Oppositional Defiance Disorder (ODD). An Introduction. Includes a Case Study for Guidance Only.

Background

ODD is considered to be a developmental disorder. That is, a person develops such a condition on the basis of the experiences they have in the critical first years of their life. Conversely, congenital disorders (existing at birth) and other medical conditions are related to a person's genetic inheritance (eg. haemophilia, cystic fibrosis, etc),

Nevertheless, despite this distinction between a developmental and organic (congenital/physical/medical) condition, it is possible that affected individuals may have a genetic predisposition involving a vulnerability to developing ODD symptoms if the necessary environmental circumstances align. As a further complication, environmental circumstances may include substances that a foetus may be exposed to prior to birth, including smoking related toxins and alcohol.

Normal versus Abnormal (Disordered) Development

At birth, most babies (excluding organic conditions noted above) have equal potential to develop normally, extensively and impressively, provided that infant's brain is exposed to environmental circumstances that are safe, stimulating and nurturing. To this extent, the brain is a self-organising system, that requires constructive stimulation to achieve its potential. Further, as completely dependent babies and relatively helpless infants, this stimulation occurs in the context of relationships with care-givers, primarily parents, but including others. Critical periods for this neurological development is most particularly in the first three years of a child's life but also includes the crucial stages of puberty and adolescence when further and significant brain development and maturation occurs.

When a child's 'normal' developmental environment is disrupted, then abnormal or disordered development may occur. Attachment theory explains this in the context of the primary care-giver relationships noted above, where a child experiencing an insecure or a disordered relationship with their primary care-giver may fail to develop 'normally' in a neurological sense. For example, a baby or infant that is living in a highly stressed, anxious, violent or neglectful environment will develop differently than a baby / infant being raised in a safe, fun and joyful environment.

Typically, children who develop Attention Deficit Hyperactivity Disorder (ADHD), ODD and Conduct Disorder (CD) have experienced insecure, traumatic or disordered care-giving in their critical first years of life. Such circumstances can include domestic violence, substance abuse and related neglect accompanying adult addictive behaviours, extreme poverty or homelessness, a mentally ill or intellectually disabled parent, sexual abuse, and much more.

By the time a young person may be diagnosed with the likes of ODD, or other developmental disorders, we could conclude that much of the 'damage is done' and is largely irreversible. Nonetheless, sometimes young people start to 'spontaneously' overcome ODD-like disorders, as their life circumstances improve and they develop motivation to pursue healthier and more constructive activities, including education. For others, ODD may persist, and often will transition,

almost inevitably, into conduct disorder and adult 'anti-social personality disorder'. Intervening as early as possible is thus vital to achieving the best therapeutic outcomes.

Regardless, ODD *can* be successfully treated in children and adolescents ***provided*** there is motivation from parents to rally the financial resources and emotional commitment to work with the appropriate mental health professionals and school personnel, for an extended period of time. This proviso / caveat is a critical factor in achieving treatment success and should not be under-estimated.

A Metaphorical Perspective

We can consider our mind-body connection as being like a computer (or smart-phone). That is, we have hardware (physical body parts), an operating system (physiology) and applications (emotions, cognitions, behaviour). With technology, most people are only interested in the 'apps' and care less about hardware and operating system (until they break or malfunction). So it is with we humans, that providing our underlying physical and physiological health is in order, we can get on with life in terms of work, play, learning, innovating, celebrating, etc.

However, for the young people who may have experienced 'disordered' development, they struggle to manage emotions, optimise their cognitive capacity and behave reasonably and helpfully, often because their physiological functioning has been compromised and has not adequately matured or stabilised at the chronologically appropriate milestones. Accordingly, a person requires a mature and fully functioning physiology to optimise their social, emotional and cognitive intelligence.

