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Oppositional defiant disorder

Background

Oppositional defiant disorder (ODD) is defined as a repetitive and persistent pattern of opposition, defiant, disobedient and disruptive behaviours toward authority figures persisting for at least 6 months.

Objective

This article reviews the nature of ODD, its relationship to attention deficit hyperactivity disorder and conduct disorder, and considers the management options available to general practitioners.

Discussion

Many of the behaviours required to meet this diagnosis are not uncommon in the preschool child or adolescent. However, in children with ODD the behaviours are persistent, cause significant distress to the family system, and impact on the child's social and educational functioning. Oppositional defiant disorder usually presents in the preschool years, although it may become evident during adolescence. There is strong evidence that early intervention to increase positive factors in family relationships and to increase both the parents' and child's skill levels can assist in the prevention of more serious disorders and mental health issues.

■ **Oppositional defiant disorder (ODD) is described in the Diagnostic and Statistical Manual of Mental Disorders – 4th edition (DSM-IV) and the International Classification of Mental and Behavioural Disorders (ICD-10) as a 'repetitive and persistent pattern of opposition, defiant, disobedient and disruptive behaviours towards authority figures persisting for at least 6 months'.^{1,2} Oppositional defiant disorder does not include the more aggressive aspects of conduct disorder (CD) which is directed toward people, animals and property.¹ Oppositional defiant disorder has a high co-occurrence with attention deficit hyperactivity disorder (ADHD) and many children with ODD go on to be diagnosed with CD. This means that families are under high levels of stress, dealing with several difficult behaviours.**

Does this child have ODD?

Characteristics of ODD as described in the DSM-IV include:

- persistent stubbornness and refusal to comply with instructions or unwillingness to compromise with adults or peers
- deliberate and persistent testing of the limits
- failing to accept responsibility for one's own actions and blaming others for one's own mistakes
- deliberately annoying others
- frequently losing one's temper.

It can be difficult to determine if a child qualifies for a diagnosis of ODD as many of the behaviours required to meet this diagnosis are not uncommon in the preschool child or adolescent. However, if the child's behaviours are consistently presented by the parent as causing distress to the family system and are impacting on the child's social and educational functioning then further evaluation is warranted.

A preschool aged child will usually behave in this way at home and with people they know well. Oppositional behaviours may not be evident in other settings or during the medical examination, thus



making the practitioner reliant on reports from family members. As the child develops and becomes involved in other environmental settings such as school, adverse experiences with peers, teachers or academic challenges can result in the child's oppositional behaviours becoming evident in that setting.³

Case study

Sandy brings her son Matt, 6 years of age, to the general practitioner. Sandy says that she cannot manage his behaviour at home and that the teacher has said that he will not follow instructions in the classroom and is bullying his friends at lunch time. The GP asks what the boy was like as a baby and toddler. He learns that Matt would cry easily and that it took Sandy a long time to settle him. As a toddler if Sandy tried to remove something he wanted, Matt would throw tantrums lasting for at least half an hour. As he got older, Matt would often kick his mother and refuse to do what she asked. Now he argues with her every day, even about small things. He fights daily with his 8 year old sister, Amy, and always blames her when things get damaged.

Sandy reports that she felt inadequate as a parent and became depressed when Matt was about 18 months of age. Further questioning about the home situation determined that Matt's father, Barry, often loses his temper and shouts at his wife and children. The family is experiencing financial difficulties and Barry is often out of work.

Matt's teacher considers that Matt is able to do his schoolwork but is stubborn and refuses to join in tasks with the other children. He gets out of his seat regularly and walks around the room. He will often flick the other children on the arms and take away their pencils. He has difficulty making friends as he always wants them to play his games and will yell at them if they do not do what he wants.

When the GP asks Matt about school and home, Matt tells him that he hasn't done anything wrong and that everyone picks on him and that he gets blamed for everything. It's Matt's view that everyone wants him to behave better and that they should just leave him alone.

In this case Matt meets the criteria for a diagnosis of ODD. He has a history of a difficult temperament, has been hostile toward his mother since he was a toddler, and has had difficulties since entering the preschool system meeting the teacher's expectations for behaviour and making friends.

Prevalence

Based on international research, Sanders, Gooley and Nicholson reported that the prevalence of ODD in nonclinical samples ranges from 6–10%.⁴ Similarly Angold and Costello concluded from a review of prevalence rates that CD/ODD in the western world is a 'gigantic public health problem' with 5–10% of children aged 8–16 years having notable behavioural problems.⁵ The problem is also significant in Australia with Al-Yaman, Bryant and Sargeant reporting that in 1999–2000 for children aged 1–14 years, ODD occurred among the most frequent specific diagnoses accounting for hospitalisation for mental health problems and behavioural disorders.⁶ The most

frequent diagnoses were activity and attention disorders (17%), oppositional defiant disorder (16%) and anorexia nervosa (6%).

Oppositional symptoms are more common in preschool boys than girls, with the behaviours in girls becoming more evident after puberty. The onset of ODD is usually gradual and becomes evident before 8 years of age and no later than early adolescence.^{1,4}

Children with early onset ODD and CD are at an increased risk of abuse by their parents and school drop out, and may go on to commit serious crimes or have long term involvement in the mental health system.^{3,7}

Comorbidity

Barkley et al reported that 65% of children diagnosed with ADHD have a co-occurring diagnosis of ODD.⁸ Practitioners may experience difficulty in determining which features of a child's presentation are due to ODD or aspects of ADHD. For example, the child's apparent failure to respond to parental directions may be due to oppositional behaviour but could also be due to a lack of concentration because of ADHD symptoms. Learning disorders and communication disorders are also common in children with ODD^{1,3} and may result in the child appearing to be oppositional when in fact they simply do not have the cognitive abilities to understand the adult's instructions.

