CD/ODD

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Oppositional Defiant Disorder and Conduct Disorders: Review and Discussion of AACAP Practice Guidelines

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Disclosures

- **Research/Grants**: None
- **Speakers Bureau**: None
- **Consultant**: None
- **Stockholder**: None
- **Other Financial Interest**: None
- **Advisory Board**: None
Learning Objective

Apply the AACAP Practice Parameters in the assessment, diagnosis, and management of oppositional defiant disorder
Disruptive Behavior Disorders

- Attention Deficit Hyperactivity Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
Disruptive Behavior Disorders

- Commonly encountered
- Often associated with aggression
- Complex etiology
- Biopsychosocial factors are important
Oppositional Defiant Disorder (ODD)

- Community prevalence of 1–16%
- Characterized by negativism, vindictiveness, and aggression (including verbal abuse and physical acts)
- Frequently comorbid with other psychiatric disorders
- Can precede conduct disorder (CD)
- Can precede substance use disorders
- Requires multimodal treatment approach

ODD

DSM-IV-TR Diagnostic Criteria

Pattern of negativistic, hostile, defiant behavior in which 4 (or more) of the following are present for at least 6 months

- Often loses temper
- Often argues with adults
- Often actively defies or refuses to comply with adult rules/requests
- Often deliberately annoys people
- Often blames others for behavior
- Often touchy or easily annoyed
- Often angry or resentful
- Often spiteful or vindictive

- Requires the establishment of therapeutic alliance with child and family
- Address cultural issues
- Obtain info about symptoms, and degree of impairment from child and parents, as well as multiple outside informants
- Consider comorbid psychiatric conditions
- Evaluate peer/school functioning
- Questionnaires and rating scales may be helpful

Develop an individualized plan based on specific situations
Consider parent management training
Medication may be helpful as adjuncts
Intensive and prolonged treatment may be required if severe and persistent
Certain interventions are not effective
  - Dramatic, one-time, time-limited, or short-term interventions not usually successful

No FDA-approved agents for ODD

Evidence available for
- Atypical antipsychotics
- Stimulants, especially when ODD is comorbid to ADHD
  - Methylphenidate
  - D-amphetamine
  - Lisdexamfetamine
- Atomoxetine

Summary

- ODD is characterized by negativism, vindictiveness, and aggression
- Frequently comorbid with other psychiatric disorders
- Can precede CD, substance use disorders, and delinquency
- Requires multimodal treatment approach
Managing Conduct Disorders and Aggressive Behavior in Youth

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Learning Objectives

Recognize the early precursors of symptom presentation of conduct disorder

Recognize population-based strategies for preventing conduct disorders

Recognize evidence-based intervention strategies to improve outcomes
Disruptive Behavior Disorders

- Attention Deficit Hyperactivity Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
Conduct Disorder

DSM-IV-TR Diagnostic Criteria

Repetitive and persistent pattern of behavior in which basic rights of others or major age-appropriate societal norms or rules are violated as manifested by the presence of 3 or more of the following criteria in past 12 months or with at least 1 criterion in the past 6 months:

- Aggressive conduct to people and animals
- Property damage or loss
- Deceitfulness or theft
- Serious violations of rules

DSM-IV-TR Classification

- Conduct disorder, childhood-onset type
  - Onset of at least 1 criterion prior to age 10
- Conduct disorder, adolescent-onset type
  - Absence of any criteria prior to age 10
- Conduct disorder, unspecified onset
  - Age on onset unknown
- Severity
  - Mild
  - Moderate
  - Severe

Essential symptoms of ADHD, ODD, and CD are identifiable as toddlers

- Hyperactive impulsive behavior noted by age 2 and remain stable through school entry\(^1\)
- Disregard for rules stable between 2.5-7 years. Highest levels of oppositional behavior persist until age 18\(^2\)
- Aggression noticeable after year 1 and increases until age 4 and then decline into adulthood\(^3\)

Development of Physical Aggression from Toddlerhood to Pre-Adolescence

Development and Prediction of Hyperactive Symptoms

## Predictors of Violence and Serious Delinquency

### Ranking of Predictors of Violent or Serious Delinquency Ages 6–11 and Ages 12–14

<table>
<thead>
<tr>
<th>Rank 1 Group</th>
<th>Predictors at Ages 6–11</th>
<th>Predictors at Ages 12–14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General offenses (.38)</td>
<td>Social ties (.39)</td>
</tr>
<tr>
<td></td>
<td>Substance use (.30)</td>
<td>Antisocial peers (.37)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank 2 Group</th>
<th>Predictors at Ages 6–11</th>
<th>Predictors at Ages 12–14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gender (male) (.26)</td>
<td>General offenses (.26)</td>
</tr>
<tr>
<td></td>
<td>Family socioeconomic status (.24)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Antisocial parents (.23)</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank 3 Group</th>
<th>Predictors at Ages 6–11</th>
<th>Predictors at Ages 12–14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aggression (.21)</td>
<td>Aggression (.19)</td>
</tr>
<tr>
<td></td>
<td>Ethnicity (.20)</td>
<td>School attitude/performance (.19)</td>
</tr>
</tbody>
</table>

Note: The value in parentheses is the mean correlation between the predictor and the outcome, adjusted to equate the source studies on relevant methodological features.