A significant part of a person's physiology is managed by the autonomic nervous system (ANS), a system that provides an interface between the brain, and other organs, muscles and critical functions (eg. immune, thermoregulation, digestive, etc). The two significant and synergistic parts of the ANS are the sympathetic (SNS) and parasympathetic nervous system (PNS). The SNS is an activation system that is often associated with the mammalian survival response of 'flight or fight'. Most people are very capable of utilising their SNS, yet with ODD affected young people, all too often their physiological activation response is disproportionate (at least for a non-traumatised or 'normal' individual) to the perceived 'threat'. Furthermore, most people are also quite capable of self-soothing or calming themselves down after an activation experience, yet ODD people are less capable. The maturation and optimisation of our PNS is an integral part of that. The PNS (like the brake in a car) provides a balancing function to the SNS (like the accelerator in the same car) and so is involved in reversing the activation response and instead helps us to calm (slow) down. Accordingly, treating young people with ODD is largely about teaching them how to manage their arousal and emotional regulation (i.e. improving their calming or self-soothing capacity), thus allowing the PNS to mature and do its best work in due course. Effectively, we aim to help young people to become more 'emotionally intelligent'.

An ODD Case Example - Developmental Factors, Consequences, and Treatment

In the case example presented below, this young person is failing to achieve his social, emotional and cognitive potential because he presently possesses an incomplete, compromised and immature physiological system. Early life experiences will explain reasons for that, and until that is addressed, largely by providing a new and secure attachment environment for that person to re-learn (and so re-wire more adaptive neural pathways) how to manage their physiology (arousal), that person can never have the basic and integral foundational scaffolding upon which subsequent emotional, social and cognitive skills can be introduced, developed and enhanced.

The young person in question is a primary school-aged male, who lives with his mother and step-father. The information presented below is based largely on an interview with the young male's biological mother only (not met the young person), and consequent hypotheses and interpretations are made by the author of this document. Further details are excluded to protect the identity and confidentiality of this person, and his family.

Predisposition

Factors below may have created an environment that proved destructive or disruptive to the usual development of the baby and infant's brain, thus compromising this young person subsequently, as increasingly sophisticated demands are placed on his brain, especially once he starts school.

a. Biological father has a mental illness, perhaps bi-polar, with severe depression.
b. His mother and father separated soon after he was born.
c. One of his older siblings has an emerging psychiatric condition, possibly borderline personality disorder. This fact and (a) above suggest some genetic predisposition also.
d. Mental health of mother unknown, both now and in the past, although it would be expected that she has been at times anxious, stressed, insecure and distracted by relationships other than those with her children.
e. It is hypothesised that this young male has experienced substantial insecure attachment with his primary care-givers in his baby and infant years, and indeed, may have been traumatised during those years (disordered attachment).

Perpetuating

a. low self worth, self loathing, wishes he was not even born (symptomatic of emerging depression)
b. overly sensitive (perhaps to the perception of abandonment or rejection)
c. poor emotional regulation, and so, easily aroused (refer SNS and PNS discussion above), low frustration tolerance (defense mechanism, usually anger, kicks in early, to deter the 'threat' ASAP).
d. learned helplessness, fear of failure (feels even less worthy, but don't try then you cannot fail!)
e. fixation on negatives (maybe so, perhaps that is learned behaviour, the culture of his family?)
f. obsessive (underpinning anxiety, thinks is he can control his environment, so he is can be safer and so become less fearful, but the more he tries, the more he fails, so he obsesses,

thinks if he just keeps fixated, then he can eventually succeed, but only serves to stress himself further, a vicious cycle, in need of a circuit breaker, yet some of this is very strongly wired in the brain)

g. inconsistent, unpredictable parenting from his father, empty promises (all create further anxiety and distress, when you cannot predict what you are getting)
h. biological mother has a new partner of two years, but he is most often working interstate and so is away from home for long periods. Supposedly this new partner also has his own anxiety issues and limited parenting experience or insight.
i. rigid (black and white) thinking: lacks intellectual maturation to be otherwise, exacerbated by poor language skills (we think in language)
j. maybe, the home environment remains stressful, insecure and unpredictable (unsubstantiated but would need to be examined and stabilised in the context of treatment)
k. young person' capacity, motivation and insight regarding a need to change very low, indeed this person's world-view is that none of this is his fault (probably is not), so he is not responsible for what he does and so has no concrete understanding of his capacity to 'change his world', so his maladaptive trajectory continues as a self-fulfilling outcome (he gets what he expects, we can ensure failure, but have to work to succeed, sadly)