Research has shown that early onset of ODD is a strong predictor of the development of CD, making early intervention desirable. Sanders et al reported that 20–60% of children with ODD have a co-occurring diagnosis of CD.⁴

What causes ODD?

There is no single factor indicated by the research evidence as the cause of ODD. It appears that a cluster of factors in the child's characteristics, parental interactions, and environmental factors contribute to its development.^{3,4}

Developmental factors include:

- a history of the child having a difficult temperament
- being difficult to soothe as a baby
- having high motor activity, and
- a propensity toward extreme emotional reactions.

If there have been periods of different care givers, a history of harsh and inconsistent or neglectful parenting, the child may also develop ODD traits. Oppositional defiant disorder appears to be more common when there is serious conflict between the parents and the presence of a history in one or both parents of mental health problems such as depression, ADHD, ODD or antisocial personality disorder.

Two pathways to the development of ODD are summarised by Sanders et al and Webster-Stratton and Reid.^{3,4} These are:

- the early onset pathway in which the behaviours develop before preschool and may continue into adolescence. These children may display a greater range of oppositional behaviours across a range of settings. Without intervention the outlook for many of these children is not good and they may develop conduct problems in adolescence or an antisocial personality disorder in adulthood



- the late starter pathway in which there appears little oppositional behaviour during early childhood but the behaviours become more observable during adolescence. This stage of onset is often associated with family stresses such as unemployment or divorce, which may cause disruption in the family management practices and monitoring of the child's activities. The young person may develop these behaviours through increased and unsupervised involvement with an inappropriate peer group. The prognosis for this group is generally more positive as usually they have developed a higher level of social skills and better relationships with their peers and parents in earlier childhood.

How can ODD be managed?

There are no easy solutions to resolving the difficulties for families when a child has a diagnosis of ODD. There is general agreement that intervention is required early in the developmental progression of the disorder so as to prevent the development of more serious problems and to reduce the impact the child's oppositional behaviour has on family and peer relationships and academic outcomes.^{3,4,7,9}

The management plan should:

- address any co-occurring ADHD or learning difficulties
- address known risk factors for each case,⁴ and
- include intervention for all factors producing stress on the family system.⁷

Generally intervention will be needed for the parents, child, family and school (*Table 1*). The GP needs to assess which needs are a priority for a particular family and child. It can be quite daunting when considering the range of interventions required for a particular family: paediatric review, psychological treatments, family therapy, family supports and social interventions, and school based interventions. However, undertaking a Mental Health Assessment and Mental Health Plan can assist the GP to clarify the issues for the family and determine the priority of interventions.¹⁰ Completing a Mental Health Care Plan will enable the family to access approved psychological services under the Medicare Benefits Schedule (MBS). The psychologist must be registered and have a Medicare provider number. The scheme provides for up to 12 individual sessions in a year and may approve 12 group therapy sessions in a year if recommended by the practitioner and psychologist.

The range of interventions available will be largely determined by the GP's locality and services available within that region, and the family's capacity to engage in appropriate services. For some families the symptoms of ODD will resolve, but for others ongoing monitoring and re-referral to services will be required.

Pharmacological treatments

There has been little research on the use of pharmacological treatments for ODD.^{4,7} In some instances when aggressive behaviours are difficult to manage by behavioural means, medication may assist in diminishing the problematic behaviours

Table 1. How to manage ODD and reduce family stress

For parents

- Improve positive parenting skills⁴
- Enhance skills in problem solving, conflict resolution and communication^{3,7}

For the child

- Development of effective communication, problem solving and anger management skills³

For the family

- Family counselling and support to deal with the stresses in their relationships and the home environment

In the classroom

- Encourage the teacher or school counsellor to provide social skills sessions to improve peer relationships

until the child and the systems around him develop the skills to cope with the oppositional behaviours.

If there is a comorbid diagnosis of ADHD, the use of stimulant medication to treat these symptoms may show some improvement in ODD symptoms.^{4,11,12} Improvements in overall behaviour have also been seen in short term controlled trials of atomoxetine (Strattera) and clonidine (Catapres) in children with ODD and ADHD. The long term efficacy and side effects of these medications in the management of ODD has not been assessed. The complexity of comorbidities and the need for thorough assessment generally require multidisciplinary management and there is no indication for pharmacological intervention on its own. The most important treatment strategy is to assist families with psychosocial interventions to deal with the many behavioural challenges from their child.

Conclusion

The characteristics and behaviours that define ODD causes stress on the family and the school system in which the child is involved. Oppositional defiant disorder usually presents in the preschool years, although it may become evident during adolescence. There is strong evidence that early intervention to increase positive factors in family relationships and to increase both the parents' and child's skill levels can assist in the prevention of more serious disorders and mental health issues. The GP can assist the family to deal with these issues by being empathic to their concerns and by directing them to parenting and family counselling services.

Resources

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- Medical Benefits Schedule. Mental Health Plan item numbers
www9.health.gov.au/mbs/fullDisplay.cfm?type=item&qt=ItemID&q=2710
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Conflict of interest: none declared.

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