and limitations of current categories and propose childhood irritability disorder (CID) as a better option. CID centers on a persistent irritable mood, with optional add-ons for outbursts or defiance. Recognizing CID would improve how clinicians identify and treat these children and help researchers design studies and interventions that better meet family needs.

ABOUT THE AUTHOR

Aderonke Oyetunji, MD, Department of Psychiatry and Behavioral Sciences, University of Kansas Medical Center, Kansas City, Kansas, USA.

CORRESPONDENCE TO:

Aderonke Oyetunji, MD; email: **aoyetunji@kumc.edu**.

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AI DISCLOSURE

The author reports the use of AI and/or AI-assisted technologies to improve the quality of the writing for specific section(s) of the manuscript.

AUTHOR CONTRIBUTIONS

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