32 - 31.12d Oppositional Defiant Disorder

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Leibenluft E, Cohen P, Gorrindo T, Brook JS, Pine DS. Chronic versus episodic irritability in youth: A community based longitudinal study of clinical and diagnostic associations. J Child Adolesc Psychopharmacol. 2006;16:456–466. Margulies DM, Weintraub S, Basile J, Grover PJ, Carlson GA. Will disruptive mood dysregulation disorder reduce false diagnosis of bipolar disorder in children? Bipolar Disord. 2012;14:488. Stringaris A, Barona A, Haimm C, Brotman MA, Lowe CH, Myers F, Rustgi E, Wheeler W, Kayser R, Towbin K, Leibenluft E. Pediatric bipolar disorder versus severe mood dysregulation: Risk for manic episodes on follow-up. J Am Acad Child Adolesc Psychiatry. 2010;49:397. Yearwood EL, Meadows-Oliver M. Mood dysregulation disorders. In: Yearwood EL, Pearson GS, Newland JA, eds. Child and Adolescent Behavioral Health: A Resource for Advance Practice Psychiatric and Primary Care Practitioners in Nursing. Hoboken, NJ: John Wiley & Sons Inc.; 2012:165. West Ae, Pavuluri MN. Psychosocial treatments for childhood and adolescent bipolar disorder. Child Adolesc Psychiatr Clin N Am. 2009;18:471–482. Yearwood EL, Meadows-Oliver M. Mood dysregulation disorders. In: Yearwood EL, Pearson GS, Newland JA, eds. Child and Adolescent Behavioral Health: A Resource for Advance Practice Psychiatric and Primary Care Practitioners in Nursing. Hoboken, NJ: John Wiley & Sons Inc.; 2012:165. Zonneyvlle-Bender MJ, Matthys W, van de Wiel NM, Lochman JE. Preventive effects of treatment of disruptive behavior disorder in middle childhood on substance use and delinquent behavior. J Am Acad Child Adolesc Psychiatry. 2007;46:33. 31.12d Oppositional Defiant Disorder Disruptive behaviors, especially oppositional patterns and aggressive behaviors, are among the most frequent reasons for children and adolescents to be referred for psychiatric evaluation. Demonstration of impulsive and oppositional behaviors are developmentally normative in young children; many youth who continue to display excessive patterns in middle childhood will find other forms of expression as they mature and will no longer demonstrate these behaviors in adolescence or adulthood. The origin of stable patterns of oppositional defiant behavior is widely accepted as a convergence of multiple contributing factors, including biological, temperamental, learned, and psychological conditions. Risk factors for the development of aggressive behavior in youth include childhood maltreatment such as physical or sexual abuse, neglect, emotional abuse, and overly harsh and punitive parenting. The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-

5), has divided oppositional defiant disorder into three types: Angry/Irritable Mood, Argumentative/Defiant Behavior, and Vindictiveness. A child may meet diagnostic criteria for oppositional defiant disorder with a 6-month pattern of at least four symptoms from the three types above. Angry/Irritable children with oppositional defiant disorder often lose their tempers, are easily annoyed, and feel irritable much of the time. Argumentative/Defiant children display a pattern of arguing with authority figures, and adults such as parents, teachers, and relatives. Children with this type of oppositional defiant disorder actively refuse to comply with requests, deliberately break rules, and purposely annoy others. These children often do not take responsibility for their actions, and often blame others for their misbehavior. Children with the Vindictive

