

CONDENSED CLINICAL PRACTICE GUIDELINES OPPOSITIONAL DEFIANT DISORDER (ODD)

- I. Role of clinical practice guidelines for ODD
 - A. These CPG are practice parameters. They are strategies for patient management, developed to aid clinicians in psychiatric decision-making
 - B. The parameters are based on the most current scientific literature and relevant clinical consensus
 - C. The parameters describe effective and generally accepted approaches to the assessment and treatment of ODD or to perform specific medical procedures
 - D. The parameters are not meant to define the standard of care. They do not include all proper methods of care, nor do they exclude other methods of care directed at achieving desired results
 - E. The final judgment regarding the care of any specific patient must be made by the clinician when considering all the circumstances presented, the diagnostic and treatment options available, and available resources

- II. Highlights of changes from DSM-IV-TR to DSM-5
 - A. New classification. ODD is part of a new category in DSM-5
 1. The former DSM-IV-TR category of “Disorders Usually First Diagnosed in Childhood and Adolescence” no longer exists
 2. ODD is now classified in the DSM-5 category called “Disruptive, Impulse-Control, and Conduct Disorders”
 - B. New criteria. Four refinements have been made to the criteria for ODD
 1. Symptoms are now grouped into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness. This change highlights that ODD reflects both emotional and behavioral symptomatology.
 2. The exclusion criterion for conduct disorder has been removed.
 3. *Frequency of symptoms* of ODD must be established. Many behaviors associated with ODD occur commonly in normally developing children and adolescents. The DSM-5 notes the frequency typically needed for a behavior to be considered symptomatic of ODD.
 4. *Severity of symptoms* of ODD must be clarified. A severity rating has been added. This reflects research showing that the degree of pervasiveness of symptoms across settings is an important indicator of severity.

- III. Clinical presentation and diagnostic considerations of ODD
 - A. Establish diagnostic accuracy
 1. ODD consists of recurring patterns of negativistic, hostile, or defiant behaviors lasting at least 6 months. The presentation also refers to angry and vindictive behavior and problems with control of temper.
 2. Behaviors occur more frequently than typically observed in individuals of comparable age and developmental level and cause significant impairment in functioning. Delineating ODD from normative oppositional behavior, transient antisocial acts, and conduct disorder is of paramount importance.

3. Symptoms are evident typically before the age of 8 years.
 4. Continued assessment over time is important, as ODD may precede the development of conduct disorder, which has more severe symptoms and requires different treatment.
- B. Consider differential diagnoses
1. Co-occurring disorders are common and include ADHD, conduct disorder, mood disorders, learning and developmental disabilities, adjustment disorders, relational disorders, depression, anxiety, and substance abuse (particularly in adolescents).
 2. Referral for a cognitive evaluation may be appropriate to rule out learning disabilities.
 3. Scheduling a pediatric medical exam and coordinating care with a PCP is encouraged to rule out chronic pediatric illness, significant head trauma or lead toxicity, all of which can cause similar symptoms of ODD.
- C. Obtain information from multiple informants using multiple methods
1. Clinical interviews: assess child's strengths and motivating factors, symptoms and symptom duration, age of onset, evidence of abuse and/or neglect, degree of social/academic function, adult reactions to the child, and family history of mental illness. Complete a functional analysis of behavior as part of the clinical interview.
 2. Behavior rating scales: suggested reliable and valid scales include Child Behavior Checklist, Behavior Assessment System for Children, and Eyberg Child Behavior Inventory. These may be helpful diagnosis and intensity of symptoms. Conner's rating scales can be used to assess for problems with attention and hyperactivity.
 3. Observational reports: gather information from primary caregivers, daycare providers, teachers, and other school professionals in addition to the child's self-report.
 4. Family assessment. evaluate parent and family characteristics to determine extent to which they may serve as barriers to treatment. To enhance the effectiveness of the child's treatment it may be necessary to encourage parents to seek treatment for their own problems.

IV. Preventive intervention

- A. Prevention is a key element in ODD intervention. Intervention can be delivered by clinicians in a variety of settings (schools, clinics, community locations) and through consultation (e.g., PCP, teachers, other professionals).
- B. Evidence-based programs include parent management training packages, Head Start, home visitation interventions, psychoeducational packages, and school-based programs. Table 1 gives a list of evidence-based parent training programs.

V. Treatment recommendations

- A. Recommendation 1: *Establish therapeutic alliance with child and family*. Treatment tasks of obtaining information, clarifying roles, raising issues, and promoting solutions are best advanced through empathic, patient alliance building with all

