



Oppositional Defiant Disorder and Conduct Disorder Treatment Guide

DSM V Criteria

Diagnostic criteria for 313.81 Oppositional Defiant Disorder

A. A pattern of angry, irritable mood, argumentative and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

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| (1) Often loses temper. | (5) Often actively defies or refuses to comply with requests from authority figures or with rules. |
| (2) Is often touchy or easily annoyed. | (6) Often deliberately annoys others. |
| (3) Is often angry and resentful. | (7) Often blames others for his or her mistakes or misbehavior. |
| (4) Often argues with authority figures or, for children and adolescents, with adults. | (8) Has been spiteful or vindictive at least twice within the past 6 months |

Note: The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic. For children younger than 5 years, the behavior should occur on most days for a period of at least 6 months unless otherwise noted (Criterion A8). For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8). While these frequency criteria provide guidance on a minimal level of frequency of defined symptoms, other factor should also be considered, such as whether the frequency and intensity of behavior are outside a range that is normative for the individual's development level, gender, and culture.

B. The disturbance in behavior is associated with distress in the individual or others in his or her immediate social context (e.g., family, peer group, work colleagues), or it impacts negatively on social, educational, occupational, or other important areas of functioning.

C. The behaviors do not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also the criteria are not met for disruptive mood dysregulation disorder.

Specify severity:

Mild: Symptoms are confined to only one setting (e.g., at home, at school, at work, with peers).

Moderate: Some symptoms are present in at least two settings.

Severe: Some symptoms are present in three or more settings.

Diagnostic criteria for 312.8 Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:



DSM V Criteria

Aggression to people and animals

- (1) often bullies, threatens, or intimidates others
- (2) often initiates physical fights
- (3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
- (4) has been physically cruel to people
- (5) has been physically cruel to animals
- (6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- (7) has forced someone into sexual activity

Destruction of property

- (8) has deliberately engaged in fire setting with the intention of causing serious damage
- (9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

- (10) has broken into someone else's house, building, or car
- (11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
- (12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

- (13) often stays out at night despite parental prohibitions, beginning before age 13 years
- (14) has run away from home overnight at least twice while living in parental or parental surrogate home, or once without returning for a lengthy period
- (15) is often truant from school, beginning before age 13 years

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Specify type based on age at onset:

Childhood-Onset Type: Individuals shows at least one symptom characteristic of conduct disorder prior to age 10. (312.81)(F91.1)

Adolescent-Onset Type: Individuals shows no symptom characteristic of conduct disorder to age 10. (312.82)(F91.2)

Unspecified Onset : Criteria for a diagnosis of conduct disorder are met, but there is not enough information available to determine whether the onset of the first system was before or after age 10. (312.89)(F91.9)

Specify severity:

Mild: Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause relatively minor harm to others (e.g., lying truancy, staying out after dark without permission, other rule breaking).

Moderate: The number of conduct problems and the effect on others are intermediate between those specified as "mild" and those in "severe" (e.g., stealing without confronting a victim, vandalism).

Severe: Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others (e.g., forced sex, physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering).



Evidence-Based Psychosocial Therapies

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

- **Parent Management Training** has been used with considerable success with aggressive youngsters, especially when parents themselves are not significantly unstable or disorganized. Often, however, teenagers are resistant to this kind of treatment and feel that adults are ganging up on them.
- **Family Therapy** can help family members learn less defensive ways of communicating with each other when teenagers are willing to work with their parents in therapy. It can foster mutual support, positive reinforcement, direct communication, and more effective problem-solving and conflict resolution within the family.
- **Social Skills Training** training focuses on teenagers in an effort to enhance their problem-solving abilities. Through such programs, a youngster can learn to identify problems, recognize causes, appreciate consequences, learn to verbalize feelings, and consider alternate ways of handling difficult situations.
- **Individual Psychotherapy** can provide the difficult child with a forum to explore his feelings and behaviors. The therapist may be able to help with more effective anger management, thus decreasing the defiant behavior.
- **Cognitive Behavioral Therapy (CBT)** may be employed to assist the child with problem solving skills and in identifying solutions to interactions that seem impossible to the child. Cognitive-Behavioral Therapy may help adolescents control their aggression and modulate their social behavior. CBT can teach defiant teens self-control, self-guidance, and more thoughtful and efficient problem-solving strategies, especially as they pertain to relationships with their peers, parents, and other adults in authority.
- **School-Based Treatment Programs** are in wide use throughout the country, whether in special residential treatment environments, designated community-based schools, or specific programs in mainstream schools. These programs can reintegrate the student into regular classes as the youngster's behavior allows.

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- Approximately half to two-thirds of adolescents with ODD also have ADHD. Stimulants have been found to reduce aggression-related behaviors in these children.
- Behavioral therapy (cognitive-behavioral therapy, social problem-solving skills training, parent management training), comprising 12 to 25 sessions with either the child alone or with teachers or parents, decreased disruptive or aggressive behaviors by 20% to 30%.

