OPPOSITIONAL DEFIANT DISORDER

Background

1. Definition
    - Recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures
        - Persists for at least 6 months
        - Leads to significant impairment in social, academic, or occupational functioning
        - Inclusive of DSM IV criteria[1]
2. General Information
    - Behaviors occur more frequently than typically seen in individuals of comparable age and developmental level[1]
    - Frequently comorbid with other psychiatric disorders, particularly ADHD[2]

Pathophysiology

1. Pathology of Disease[2,3]
    - Behavioral disorder – not associated with any known physical or biochemical abnormality
    - Cause generally related to social, parental, and child factors
    - Strong correlation between parental behavior and oppositional behavior
        - Parents tend to be critical, rejecting, lacking in warmth, passive, and un-stimulating
        - Mothers in particular demonstrate high levels of anxiety and depression
        - Family/marital relationships often strained
    - Aggressive children underutilize pertinent social clues
        - Misattribute hostile intent to peers
        - Generate fewer solutions to problems
        - Expect to be rewarded for aggressive responses
2. Incidence, Prevalence[3,4]
    - Prevalence varies from 2% to 16% of school-aged children
    - Increasing rate of diagnosis grade school → middle school → high school; then decreases in college students
    - Relatively equal distribution in boys and girls; girls more likely to use verbal, rather than physical, aggression
3. Risk Factors[3]
    - Correlation between ODD and living in crowded conditions
    - Correlation between social class and ODD
    - Some correlation to quality of day care if mother employed
    - More common in families where at least one parent has mood disorder, conduct disorder, antisocial personality disorder, or substance-related disorder
    - No correlation to paternal or maternal employment
    - 18% of children with ODD have alcoholic fathers
4. Morbidity / Mortality[3,4]
    - ODD children have problems with low self-esteem, lability of mood, and low tolerance of/for frustration

- More likely to be involved with substance abuse
- Demonstrate verbal aggression at early age; may progress to physical aggression
- Aggression usually directed at caretakers or parents, rarely at strangers
- ADHD common comorbidity
- Most serious consequence of ODD is development of more dangerous conduct problems
    - Approximately one third of children with ODD subsequently develop conduct disorder
    - 40% of children who develop conduct disorder will progress to antisocial personality disorder in adulthood

Diagnostics

1. History[1,2]
    - Natural history not well understood
    - Recurrent pattern of negativistic, hostile, or defiant behavior
    - Symptoms occur for at least 6 months
    - Commonly presents in late preschool or early school age
        - Before age 8; not after early adolescence
    - Onset gradual, course of months to years
        - ODD-type behaviors can appear 2-3 years earlier than diagnosis
    - Oppositional symptoms often emerge first in home setting, crossing later to other areas
    - Oppositional symptoms tend to increase with age
    - More prevalent in males than females before puberty; equal gender ratio after puberty
    - Most behaviors directed at someone, usually authoritative figure well known to individual
    - Does not show major antisocial violations of others' rights or violations of age-appropriate societal norms or rules
        - Think Conduct Disorder if these behaviors occur
2. Physical Examination
    - Typically normal unless other comorbid disorders
3. Diagnostic Testing[4]
    - Diagnosis mainly based on history from multiple resources (patient, caregiver, preschool, teacher)
    - No specific testing for ODD; tools used to rule out other disorders
        - National Initiative for Children's Healthcare Quality Vanderbilt Assessment Scale
        - SNAP-IV
        - Pediatric Symptom Checklist
4. Laboratory evaluation
    - Not necessary
5. Diagnostic imaging
    - Neuroimaging has no clinical role[4]
6. Diagnostic "Criteria"[1]

- Pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:
  - Often loses temper
  - Often argues with adults
  - Often actively defies or refuses to comply with adults requests for rules
  - Often deliberately annoys people
  - Often blames others for his or her mistakes or misbehaviors
  - Often touchy or easily annoyed by others
  - Often angry and resentful
  - Often spiteful and vindictive
- Behavior disturbance causes clinically significant impairment in social, academic, or occupational functioning
- Behaviors do not occur exclusively during course of Psychotic or Mood Disorder
- Criteria not met for Conduct Disorder or Antisocial Personality Disorder
- Note: criterion met only if behavior occurs more frequently than typically observed in individuals of comparable age and developmental level