type of oppositional defiant disorder are spiteful, and have shown vindictive or spiteful actions at least twice in 6 months to meet diagnostic criteria. Oppositional defiant disorder is characterized by enduring patterns of negativistic, disobedient, and hostile behavior toward authority figures, as well as an inability to take responsibility for mistakes, leading to placing blame on others. Children with oppositional defiant disorder frequently argue with adults and become easily annoyed by others, leading to a state of anger and resentment. Children with oppositional defiant disorder may have difficulty in the classroom and with peer relationships, but generally do not resort to physical aggression or significantly destructive behavior. In contrast, children with conduct disorder engage in severe repeated acts of aggression that can cause physical harm to themselves and others and frequently violate the rights of others. In oppositional defiant disorder, a child’s temper outbursts, active refusal to comply with rules, and annoying behaviors exceed expectations for these behaviors for children of the same age. The disorder is an enduring pattern of negativistic, hostile, and defiant behaviors in the absence of serious violations of the rights of others. EPIDEMIOLOGY Oppositional and negativistic behavior, in moderation, is developmentally normal in early childhood and adolescence. Epidemiological studies of negativistic traits in nonclinical populations found such behavior in 16 to 22 percent of school-age children. Although oppositional defiant disorder can begin as early as 3 years of age, it typically is noted by 8 years of age and usually not later than early adolescence. Oppositional defiant disorder has been reported to occur at rates ranging from 2 to 16 percent with increased rates reported in boys before puberty, and an equal sex ratio reported after puberty. The prevalence of oppositional defiant behavior in males and females diminishes in youth older than 12 years of age. ETIOLOGY The most dramatic example of normal oppositional behavior peaks between 18 and 24 months, the “terrible twos,” when toddlers behave negativistically as an expression of growing autonomy. Pathology begins when this developmental phase persists abnormally, authority figures overreact, or oppositional behavior recurs considerably more frequently than in most children of the same mental age. Among the criteria included in oppositional defiant disorder, irritability appears to be the one most predictive of later psychiatric disorders, whereas the other elements may be considered components of temperament. Children exhibit a range of temperamental predispositions to strong will, strong preferences, or great assertiveness. Parents who model more extreme ways of expressing and enforcing their own will may contribute to the development of chronic struggles with their children that are then reenacted with other authority figures. What begins for an infant as an effort to establish self-determination may become transformed into an

exaggerated behavioral pattern. In late childhood, environmental trauma, illness, or chronic incapacity, such as mental retardation, can trigger oppositionality as a defense against

helplessness, anxiety, and loss of self-esteem. Another normative oppositional stage occurs in adolescence as an expression of the need to separate from the parents and to establish an autonomous identity. Classic psychoanalytic theory implicates unresolved conflicts as fueling defiant behaviors targeting authority figures. Behaviorists have observed that in children, oppositionality may be a reinforced, learned behavior through which a child exerts control over authority figures; for example, if having a temper tantrum when a request or demand is made of the child coerces the parents to withdraw their request, then tantrum behavior becomes strongly reinforced. In addition, increased parental attention during a tantrum can reinforce the behavior. DIAGNOSIS AND CLINICAL FEATURES Children with oppositional defiant disorder often argue with adults, lose their temper, and are angry, resentful, and easily annoyed by others at a level and frequency that is outside of the expected range for their age and developmental level. Frequently, youth with oppositional defiant disorder actively defy adults' requests or rules and deliberately annoy other persons. They tend to blame others for their own mistakes and misbehavior, more often than is appropriate for their developmental age. Manifestations of the disorder are almost invariably present in the home, but they may not be present at school or with other adults or peers. In some cases, features of the disorder from the beginning of the disturbance are displayed outside the home; in other cases, the behavior starts in the home, but is later displayed outside. Typically, symptoms of the disorder are most evident in interactions with adults or peers whom the child knows well. Thus, a child with oppositional defiant disorder may not show signs of the disorder when examined clinically. Although children with oppositional defiant disorder may be aware that others disapprove of their behavior, they may still justify it as a response to unfair or unreasonable circumstances. The disorder appears to cause more distress to those around the child than to the child. Chronic oppositional defiant disorder or irritability almost always interferes with interpersonal relationships and school performance. These children are often rejected by peers, and may become isolated and lonely. Despite adequate intelligence, they may do poorly or fail in school, due to their lack of cooperation, poor participation, and inability to accept help. Secondary to these difficulties are low self-esteem, poor frustration tolerance, depressed mood, and temper outbursts. Adolescents who are ostracized may turn to alcohol and illegal substances as a modality to fit in with peers. Children who are chronically irritable often develop mood disorders in adolescence or adulthood. Pathology and Laboratory Examination No specific laboratory tests or pathological findings help diagnose oppositional defiant