Treatment Suggestions

While not adequately abreast of this young person's treatment plan now, there is some evidence that he has and continues to receive both on-going psychiatric and psychological treatment. Perhaps what is missing is achieving consent from this young person's parent(s) to allow the school to speak to these external mental health practitioners and gain some guidance of how the school can participate in and contribute consistently to his treatment. 'Closing the loop' or achieving 'triangulation' (so all therapeutic relationships are joined and collaborative and cooperative effort emerges, in terms of the relationships between parent, health practitioner and school representative) appears to be a recommended priority.

In the event that health practitioners resist sharing information or collaborating with the school, provided there is formal consent from the parent or guardian, or actual student if they are of an age, it is important to ascertain why this is so. If this is simply laziness, incompetence or time-poverty on the behalf of the practitioner, then this needs to be overcome with persistence and assertiveness. If there are stringent or legitimate therapeutic reasons for such non-disclosure, then usually it is best for the school to respect such boundaries. Nevertheless, there are some occasions where health practitioners do hide behind such confidentiality scenarios, as a self-serving exercise, which ultimately may not be acting in the best interest of their client and the school's student. Some vigilance regarding this last possibility is also warranted.

Schools and the Management and Treatment of ODD

Schools alone cannot (nor be expected to) treat ODD, like they may be able to initiate or manage a reading-recovery program. However, provided the parent(s) of the young person is committed to activating an appropriate intervention program involving appropriate health practitioners (GPs, paediatricians, psychologists, speech pathologists, play therapists, etc), and have the endurance and financial resources to see this through, then the school has an integral contribution to make to the on-going treatment of the affected young person. That is, hopefully the school can provide a learning and nurturing environment that is consistent and congruent with the efforts of the treating practitioners to establish a new secure and safe attachment (involving critical and key relationships) environment, at home, school and elsewhere.

To this extent, the school can work in harmony with the treatment program, to maximise its benefits. In any case, a school will benefit from establishing such safe 'attachment' environments anyway, to act in a preventive capacity for other children affected by ODD like circumstances. As noted, the best local example of this school environment is the Maryborough Education Centre (Victoria) and their innovative teaching and management practices.

Discussion and Reflections

a. Teachers and schools have very limited capacity to facilitate positive outcomes for students with ADHD, ODD or CD without adequate support and cooperation from affected families and significant care-givers. Nevertheless, even where support, resources and financial capacity exist, prognosis remains marginal unless a systematic, structured, consistent and enduring intervention strategy can be implemented.
b. Be realistic and pragmatic about your capacity to 'make a difference'. Unreasonably inflated expectations can lead to distress, and potentially, burnout.
c. Fundamentally, the solution resides with the family, even though the school, individual teachers and many other students are adversely affected on a daily basis by ODD or CD affected children or adolescents.
d. The school has capacity to assist with the solution but ownership of the problem needs to reside with the family. Unfortunately, and ironically (sadly), this ownership is often the nub of the problem, where parents too have similar emotional, behavioural and psychiatric problems, thus precluding them participating as mature and helpful adults, instead being belligerent, avoidant, in denial, and so on.
e. It is not possible for one clinician, or an individual teacher, principal, or welfare officer, etc, to solve these problems alone. Instead there is a need to build a system and/or community-based approach to these challenging scenarios. At the school level at least, The Maryborough Education Centre experience is a good case study into how to approach this problem in a strategic or systems way.
f. Suspension or expulsion is not a sustainable or desirable option in consideration of the longer-term prospects for the individual concerned, as delinquency, crime and incarceration beckon. Certainly, this may appear in conflict with the utilitarian needs of a school to keep others safe, yet this reality is a fact, and efforts to keep a troubled young person engaged in school remains critical to their restorative prospects.

g. Prevention is always better than the cure. Secure and nurturing care-giving for all babies, infants and children must remain our aim to avoid the scourge of these very significant developmental disorders.
h. To what extent can this school, in partnership with other community-based organisations, work sensitively, collaboratively and meaningfully with affected families and parents? Indeed, the prospects of helping ODD affected young people may be advanced to a greater extent by working with the family (and other agencies, with the consent of the family), rather than the young person alone.