Differential Diagnosis

1. Key Differential Diagnoses[1,2]
   - ADHD
   - Conduct Disorder
   - Substance abuse
   - Mood disorder (including Bipolar)
   - Developmental Delay
   - Language and Learning Disorders
   - Psychotic Disorders
   - Normal Individualization

Therapeutics

1. Acute Care
   - Patient and family safety
     - Determine access to and supervision of weapons in home
2. Long-Term Care
   - Treatment difficult: should involve psychosocial therapy, with occasional medication therapy
   - Early intervention more likely to succeed and prevent progression into more problematic behaviors
   - Treatment plans individualized to specific clinical situation of patient
     - Tailor approaches to specific encountered problems
     - Based on developing problem solving skills
     - Family interventions oriented toward effective disciplining and age-appropriate supervision
   - Dramatic, one-time or short-term treatments (boot camp, shock incarceration, etc.) rarely successful
   - Physician goals in care:

        - Solicit information from daycare providers, teachers, and other professionals in addition to parents
        - Engage with child by empathizing with patient's anger and frustration while refraining from sanctioning oppositional/ aggressive behavior
        - Constructively raise issues regarding efficacy of parenting without making parent feel accused or judged
3. Recommendation
    - Parenting skills training and behavioral therapy reduce conflict behaviors in adolescents with ODD (SOR C)[5]
    - When ODD associated with ADHD or other medication-responsive comorbidities, medical treatment reduces overall symptoms (SOR B)[5]
    - Psychopharmacologic treatment not appropriate for ODD without comorbidity unless severe aggressive behavior persists after psychosocial treatments of established efficacy (SOR C)[2]
    - Psychostimulants reduce ODD behaviors in children with coexisting ADHD (SOR A)[4]
    - Media-based parent training effective for improving behavioral problem outcomes in children with ODD (SOR B)[4]

Follow-Up

1. Refer to Specialist
    - Consult pediatric psychiatrist for children who do not respond to nonmedical interventions or are extremely impaired[3]

Prognosis

1. Stable diagnosis over time
2. Most individuals have symptom resolution over 3 year follow-up period
3. Earlier age at onset tends toward poorer prognosis with progression toward CD and anti-social personality disorder
    - Three-fold increase in development of CD with earlier onset of symptoms
4. Association of ODD and ADHD portends poorer prognosis
5. Increased risk of comorbid diseases (ADHD, anxiety, or mood disorders) with increasing age
6. Youth have significantly higher rates of comorbid psychiatric disorders and greater family social dysfunction[2]

Prevention

1. Prevention is key element in ODD and other disruptive behavior disorders
2. Interventions can be presented in schools, clinics, or other community locations
    - Preschool: Head Start, home visitation to high-risk families
    - School age: parent management strategies
        - Psychoeducational packages targeting social skills, conflict resolution, anger management
    - Adolescence: psychoeducation packages with skills training, cognitive interventions, vocational training, and academic preparation[2]

Patient Education

1. Mayo Clinic: http://www.mayoclinic.com/health/oppositional-defiant-disorder/DS00630
2. American Academy of Child and Adolescent Psychiatry – Facts for Families: http://aacap.org/cs/root/facts_for_families/facts_for_families
3. Medline Plus: http://www.nlm.nih.gov/medlineplus/ency/article/001537.htm

References

1. Oppositional Defiant Disorder. In: First M, ed. *Diagnostic and Statistical Manual of Mental Disorders – 4th Ed.* Washington, DC: American Psychiatric Association; 2000: 313.81.
2. Steiner H, Remsing L. Practice Parameters for the Assessment and Treatment of Children and Adolescents With Oppositional Defiant Disorder. *Journal of the American Academy of Child Adolescent Psychiatry*. 2007; 46(1):126-141.
3. Disruptive Behavioral Disorders in Children
4. Hamilton SS, Armando J. Oppositional Defiant Disorder. *American Family Physician.* 2008; 78(7):861-866, 867-868.
5. What are Effective Treatments for Oppositional Defiant Behaviors in Adolescents?

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