

OPPOSITIONAL DEFIANT DISORDER

DSM-IV Diagnostic Code: 313.81

Diagnostic Guidelines

1. Establish diagnostic accuracy as defined by DSM-IV-TR.
2. Consider differential diagnoses including Conduct Disorder, ADHD, mood disorders, psychotic disorders, mental retardation and normal adolescent turmoil. Note that co-morbidity with other disorders is common particularly with ADHD and/or depression/anxiety.
3. Consider co-morbid 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. Consider a psychoeducational evaluation to rule out the presence of learning disabilities contributing to disruptive oppositional behaviors at school.
7. Use of parent and teacher behavior rating scales such as the Achenbach Child Behavioral Checklist is strongly encouraged in the diagnostic process.
8. Establish accurate diagnosis through continued assessment of diagnosis over time, ruling out other diagnoses as necessary.
9. 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 which would indicate an adjustment reaction.

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. A major tranquilizer may be considered for decreasing impulsiveness, excitability and explosiveness.
3. Individual psychotherapy should be focused and directive and 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 establishing developmentally appropriate expectations, consistent limit-setting and enforcement, as well as reinforcing appropriate family interaction with the individual. For example, families often take an angry stance towards the individual and can alienate them from the rest of the family system. Family sculpting can help to define family roles and behaviors. Challenge the parent to allow natural and logical consequences to occur for the child. Model and role play child interaction techniques to increase the efficacy and confidence of the parent.
5. Consider group therapy for adolescents with ODD, as they tend to respond to peer interaction. Groups may help in addressing issues such as communication and behavior management thereby improving social judgment skills. Cognitively oriented problem-focused groups that are structured and therapist directed might be beneficial. However, consider the possibility that antisocial/disruptive behaviors may be increased 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 individual, e.g., teachers, coaches, ministers/rabbis.
7. Psychotherapy should be focused, directive and supportive and may include cognitive, behavioral, experiential and interpersonal approaches. Encourage participation in extracurricular and positive peer group activity to aid in the development of social skills and self worth. Assertiveness training may help to develop skills to express feeling constructively. Self-awareness strategies such as relaxation and self-monitoring exercises can help to improve impulse control.

8. Consider use of multi-systemic therapy in the treatment (see MST clinical guidelines).

BIBLIOGRAPHY

Quay, Herbert (Editor), Hogan, Anne (Editor) "Handbook of Disruptive Behavior Disorders", Kluwer Academic Publishers (1999).

Baer, Ruth A., and Nietzel, Michael T. "Cognitive and Behavior Treatment of Impulsivity in Children: A Meta-Analytic Review of the Outcome Literature." *Journal of Clinical Child Psychology* 20 (1991): 400-412.

Bloomquist, Michael L., August, Gerald J., and Ostrander, Rick. "Effects of a School-Based Cognitive-Behavior Intervention for ADHD Children." *Journal of Abnormal Psychology* 19 (1991): 591-605.

Braswell, Laruen. "Cognitive-Behavioral Groups for Children Manifesting ADHD and Other Disruptive Behavior Disorders." *Special Services in the Schools* 9 (1993): 91-117.

Kendall, Phillip C., and Braswell, Laruen. *Cognitive-Behavior Therapy for Impulsive Children*. New York: Guilford Press.

Sprick, R.S., & Nolet, V. (1991). Prevention and management of secondary-level behavior problems. In G. Stoner, M.R. Shinn, & H.M. Walker (Eds.), *Interventions for achievement and behavior problems* (pp. 519-538). Silver Spring, MD: National Association of School Psychologists.

Robin, A.L., & Foster, S.L. (1989). *Negotiating parent-adolescent conflict: A behavioral-family systems approach*. New York: Guilford Press.

Fraser, M.W., Nelson, K.E., Rivard, J.C. (in press). The effectiveness of family preservation services, *Social Work Research*.

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D. & Cunningham, P.B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York: Guilford Press.

Jongsma, A. E. Jr., Peterson, L. Mark and McInnis, William P. (2000) *The Child Psychotherapy Treatment Planner, second edition*. New York: John Wiley & Sons, Inc., 196-206.

Kazdin, A.E. & Weisz, J.R. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology*, 66, 19-36.

Steiner H, Rensing L, Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. J Am Acad Child Adolesc Psychiatry 2007 Jan; 46(1):126-41. [108 references]

Refer also to CHN Clinical Guidelines for use of MST.