Oppositional Defiant Disorder

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DSM-5 Criteria for Diagnosis

- Angry, irritable mood, argumentative, defiant behavior, and vindictiveness of at least 6 months duration
- Clinically significant impairment
- Not occurring only with psychosis or mood disorder

Symptoms of ODD

- Loses temper
- Touchy, easily annoyed
- Angry, resentful
- Argues with adults
- Defiant, refuses to comply with adults
- Annoys others
- Blames others for his problems
- Spiteful, vindictive

Frequency Cut Offs for ODD

- Any time: spiteful or vindictive; blames others for his mistakes
- At least twice a week: touchy, loses temper, argues with adults, defiant
- At least 4 times a week: angry or resentful, annoys others

Angold, Costello 1996

Diff Dx: Normal Child

- Temperament
  - Very active, poorly regulated
  - Hypersensitive, anxious
- Preschool temper tantrums
- Independence seeking adolescent

Unhealthy Tantrums

- More than 10-20 days/month
- More than 5 episodes/day
- Duration >25 minutes
- Inability to calm without assistance
- Self-injurious behavior
- Violent destructive behavior

J Pediatrics 2008; 152: 117-122.

Epidemiology of ODD

- Prevalence: 2-16%
- Gender: more boys than girls in childhood, equal in adolescence
- Age: may be more common in preschoolers and adolescents

Natural History Of ODD

- Onset prior to 8 years of age
- Persists into adolescence
- Children with conduct disorder have prodromal ODD, but children with ODD seldom develop conduct disorder

Differential Diagnosis

- Conduct disorder: more aggression, major violation of rules
- ADHD: does not listen or comply because of daydreaming, inattention not defiance
- Depression: irritable, withdrawn
- Communication disorders: fails to understand requests
- Normal: Preschool, young child with MR

Etiology

- Genetic: more common in families with a parent with mood disorder, ODD, CD, ADHD, or antisocial personality
- Genetic overlap with ADHD
- Families: association with attachment problems and maternal depression
- Physical illness: association with chronic illness, and CNS injury

Behavior and aggression

- Poor impulse control

  disinhibited, overactive

  Dx: ADHD, ODD/CD
- Affective

  irritable, dysphoric, hypersensitive

  Dx: ODD/CD, mood and anxiety disorder

Socialization and aggression

- Abuse or neglect
- Inadequate discipline, supervision
- Chaotic home, modeling
- Peer and neighborhood influences

CNS dysfunction and aggression

- Frontotemporal damage
- Intellectual disability
- Drugs: adverse effect and abuse
- Psychosis

