dr. caleb lack's

Oppositional Defiant Disorder & Conduct Disorder

psychopathology

dr. caleb lack's

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

psychopathology

dr. caleb lack's

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)

psychopathology

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

Defining the Problem

- 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

Types of Aggression & ASB

- 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

dr. caleb lack's

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 wile confronting a victim
  - Mugging, purse snatching, extortion, armed robbery
- Has forced someone into sexual activity

dr. caleb lack's

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)

dr. caleb lack's

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

dr. caleb lack's

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

psychopathology

dr. caleb lack's

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

psychopathology

dr. caleb lack's

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

psychopathology

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

Risk Factors

- Family factors
  - Parental substance use
  - Modeling of antisocial/deliquent 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

Risk Factors

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

Risk Factors

- 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

Treatment

- 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

Treatment

- 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

Treatment

- 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