### Ranking of Predictors of Violent or Serious Delinquency

**Ages 6–11 and Ages 12–14**

<table>
<thead>
<tr>
<th>Rank 4 Group</th>
<th>Predictors at Ages 6–11</th>
<th>Predictors at Ages 12–14</th>
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</thead>
<tbody>
<tr>
<td>Psychological condition (.15)</td>
<td>Parent-child relationship (.15)</td>
<td>Antisocial parents (.16)</td>
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<tr>
<td></td>
<td>Parent-child relationship (.15)</td>
<td>Person crimes (.14)</td>
</tr>
<tr>
<td>Social ties (.15)</td>
<td>Problem behavior (.13)</td>
<td>Problem behavior (.12)</td>
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<tr>
<td>Problem behavior (.13)</td>
<td>School attitude/performance (.13)</td>
<td>IQ (.11)</td>
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<tr>
<td>School attitude/performance (.13)</td>
<td>Medical/physical characteristics (.13)</td>
<td></td>
</tr>
<tr>
<td>Medical/physical characteristics (.13)</td>
<td>IQ (.12)</td>
<td></td>
</tr>
<tr>
<td>IQ (.12)</td>
<td>Other family characteristics (.12)</td>
<td></td>
</tr>
<tr>
<td>Other family characteristics (.12)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank 5 Group</th>
<th>Predictors at Ages 6–11</th>
<th>Predictors at Ages 12–14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broken home (.09)</td>
<td>Abusive parents (.07)</td>
<td>Broken home (.10)</td>
</tr>
<tr>
<td>Abusive parents (.07)</td>
<td>Antisocial peers (.04)</td>
<td>Family socioeconomic status (.10)</td>
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<tr>
<td>Antisocial peers (.04)</td>
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<td>Abusive parents (.09)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other family characteristics (.08)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Substance abuse (.06)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ethnicity (.04)</td>
</tr>
</tbody>
</table>

Comorbidities of CD

- Attention deficit hyperactivity disorder
- Oppositional defiant disorder
- Intermittent explosive disorder
- Substance use disorder
- Mood disorders (bipolar and depressive)
- Post-traumatic stress disorder
- Dissociative disorders
- Borderline personality disorder
- Somatization disorder
- Adjustment disorders
- Organic brain disorder
- Seizure disorder
- Paraphilias
- Narcissistic personality disorder
- Learning disabilities
- Mental retardation
- Schizophrenia

Psychopharmacology

- Insufficient to treat CD
- Often useful in crisis management or treatment of comorbid disorders
- More recently, a trend of using atypical antipsychotics, particularly risperidone, in aggressive CD patients has emerged\(^1\)
- Insufficient RCT studies at present

Evidence-Based Early Prevention and Intervention Programs

- Helping the Noncompliant Child Program
- Parent-Child Interaction Therapy
- The Incredible Years BASIC (2-year-olds)
- Family Check Up—19-29 months
- Nurse Family Partnership (NFP)
  - Broader scope RCT—Elmira, Denver, Memphis
- Triple P + motivational interviews for parents
- Multisystemic therapy (MST)
- Multidimensional treatment foster care (MTFC)

See supplemental bibliography for full references.
Prevention of CD and Cost to Society

- The cost of each delinquent’s life-long criminal career is between $1.7m to $2.3m over each person’s lifetime.
- We need to identify risk factors for CD that are both plausible causal factors and alterable with intervention.
- These factors should have a high attributable risk for negative outcome and have a high enough prevalence that their eradication would significantly reduce the number of cases with negative outcome.

Cohen MA. *J Quant Criminol* 1998;14:5-33.
Life Course View of Prevention of CD

- Target maternal health behavior during pregnancy
- Address parenting behavior at crucial points during infancy, early childhood, and adolescence
- Target child social behavior and cognitive skills in early and middle childhood
- Address birth control in early adolescence

Symptoms of CD are identifiable in toddlers

Need to identify risk factors for CD

High rate of psychiatric comorbidities

Important to address parenting behavior at crucial points in infancy through adolescence
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Romano E, Tremblay RE, Farhat A, Cote S. Development and prediction of hyperactive symptoms from 2 to 7 years in a population-based sample *Pediatrics* 2006;117:2101-2110.


Supplemental Bibliography for:

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Slide Title: Evidence-Based Early Prevention and Intervention Programs