- treatment parties. The clinician needs to convey empathy with both the patient's anger and the parent's frustration without allying unduly with any party.
- B. Recommendation 2: *Consider cultural issues in diagnosis and treatment.* There is a substantial body of literature on different standards of parenting in different ethnic subgroups and the efficacy and risks of such practices. To become effective, the clinician needs to be sensitive to these areas of mismatch in patient/clinician backgrounds and should be prepared to be educated, especially in the area of parental discipline.
 - C. Recommendation 3: *Obtain information directly from the child and parents in assessment activities.* Assessment should include: 1) the possibility that ODD behavior is triggered or caused by physical abuse, sexual abuse, or neglect in the family or in the child's social orbit; 2) a functional analysis of the child's behavior; 3) evaluation of interactions between the child and primary caregiver(s); 4) the unrelenting nature of the problem; 5) the child's access to weapons and supervision of such; and 6) the child's involvement in bullying as either a victim or perpetrator.
 - D. Recommendation 4: *Consider comorbid psychiatric conditions in diagnosis and treatment.* ODD is usually highly comorbid. The clinician needs to determine whether ODD is present or a simple adjustment reaction. Then the clinician needs to determine whether the presentation is still ODD or has already progressed to a conduct disorder. Comorbid conditions, including chronic pediatric illness, require treatment along with treatment of the ODD behaviors. Therefore the clinician should establish whether the child is receiving ongoing pediatric care.
 - E. Recommendation 5: *Obtain information from multiple outside informants.*
 - F. Recommendation 6: *Use questionnaires and rating scales in assessment and treatment.* Table 2 gives a list of reliable and valid instruments to use as diagnostic aids and tools for tracking treatment progress.
 - G. Recommendation 7: *Develop individualized treatment plan based on the specific clinical situation.* A treatment plan should be developed based on a biopsychosocial formulation of the case. Interventions should target domains that are assessed as dysfunctional. Treatment should be multitarget, multimodal, and extensive, combining individual psychotherapy, family psychotherapy, pharmacotherapy, and ecological interventions (including placement and school-based interventions). Treatment must be delivered for an adequate duration (usually several months or longer) and may require multiple episodes either continuously or as periodic booster sessions to reinforce prior skills or improvements. The two types of evidence-based treatment for ODD are individual approaches (problem solving skills) and family interventions (parent management training).
 - H. Recommendation 8: *Consider empirically tested interventions for parents.* Principles underlying effective parent training methods are: 1) reduce positive reinforcement of disruptive behavior; 2) increase reinforcement of prosocial and compliant behavior; 3) apply consequences and/or punishment for disruptive behavior; 4) make parent response predictable, contingent, and immediate. See Table 1 for recommended parent management training programs.
 - I. Recommendation 9: *Consider medications as adjuncts to treatment to address symptoms and comorbid conditions.* Medication should not be the sole intervention in ODD, and if comorbid conditions are present then medication should be targeted to

those specific syndromes. Medication trials are most effective after a strong treatment alliance is established. After starting medications, adherence, compliance, and possible diversion need to be monitored carefully. Pharmacotherapeutic interventions for ODD are not well studied but stimulants and atomoxetine, when used to treat ODD in the context of other principal diagnoses such as ADHD, may result in improvement of the oppositional behavior as well. Results from controlled clinical trials when other co-occurring diagnoses are present are addressed.

- J. Recommendation 10: *Consider intensive and prolonged treatment if ODD is severe.* Lack of progress in treatment, safety issues, and planned aggressive behavior are factors that should influence decisions to refer the patient for more intensive and restrictive services. When determining the appropriate level of care, treatment ought to be: 1) in the least restrictive setting; 2) over the shortest amount of time; 3) provided in a safe and efficient manner; and 4) returned to community and family settings as the basic goal. Intensive in-home therapies are preferable alternatives to residential placement. Day treatment, residential, and hospital facilities may need to be considered if the family is unable or unwilling to collaborate with treatment of more severe cases of ODD. The risks and benefits of these out-of-home treatments/placements need to be carefully weighed.
- K. Recommendation 11: *Avoid ineffective interventions.* Any dramatic, one-time, time-limited, or short-term intervention is usually not going to be successful. Inoculation approaches (e.g., boot camps, shock incarceration) are considered ineffective and/or injurious, especially when used apart from evidence-based approaches.

References

Ala-teen website: <http://al-anon.alateen.org/for-alateen>

American Academy of Child and Adolescent Psychiatry. *Practice Parameter for the Assessment and Treatment of Children and Adolescents With Oppositional Defiant Disorder*. Journal of the American Academy of Child and Adolescent Psychiatry 2007; 46(1):126-141.

http://aacap.org/galleries/PracticeParameters/JAACAP_ODD_2007.pdf

American Academy of Child and Adolescent Psychiatry. *Oppositional Defiant Disorder: A Guide for Families*. Adapted from American Academy of Child and Adolescent Psychiatry's *Practice Parameter for the Assessment and Treatment of Children and Adolescents With Oppositional Defiant Disorder*. 2009

American Academy of Child and Adolescent Psychiatry-ODD resources

<http://aacap.org/cs/ODD.ResourceCenter>

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-V)*. Arlington, VA: American Psychiatric Publishing, Inc.; 2013.

Barkley, R. (1997). *Defiant Children: A Clinician's Manual for Parent Training (Second Edition)*. New York: Guilford Press.

Eyberg, S.M., Nelson, M.M., & Boggs, S.R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical and Child Adolescent Psychology*, 37(1), 215-237.

Eyberg Child Behavior Inventory (ECBI) (clinically significant scores are Intensity score >147 and Prob score >15. Helps understand how intense and varied child's bxs are and whether or not they pose a challenge to the parent) http://www.imagesoftheself.com/images/childBehavior_inventory.pdf

Gordon, B. & Shroder, C. (2002). "Assessment and Treatment of Childhood Problems: A Clinician's Guide" Second edition. Chapter 10.

Johnson, M.E., & Waller, R.J. (2006). A review of effective interventions for youth with aggressive behaviors who meet diagnostic criteria for conduct disorder or oppositional defiant disorder. *Journal of Family Psychotherapy*, 17(2), 67-80.

Link to online manual of Parent Child Interaction Therapy

<http://pcit.php.ufl.edu/Presentations/PCIT%20Integrity%20Checklists%20and%20Materials%204-13-06.pdf>

Quy, K., Stingaris, A. Oppositional Defiant Disorder. In Rey, J.M. (ed.). *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions 2012: 1-14.