Diagnostic Criteria for ODD. DSM IV and DSM V.

Reference: Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition. DSM-IV[1]-TR. American Psychiatric Association, p102, 2000).

A. A pattern of negativistic, hostile and defiant behaviour lasting at least 6 months, during which four (or more) of the following are present:
    1. often loses temper
    2. often argues with adults
    3. often actively defies or refuses to comply with adults' requests or rules
    4. often deliberately annoys people
    5. often blames others for his or her mistakes or misbehaviour
    6. is often touchy or easily annoyed by others
    7. is often angry or resentful
    8. is often spiteful or vindictive
B. The disturbance in behaviour causes clinically significant impairment in social, academic or occupational functioning.
C. The behaviours do not occur exclusively during the course of a Psychotic or Mood Disorder.
D. Criteria are not met for Conduct Disorder, and, if the individual is 18 years or older, criteria are not met for Antisocial Personality Disorder.

DSM V Changes and Emphasis

ODD characterised by a lack of emotional and behaviour self-control.
ADHD is often co-morbid (occurs) with ODD.
ODD symptoms grouped in three key types, being
1. angry / irritable mood
2. argumentative / defiant behaviour
3. vindictiveness

Exclusion criteria (see D. above) for Conduct Disorder removed.
ODD symptoms overlap with normal behaviour so frequency of symptoms is a defining factor, as is the pervasiveness of symptoms across a young person's various life settings.

A Summary of Associated Features of ODD

Onset	Becomes evident around age 8 and usually not later than early adolescence. Usually evident in the home first. More evident first with adults or peers who individual knows well.
Gender	More males before puberty, about equal after.
ADHD	May often occur together, or one, without the other.
Trajectory	When ODD starts in infancy, persists, and occurs in a dysfunctional family context, ODD often evolves into CD.
Familial Pattern	More common in families where at least one parent has a history of a mood disorder, ODD, CD, ADHD, antisocial personality disorder or substance-related disorder. Refer attachment theory (secure, avoidant, ambivalent, disorganised).
Insight	Often poor. Usually individuals will not regard themselves as oppositional or defiant but justify their behaviour as a response to unreasonable demands or circumstances.

[1] DSM IV was superseded by DSM V in May 2013. Mental health practitioners have now transitioned to this revised classification system. However, these notes prepared in 2013.

Correlates	a. Poor emotional regulation (also under-arousal) b. In school years, may be low or overly inflated self-esteem c. Mood lability (often changing, unpredictable mood) d. Low frustration tolerance, swearing e. Precocious use of alcohol, tobacco or illicit drugs f. Over-controlling parents denying child some freedom appropriate to age g. Higher prevalence in families where child care is disrupted by a succession of different caregivers, or in families where harsh, inconsistent, or neglectful child-rearing practices are common (i.e child abuse or maltreatment) h. Also refer attachment theory (secure, avoidant, ambivalent or disorganised). This is a recurring theme and one that both explains and may also inform treatment. i. ADHD is common with ODD, as are learning and communication disorder.
Differential diagnosis	• Depression - may be angry and oppositional • Anxious or obsessive children may be uncooperative when forced to confront feared situations or prevented from performing their rituals • Psychotic young people can appear defiant • Often a developmental antecedent for Conduct Disorder, but not inevitable. Disruptive behaviours are less severe than individuals with CD, and so typically do not include aggression toward people or animals, destruction of property, or a pattern of theft or deceit.
Prognosis	Poor unless good family support can be engaged or facilitated. Other salient factors include support for carers, adequate financial resources and access to competent therapists and services in the family's region.
Treatment	Treatment relies on teaching parenting skills and on family therapy. Specific treatment of co-morbid conditions (ADHD or depression) is necessary also.