Oppositional Defiant Disorder & Conduct Disorder

Antisocial & Aggressive Behavior

- ASB in children and adolescents can fall into two primary categories in the DSM-IV-TR
  - Conduct Disorder (CD)
  - Oppositional Defiant Disorder (ODD)

- Official rates of ASB have fallen since the 1990’s, but still much higher in US than in other industrialized nations

Defining the Problem

- Legal perspective
  - “Delinquency” in children, “criminal” acts as adults
  - Can be just one act, not a series of acts
  - Official (what they got caught for) versus self-reported (what they admit to doing)
Defining the Problem

• Empirical, psychological perspective
  – Externalizing (acting out) versus internalizing (acting in) behaviors
  – ASB are in the externalizing, disruptive, acting-out arena
    • Aggression and ASB, not ADHD-type behaviors
    • Frequently co-occur, but distinctly different

• Diagnostic perspective
  – ODD and CD as disruptive behavior disorders in children / adolescents
  – ASPD for adults

• Developmental perspective
  – Examines development of callous / unemotional traits in childhood, and how it relates to traits of psychopathy in adults

Types of Aggression & ASB

• Verbal vs. physical
  – Physical emerges earlier with peak during preschool years, verbal shows later onset
    • High levels of physical during middle childhood may warrant clinical attention, as may early emergence of verbal aggression
  – Physical aggression may become violent in later development
**Types of Aggression & ASB**

- Instrumental (goal-directed) vs. hostile
  (inflicting pain is the goal)

- Proactive (bullying) vs. reactive (retaliatory)
  – Highly related, but use evidence different kinds of processing deficits

- Direct vs. indirect / relational
  – Indirect seen more often in females

- Broadly, overt vs. covert
  – Overt is the above categories, covert relates more to lying, stealing, destroying property, etc.

**ASB Diagnostic History**

- Research on differences in ASB children for over 60 years
  – Early focused on “undersocialized” versus “socialized” behaviors

- DSM-III changes included
  – Operational criteria for CD
  – Four subtypes: Socialized vs. undersocialized and aggressive vs. nonaggressive
  – Introduced a mild version called “oppositional disorder”
ASB Diagnostic History

- DSM-III-R changed significantly
  - Increased number of symptoms needed
  - Subtypes became group/socialized type, solitary/aggressive, and undifferentiated
  - “Oppositional disorder” was renamed ODD

- DSM-IV-TR kept these two categories separate, introduced several other differences

ODD Features

- Recurrent pattern of negativistic, defiant, disobedient, and hostile behavior towards authority figures

- Occurs outside of normal developmental levels and lead to impairment in functioning

DSM-IV-TR Criteria

- Displaying four (or more) of these behaviors consistently over at least a six month period
  - Often loses temper
  - Often argues with adults
  - Often actively defies or refuses to comply with adults’ requests or rules
  - Often deliberately annoys people
  - Often blames other for his or her mistakes or misbehaviors
  - Is often touchy or easily annoyed by others
  - Is often angry and resentful
  - Is often spiteful or vindictive
DSM-IV-TR CRITERIA

• Behavior problems cause clinically significant impairment in social, academic, or occupational functioning

• Behaviors not part of a psychotic or mood disorder

• Criteria not met for Conduct Disorder or Antisocial Personality Disorder

CD FEATURES

• Repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated

• Four main categories of symptoms
  – Aggressive conduct that threatens physical harm
  – Nonaggressive conduct that causes property damage
  – Deceitfulness or theft
  – Serious violations of rules

DSM-IV-TR CRITERIA

• Have to have three (or more) of the following symptoms in past 12 months, with at least one in last 6 months

• Behavior problems cause clinically significant impairment in social, academic, or occupational functioning

• Criteria not met for Antisocial Personality Disorder if above age 18
**Aggression to People and Animals**

- Often bullies, threatens, or intimidates others
- Often initiates physical fights
- Has used a weapon that can cause serious physical harm to others
  - A bat, brick, broken bottle, knife, gun
- Has been physically cruel to people
- Has been physically cruel to animals
- Has stolen while confronting a victim
  - Mugging, purse snatching, extortion, armed robbery
- Has forced someone into sexual activity

**Destruction of Property**

- Had deliberately engaged in fire setting with the intention of causing serious damage
- Has deliberately destroyed others’ property (by means other than fire setting)

**Deceitfulness or Theft**

- Has broken into someone else’s house, building, or car
- Often lies to obtain goods or favors or to avoid obligations
  - “Cons” others
- Has stolen items of nontrivial value without confronting a victim
  - Shoplifting, but without B&E; forgery
SERIOUS VIOLATIONS OF RULES

- Often stays out at night despite parental prohibitions
  - Beginning before age 13 years
- Has run away from home overnight at least twice while living in parental home
- Is often truant from school
  - Beginning before age 13 years

CD SUBTYPES

- Child-Onset Type
  - Onset of at least one criteria before age 10
- Adolescent-Onset Type
  - Absence of any criteria before age 10
- Unspecified Onset
- Code severity
  - Mild, Moderate, Severe