Initial Assessment

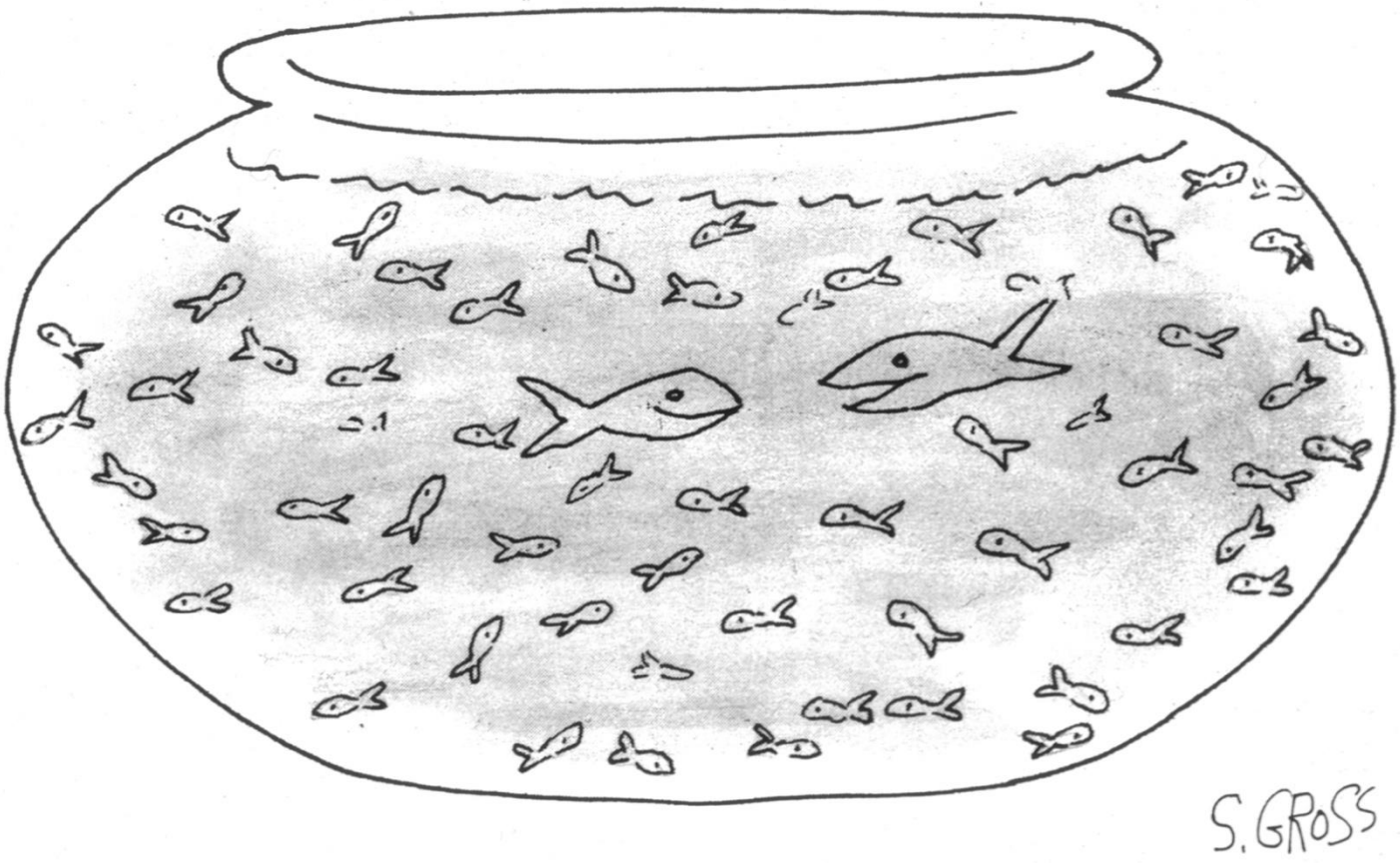
- Episodes: triggers, character of the episode-severity, duration, types of aggression
- Environment: family, friends
- Temperament
- Physical: language and cognitive skills, illness, chronic disorders, medications
- Emotional and behavioral disorders

Assessment

- General scales: Childhood Behavioral Checklist; Child and Adolescent Symptom Inventory; Conners rating scales
- School measures: CBCL Teacher Report Form
- Disruptive behavior scale: CHAOS; 22-item parent checklist

Outburst Monitoring Scale

- 20-items, 0-4 scale (never to very often)
- Verbal aggression
- Property destruction
- Self-injurious behavior
- Physical aggression toward others



"I guess we'd be considered a family. We're living together, we love each other, and we haven't eaten the children yet."

Management of ODD

- Parent management training
- Family therapy
- Psychopharmacology

Parent Management Training

- Identify the problem
- Avoid harsh discipline, inconsistency, reinforcement of negative behavior or failure to acknowledge good behavior
- Teach prompting, instruction, modeling
- Teach positive reinforcement

Barkley: Your Defiant Child

- Give undivided attention 15 minutes a day
- Acknowledge and praise good behavior
- Use rewards and incentives
- For bad behavior, deduct tokens, time out
- Expand use of time out
- Plan for public exposure, anticipate
- Work with school

Phelan: 1-2-3 Magic

- Avoid excess discussion, excess emotion
- To stop behaviors: no talk or emotion, count of 3, then time out.
- T start behaviors: request, then praise, use timers, withdraw tokens, allow natural consequences, add rewards, use modified 1-2-3

Psychopharmacology for ODD

- Methylphenidate and amphetamine
- RCT show MPH effective for ODD with ADHD and ODD with no symptoms of ADHD
- For ODD+ADHD, if stimulant not successful, add guanfacine, maybe clonidine
- Atomoxetine at 1.8 mg/kg/day may help

TOSCA

- Start with parent training plus stimulant for 4-6 weeks
- Failure and anxious or depressed, add SSRI
- Failure and not anxious or fails SSRI, add risperidone 0.5 mg HS, increased to mean 1.7 $\pm$ 0.75 mg per day

Side Effects of Atypical Antipsychotics

- Weight gain
- Metabolic syndrome
- Elevated prolactin
- Prolongation of QTc interval
- EPS
- others

Psychopharmacology

- Alpha adrenergic: guanfacine or clonidine
- Atypical antipsychotic
- Mood stabilizers: valproic acid or lithium

Role of the pediatrician

- Normal child: educate parent
- ADHD, ODD: start treatment
- Conduct disorder: counseling
- Moderate to severe aggression needing antipsychotics or mood stabilizer: refer