Oppositional Defiant Disorder (ODD) Clinical Guidelines

Developed in collaboration with the mental health centers associated with NBHP and FBHP

DSM-IV-TR Diagnostic Code: 313.81

Diagnostic Considerations:

1. Establish diagnostic accuracy. Key symptoms of ODD include:

- A pattern of negative, defiant, disobedient, or argumentative behavior (lasting at least 6 months);
- behaviors occur more frequently than typically observed in individuals of comparable age and developmental level;
- behaviors cause significant impairment in functioning; and
- symptoms typically evident before age 8.

Continued assessment over time is important, as ODD may precede the development of conduct disorder, which has more severe symptoms (e.g. aggression toward people or animals, destruction of property, or a pattern of theft or deceit), and requires different treatment.

2. Consider differential diagnoses including conduct disorder, ADHD, mood disorders, learning disabilities, developmental disabilities, adjustment disorders, v-code relational disorders, substance abuse (particularly in adolescents), and normal developmental difficulties. Co-occurring disorders are common, particularly ADHD, depression, and/or anxiety. Referral for a cognitive evaluation may be appropriate to rule out learning disabilities. In some cases, chronic pediatric illness, significant head trauma or lead toxicity may lead to similar symptoms. It is helpful to have the child's most recent pediatric exam records available for review. Encourage scheduling a pediatric medical exam if there was none in the last year and coordinate care with the PCP as needed.

3. Obtain information from multiple informants using multiple methods including:

- *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 functioning, adults reactions to the child (ODD tends to elicit anger and power struggles), and family history of mental illness (ODD appears more common in families where at least one parent has had a mood disorder, ODD, CD, ADHD, antisocial personality disorder, or a substance-related disorder).
- *Behavior rating scales*: Child Behavior Checklist (CBCL), Behavior Assessment System for Children (BASC), and Eyberg Child Behavior Inventory (ECBI) are helpful for diagnosis and intensity of symptoms. Conner's rating scales can be used to assess for problems with attention and hyperactivity (see references for more information).
- *Observational reports*: Gather information from primary caregivers, daycare providers, teachers, and other school professionals in addition to the child's self-report.

4. Complete a functional analysis of behavior as part of the clinical interview. What are the triggers and consequences of the child's disruptive behaviors and pro-social behaviors? Triggers may include child's emotional state, such as fear or anxiety leading to disruptive behavior. Is behavior consistent across settings/with different authority figures? What actions by others could be reinforcing negative behaviors or failing to reinforce positive behaviors? A functional analysis will reveal that behaviors are done to ESCAPE or AVOID a task, person, or situation or to OBTAIN attention, an object, or a privilege. Interventions must be informed by the function of the behavior. Assess whether the behavior is internally or externally motivated, as it may be in response to a situation or environmental circumstance, indicating an adjustment reaction, rather than an ODD diagnosis.

5. Assess Parent and Family Characteristics to determine extent to which they may serve as barriers to treatment. Assess severity of marital conflict, depression, substance use, or other psychopathology in the family. To enhance effectiveness of child's treatment, you may need to encourage parents to seek treatment for their own problems before or in conjunction with treatment for the child.

Treatment Guidelines:

1. Establish a therapeutic alliance with the child and the family. Build rapport by empathizing with the child's potential frustration and anger about receiving treatment or feeling misjudged, while not condoning oppositional behavior. Work with parents to raise awareness of parenting issues while avoiding judgments or criticisms, and providing empathy. One way to do this is to work with the family to identify strategies they have tried and whether they were successful or not.

2. Consider cultural issues in diagnosis and treatment as there are different standards and expectations for obedience and parenting across cultures and ethnic groups. Be aware of and sensitive to these differences in your treatment recommendations.

3. Develop an individualized treatment plan using multimodal interventions. A combination of parent management training (e.g. parenting skills, parenting classes), family, and individual therapy, is most effective. Effective treatment usually lasts several months or longer. Interventions should focus on identified problem behaviors, based upon the assessment, child's strengths, and functional analysis. Keep in mind severity of symptoms, child's age, and resources available. Younger children benefit from parent management training, family and school-based interventions as the primary treatment. Coordination of family and school-based interventions will ensure consistency of treatment. Adolescents benefit from family interventions and parent skills training, with individual therapy when appropriate.

4. Parent and family interventions should be the primary focus of treatment. Parent management training (including behavior management training, parenting skills, etc.) is the most widely supported group of evidence based practices for ODD. Modeling and role playing with parents can increase efficacy and confidence using the core processes of parent management training: effective behavioral reinforcement, age-appropriate expectations and supervision. Principles of reinforcement include:

- reducing positive reinforcement of disruptive behavior;
- increasing reinforcement of pro-social and compliant behavior (parental attention is emphasized above tangible rewards);
- consequences consisting of time-outs, loss of privileges; and
- reinforcement and consequences should be consistent, predictable, immediate, and contingent on defined behaviors.

5. Individual psychotherapy should be focused and directive. Establish rapport and build upon strengths. Include behavioral interventions to control aggression, modify behaviors, and enhance communication skills. Use cognitive, experiential or interpersonal approaches to develop self-control, self-guidance and problem-solving skills. Relaxation and self-monitoring can improve impulse control, and assertiveness training develops skills to express feelings constructively.

6. Track progress towards goals. Short scales (such as the ECBI) can be used to measure progress and response to interventions.

7. Avoid unhelpful interventions. Experts and researchers agree that one time or short-term interventions are not usually successful. In addition, research has shown inoculation approaches (boot camps, shock incarcerations) to be ineffective and potentially injurious.

8. Medication is generally not indicated for the treatment of ODD, but may be helpful in treating any co-occurring conditions. Refer to a mental health prescriber where appropriate.

9. Encourage participation with social support systems, e.g., athletics, church, schools, community centers, and support groups (i.e. Ala-teen.) Encourage participation in extracurricular and positive peer group activity to aid in the development of social skills and self-esteem.

References and Resources

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

American Academy of Child and Adolescent Psychiatry-ODD resources
http://aacap.org/cs/ODD.ResourceCenter

American Academy of Child and Adolescent Psychiatry: Practice Parameters
http://aacap.org/galleries/PracticeParameters/JAACAP_ODD_2007.pdf

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/childBehaivor_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.phhp.ufl.edu/Presentations/PCIT%20Integrity%20Checklists%20and%20Materials%204-13-06.pdf

Patterson, G. (1976). Living with Children. Champaign, IL: Research Press.

Steiner H, Remsing L, Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. J Am Acad Child Adolesc Psychiatry 2007 Jan; 46(1):126-41.