disorder. Because some children with oppositional defiant disorder become physically aggressive and violate the rights of others as they get older, they may share some characteristics with people with high levels of aggression, such as low central nervous system serotonin. DIFFERENTIAL DIAGNOSIS Oppositional behaviors are both normal and adaptive within an expected range at specific developmental stages. Periods of normative negativism must be distinguished from oppositional defiant disorder. Developmentally appropriate oppositional behavior is neither considerably more frequent nor more intense than that seen in other children of the same mental age. Oppositional defiant disorder must be distinguished from Disruptive Mood Dysregulation Disorder in so far as they are both characterized by chronic irritability and inappropriate temper outbursts. According to the DSM-5, oppositional defiant disorder cannot be diagnosed in the presence of disruptive mood dysregulation disorder. (See Section 31.12c for a further discussion of disruptive mood dysregulation disorder.) Oppositional defiant behavior occurring temporarily in reaction to a stressor should be diagnosed as an adjustment disorder. When features of oppositional defiant disorder appear during the course of conduct disorder, schizophrenia, or a

mood disorder, the diagnosis of oppositional defiant disorder should not be made. Oppositional and negativistic behaviors can also be present in ADHD, cognitive disorders, and mental retardation. Whether a concomitant diagnosis of oppositional defiant disorder should be made depends on the severity, pervasiveness, and duration of such behavior. Some young children who receive a diagnosis of oppositional defiant disorder go on in several years to meet the criteria for conduct disorder. Some investigators believe that the two disorders may be developmental variants of each other, with conduct disorder being the natural progression of oppositional defiant behavior when a child matures. Most children with oppositional defiant disorder, however, do not later meet the criteria for conduct disorder, and up to one fourth of children with oppositional defiant disorder may not meet the diagnosis several years later. The subtype of oppositional defiant disorder that tends to progress to conduct disorder is one in which aggression is prominent, for example, the Angry/Irritable type and the Vindictive type. Many children who have ADHD and oppositional defiant disorder develop conduct disorder before the age of 12 years. Many children who develop conduct disorder have a history of oppositional defiant disorder. Overall, the current consensus is that two subtypes of oppositional defiant disorder may exist. One type, which is likely to progress to conduct disorder, includes certain symptoms of conduct disorder (e.g., fighting, bullying). The other type, which is characterized by less aggression and fewer antisocial traits, does not progress to conduct disorder. However, in either case, when both oppositional defiant disorder and conduct disorder are present, according to DSM-5, they may be diagnosed concurrently.

Jackson, age 8 years, was brought to the clinic for evaluation of irritability, negativity and defiant behavior by his mother. She complained that he had frequent prolonged tantrums, triggered by not “getting his way.” Jackson’s mother described the tantrums as consisting of shouting, cursing, crying, slamming doors, and sometimes throwing books or objects on the floor. Jackson had been having troubles in school as well and his teacher had reported to the family that he seemed to have a habit of provoking other students as well as the teacher by making noises, rocking in his seat, and whistling in class. Recently, at home, Jackson was kicking his foot against his mother’s chair and she asked him to stop. He looked at her and continued to kick her chair until she became angry and sent him to his room. He then started yelling and stated that he wasn’t doing anything and that his mother was just picking on him. Jackson’s mother reports that she has given up on asking him to help with chores, because it inevitably results in an argument. Jackson appears sullen and irritable on interview. He insists that his problems are all his mother’s fault and she is always nagging him unfairly. During the interview with his mother, he interrupted her several times, to say that she was lying and to contradict her story. Despite Jackson’s behavioral problem he has been able to succeed academically and scores highly on standardized tests. His mother reports that Jackson used to have some friends in kindergarten, but as he has gotten older, he has lost almost all of his friends because he has difficulty sharing his things and tends to be bossy. Jackson’s mother reports that ever since his sister was born when he was 2 years old, he has been aggressive and rivalrous toward her. Jackson’s parents separated and divorced when he was 3. He has had no contact with his father since then. Jackson’s mother was depressed for a year after the divorce until she sought treatment. She has always felt guilty that his father is not in his life, and Jackson blames her for not having his father around. She believes his behaviors have become worse since she recently started dating again. COURSE AND PROGNOSIS The course of oppositional defiant disorder depends on the severity of the symptoms and the ability of the child to develop more adaptive responses to authority. The stability of oppositional defiant disorder varies over time, with approximately 25 percent of children with the disorder no longer meeting diagnostic

