

## **OPPOSITIONAL DEFIANT DISORDER**

DSM-IV Diagnostic Code: 313.81 Oppositional Defiant Disorder

### Diagnostic Guidelines

1. Establish diagnostic accuracy as defined by DSM-IV. Use of parent and teacher behavior rating scales is strongly encouraged in the diagnostic process.
2. Consider differential diagnoses including Conduct Disorder, ADHD, mood disorders, psychotic disorders, and mental retardation. Note that comorbidity with other disorders is common particularly with ADHD or depression/anxiety.
3. Consider comorbid substance use/abuse or organicity, e.g., history of significant head trauma and lead toxicity. Assess whether further medical work-up is needed. Coordinate care with primary care physician.
4. Assess family history as ODD appears to be more common in families in which at least one parent has a history of a mood disorder, ODD, conduct disorder, ADHD, antisocial personality disorder, or a substance-related disorder.
5. Criteria for this disorder is only met if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level, particularly preschool age and adolescence where oppositional symptoms are more prevalent and considered part of normal development for the stage.
6. The Child Behavioral Checklist may be a useful tool to assist with differential diagnosis.
7. ODD is seen as an internally driven disorder. It is important to assess whether the behavior is internally driven or is externally driven in response to a situation or environmental circumstance.

### Treatment Guidelines

1. Prioritize treatment to focus on high-risk behaviors first such as physical aggression, fire setting, etc. Treatment should focus on targeted problem areas that may include:
  - impulsivity
  - aggression
  - explosiveness
  - non-compliance
  - relationships with peers, family, teachers
  - other antisocial behavior

Resolving these become endpoints for treatment.

2. Medication may be considered for uncontrollable aggressive behavior or target symptoms suggesting medication responsiveness, e.g., consider a mood stabilizer for persistent mood swings, impulsiveness, and explosiveness.
3. Psychotherapy should be focused and directive and should include cognitive/behavioral interventions as well as family-based systemic approaches. Establishing rapport will be a significant factor in potential success in individual therapy.
4. Family therapy should be a major part of the treatment, emphasizing parenting skills such as developmentally appropriate expectations, consistent limit setting and enforcement, as well as appropriate family interaction with the client. E.g., families often take an angry stance towards the client and can alienate them from the rest of the family system.
5. Consider group therapy for adolescent clients as they tend to respond to peer interaction. Groups might help in addressing issues such as communication and behavior management. Cognitively oriented problem-focused groups that are structured and therapist directed might be beneficial however, consider the possibility of exacerbation of antisocial/disruptive behaviors in the group setting.
6. Coordinate treatment with other social supports, e.g., Ala-Teen, athletics, church, probation, and social services. Get input from those who know patient, e.g., teachers, coaches, ministers/rabbis.
7. Consider use of multi-systemic therapy in the treatment (see clinical guidelines regarding MST).

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Refer also to CHN Clinical Guidelines for use of MST.