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- Ages 3–15: **Parent Training**
- Ages 9–15: **Anger Coping Therapy**
- Ages 6–17: **Brief Strategic Family Therapy (BSFT)**
- Ages 13–16: **Functional Family Therapy (FFT)**
- Ages 9–18: **Treatment Foster Care (TFC)**
- Ages 12–17: **Multisystemic Therapy (MST)**
- Ages 12–17: **Mentoring**
- Ages 9–18: **Cognitive Based Therapy (CBT)**

SOURCES

1. American Academy of Child & Adolescent Psychiatry.
 - a. [Your Adolescent on Conduct Disorders](#).
 - b. Practice Parameters for [ODD](#) and [CD](#).
 - c. Resource Center for [ODD](#) and [CD](#).
2. *Disruptive Behavior and Aggression by American Academy of Pediatrics in Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit*.
3. [What are effective treatments for oppositional defiant behaviors in adolescents?](#) by Gary Kelsberg and Leilani St. Anna in the *Journal of Family Practice*.
4. [Choosing the Right Treatment: What Families Need to Know About Evidence Based Practices](#) by NAMI, The National Alliance on Mental Illness.



Medication Management

• The US Food and Drug Administration (FDA) has no approved indications for aggression in children and adolescents, apart from irritability-associated aggression in children with autism. In other populations, recent federally supported evidence-based reviews suggest efficacy for some psychotherapeutic agents, but primary care clinicians are urged to consult with mental health specialists before prescribing medications for aggression.¹

• Since conduct problems tend to arise from a tangle of biological, emotional, and social stresses, there is no single class of medication that has been found especially useful. ODD/CD are highly comorbid with other psychiatric problems (such as ADHD, depression, manic-depressive illness, or schizophrenia), however, medication used to treat these conditions may not be sufficient to alter significantly the conduct disorder symptoms. Used judiciously to address specific clinical findings in each individual case, appropriate medication can enhance the success of other treatment modalities.²

o If the teenager has underlying ADHD, the use of stimulants may help reduce negative behaviors and impulsiveness.

o Lithium, a mood stabilizer, has also been shown in some studies to reduce aggression.

o In some cases, anticonvulsant medications, when used as mood stabilizers, reduce aggression. Examples of these medications are valproic acid, also called divalproex sodium (Depakote), carbamazepine (Tegretol), lamotrigine (Lamictal) and oxcarbazepine (Trileptal).*

***Prescribers should be cautious** and aware of the interactions between various anticonvulsant medications and the interaction of anticonvulsant medications with other types of medications.



Practice Guidelines

American Academy of Pediatrics

Phase 1

1. Engage Patient and Parents During Initial Evaluation.
2. Conduct a Thorough Initial Evaluation and Diagnostic Workup Before Initiating Pharmacological Treatment.
3. Assess Treatment Effects and Outcomes With Standardized Measures.
4. When Acute Aggression Is the Reason for Referral, Conduct a Risk Assessment and, If Necessary, Consider Referral to a Psychiatrist or an Emergency Department for Evaluation.

Phase 2

5. Continuously Track and Reassess Aggression Problems Obtain Additional Collateral Information as Needed.
6. Obtain Additional Collateral Information as Needed
7. Provide Psychoeducation for Patients and Families.
8. Develop an Appropriate Treatment Plan With the Patient/Family and Obtain Buy-in.

Phase 3

9. Help the Family Establish Community Supports.

Ongoing

10. Provide or Assist the Family in Obtaining Evidence-Based Parent and Child Skills Training During All Phases of Care.
11. Engage the Child and Family in Taking an Active Role in Implementing Psychosocial Strategies and Help Them to Maintain Consistency.
12. Initial Medication Treatment Should Target the Underlying Disorder(s).
13. When Available, Follow Evidence- Based Guidelines for the Primary Disorder.
14. Consider Adding an Antipsychotic Medication, Taking Into Account the Latest Available Evidence on Efficacy and Safety of Individual Agents, If Severe Aggression Persists After an Adequate Trial of Treatments for the Underlying Disorder (Including Psychosocial Treatments).
15. Use Recommended Titration Schedules and Deliver an Adequate Medication Trial Before Changing or Adding Medication.
16. If Insufficient Response, Try a Different Antipsychotic Medication.
17. For a Partial Response to an Initial First-Line Antipsychotic, Consider Augmentation With a Mood Stabilizer.
18. Avoid Using More Than 2 Psychotropic Medications Simultaneously.
19. Conduct Side Effect and Metabolic Assessments and Laboratory Tests That Are Clinically Relevant, Comprehensive, and Based on Established Guidelines.
20. Provide Accessible Information to Parents and Families About Identifying and Managing Side Effects.

SOURCE: [American Academy of Pediatrics](#). Treatment of Maladaptive Aggression in Youth: CERT Guidelines I. Engagement, Assessment, and Management, Pediatrics and CERT Guidelines II. Treatments and Ongoing Management.

NOTE: This resource is for reference purposes only and should not be used to replace medical information from prescribing health care professionals or pharmacies.