criteria. Persistence of oppositional defiant symptoms poses an increased risk of additional disorders, such as mood disorders, conduct disorder and substance use disorders. Positive outcomes are more likely for intact families who can modify their own expression of demands and give less attention to the child’s argumentative behaviors. An association exists between oppositional defiant disorder and ADHD, as well as with mood disorders. In children who have a long history of aggression and oppositional defiant disorder, there is a greater risk of the development of conduct disorder and later

substance use disorders. Parental psychopathology, such as antisocial personality disorder and substance abuse, appears to be more common in families with children who have oppositional defiant disorder than in the general population, which creates additional risks for chaotic and troubled home environments. The prognosis for oppositional defiant disorder in a child depends somewhat on family functioning and the development of comorbid psychopathology. TREATMENT The primary treatment of oppositional defiant disorder is family intervention using both direct training of the parents in child management skills and careful assessment of family interactions. The goals of this intervention are to reinforce more prosocial behaviors and to diminish undesired behaviors at the same time. Cognitive behavioral therapists emphasize teaching parents how to alter their behavior to discourage the child’s oppositional behavior by diminishing attention to it, and encourage appropriate therapy focuses on selectively reinforcing and praising appropriate behavior and ignoring or not reinforcing undesired behavior. Children with oppositional defiant behavior may also benefit from individual psychotherapy in which they role play and “practice” more adaptive responses. In the therapeutic relationship, the child can learn new strategies to develop a sense of mastery and success in social situations with peers and families. In the safety of a more “neutral” relationship, children may discover that they are capable of less provocative behavior. Often, self-esteem must be restored before a child with oppositional defiant disorder can make more positive responses to external control. Parent–child conflict strongly predicts conduct problems; patterns of harsh physical and verbal punishment particularly evoke the emergence of aggression in children. Replacing harsh, punitive parenting and increasing positive parent–child interactions may positively influence the course of oppositional and defiant behaviors. REFERENCES Boxer P, Huesmann LR, Bushman BJ, O’Brien M, Moceri D. The role of violent media preference in cumulative developmental risk for violence and general aggression. J Youth Adolesc. 2009;38:417–428. Canino G, Polanczyk G, Bauermeister JJ, Rhode LA, Frick P. Does the prevalence of CD and ODD vary across cultures? Soc Psychiatry Psychiatr Epidemiol. 2010;45:695–704. Correll CU, Kratochvil CJ, March J. Developments in pediatric psychopharmacology: Focus on stimulants, antidepressants, and antipsychotics. J Clin Psychiatry. 2011;72:655–670. Dodge KA & Conduct Problems Prevention Research Group. The effects of the Fast Track Preventive Intervention on the development of conduct disorder across childhood. Child Develop. 2011;82:331–345. Kim HW, Cho SC, Kim BN, Kim JW, Shin MS, Yeo JY. Does oppositional defiant disorder have temperament and psychopathological profiles independent of attention deficit/hyperactivity disorder? Compr Psychiatry. 2010;51:412– 418. LeBlanc JC, Binder CE, Armenteros JL, Aman MG, Want JS, Hew H, Kusumakar V. Risperidone reduces aggression in boys with a disruptive behavior disorder and below average intelligence quotient: Analysis of two placebo-controlled

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