VIABILITY OF CD AND ODD

- Both are divergent from ADHD
  - Do show significant overlap in behavioral pattern and risk factors
- Different developmental course for
  - Diagnosed with ODD only
  - Diagnosed with ODD and then CD
  - Diagnosed only with CD
VIABILITY OF CD AND ODD

- No strong evidence for discontinuity of symptoms in CD predicting course

- ODD is characterized by normal, developmentally appropriate behaviors
  - Often criticized for this fact in popular press
  - Most with CD have ODD, but not all; most with ODD do not have CD

VIABILITY OF CD AND ODD

- Number of possible symptoms in CD diagnosis guarantees heterogeneity of disorder
  - Can have overt, covert, or mixed presentation

- DSM-IV included warnings not to ignore environmental context of aggressive behaviors

PREVALENCE RATES

- With shifting diagnostic criteria over past 20 years, hard to get good long-term data

- Median estimates of 3% for ODD
  - Range from 1-20%

- CD estimates from 1-10%, depending on criteria
**SEX DIFFERENCES**

- Initially, no sex differences in activity level, noncompliance, and other types of "difficult temperament" traits
- By elementary school, evident sex differences, with males showing more of every type of aggression
- May be that females' developmental course steers them more towards internalizing problems
  - May also be the differences in externalizing symptoms in females (e.g. sexual promiscuity, substance use, somatization)

**SEX DIFFERENCES**

- ODD rates are equal in early childhood, but males predominate by early elementary years
- CD rates in childhood and preadolescence show a 4:1 male-female ratio
  - Sex differences appear to disappear by adolescence
- Differences are notable in indirect/relational aggression, where females show much higher rates

**COMORBIDITY**

- Large amounts of comorbid problems in both ODD and CD
- ADHD
  - Associated with worse outcomes, such as more likely ASPD and higher levels of aggression
- Academic problems
  - Mediated by presence of ADHD in middle childhood
  - "Snowball" effect
Comorbidity

- Internalizing problems
  - Social withdrawal forms of anxiety appear to be predictive of more aggression
  - Fear/inhibition related to less aggression
  - High comorbidity with depression, but uncertain relationship

Risk Factors

- Child factors
  - Difficult temperament
  - Hyperactivity (if co-occurs with CD)
  - Impulsivity
  - Substance use
  - Aggression
  - Early-onset of disruptive behaviors
  - Withdrawal
  - Low intelligence / executive function / information processing problems

- Family factors
  - Parental substance use
  - Modeling of antisocial/delinquent behavior by parents
  - Parental history of mental problems, particularly father’s ASB and mother’s depression

- Peer factors
  - Rejection by peers
  - Association with delinquent peers/siblings
RISK FACTORS

• Parenting practices
  – Poor parent-child relations
  – Poor supervision / communication
  – Physical punishment
  – Parental neglect / abuse
  – Maternal nicotine use during pregnancy
  – Teenage / single parenthood
  – Disagreement on discipline among parents
  – Low SES / large family
  – Unemployed / poorly educated parents
  – High turnover of caretakers
  – Carelessness in allowing access to weapons

• School factors
  – Poor academic performance
  – Being older than classmates
  – Weak bonding to school
  – Low educational aspirations
  – Low school motivation
  – Poor school system

• Neighborhood factors
  – Neighborhood disadvantage or poverty
  – Disorganized neighborhood
  – Availability of weapons
  – Media portrayal of violence
ASSESSMENT & DIAGNOSIS

• Structured or semi-structured clinical interview
  – Should cover developmental and family history, DSM-IV ODD/CD symptoms, and symptoms of typical co-morbid problems
    • E.g. ADHD, LDs, anxiety/mood disorders, etc.

• Parent, teacher, and self-reports of behavior
  – Good scales to use include BASC and CBCL for overall screeners
    • Due to high co-morbidity with ADHD, may want to use specific measures (e.g. Conners’)

TREATMENT

• Treatment outcomes are much better for ODD than for CD

• Effective treatments are based on operant conditioning and social-cognitive learning principles

• Four empirically supported treatments

  • Contingency management programs
    – Establish clear behavioral goals to shape towards appropriate behavior
    – Monitor the child’s progress toward goals
    – Reinforce appropriate steps towards those goals
    – Provide consequences for inappropriate behavior
**TREATMENT**

- **Parent Management Training (PMT)**
  - Goal is to teach parents how to develop and implement structured contingency management programs at home
  - Also focus on
    - Improving parent-child interactions
    - Changing antecedents to problem behaviors
    - Improving parent’s monitoring of child’s behavior
    - Using more effective disciplines strategies

- **CBT approach**
  - Goal is to overcome deficits in social cognitions and problems solving
  - Includes role-playing, modeling

- **Stimulant medication**
  - Useful in children with ADHD who have co-occurring behavior problems

- **Multisystemic therapy (MST)**
  - Grows out of a family systems approach
  - Intensive treatments that see problems in children’s behavior as stemming from a larger family context
  - Focuses on the role of the misbehavior in the family, then adjusting how the family responds and reacts to both the child and each other