DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

Oppositional Defiant Disorder

ODD

DSM-5-TR 313.81 | ICD-10-CM F91.3

Persistent angry or irritable mood, argumentative and defiant behavior, and vindictiveness directed mainly at authority figures.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~3.3% of children	Preschool to early school age	1.4:1 male:female (childhood)	~30% progress to conduct dx

CLINICAL PICTURE

- Frequent temper outbursts, chronic irritability, and low frustration tolerance directed mainly at familiar adults rather than strangers.
- Argues with parents and teachers, refuses reasonable requests, and deliberately breaks rules the adult is visibly invested in enforcing.
- Blames others for personal mistakes and misbehavior, and describes feeling unfairly singled out rather than accepting responsibility.
- Deliberate annoyance of others, spitefulness, and grudge holding distinguish the disorder from ordinary developmental limit testing.
- Behavior is often confined to home at first, and teachers may describe a compliant child while parents report daily escalating conflict.
- Property destruction, physical aggression, theft, and deceit are absent; their presence points instead toward conduct disorder.

DIAGNOSTIC CRITERIA AT A GLANCE

- Requires at least four symptoms drawn from angry/irritable mood, argumentative/defiant behavior, or vindictiveness clusters.
- Duration must be at least six months, with symptoms occurring in interaction with at least one individual who is not a sibling.
- Frequency must exceed developmental and cultural norms: most days under age 5, and at least weekly from age 5 onward.
- Severity is specified by setting count: mild in one setting, moderate in two, and severe in three or more settings.
- Behavior must not occur exclusively during a mood, psychotic, or substance use disorder, and DMDD takes diagnostic precedence.

NEUROBIOLOGY & PHYSIOLOGY

- Heritability is roughly **50%**, with genetic risk overlapping substantially with **ADHD** and conduct disorder rather than being specific.
- Blunted autonomic reactivity, including low resting heart rate and reduced skin conductance response, correlates with aggressive behavior.
- Reduced prefrontal top-down control over an overreactive amygdala biases processing toward threat and reactive aggression.
- A hypoactive HPA axis with low morning cortisol appears in chronically aggressive youth, unlike anxious or internalizing presentations.
- Serotonergic hypofunction and altered dopaminergic reward learning are linked to persistent irritability and reward insensitivity.
- Prenatal nicotine and alcohol exposure, lead burden, and low birth weight raise risk in interaction with harsh or inconsistent parenting.

PSYCHOLOGICAL MECHANISMS

- Patterson's coercive family process describes parental demand, child escalation, and parental withdrawal that negatively reinforces defiance.
- Hostile attribution bias leads to interpreting ambiguous social cues as deliberately hostile, prompting preemptive verbal or physical aggression.
- Emotion regulation deficits, especially slow recovery from anger arousal, drive the irritable dimension of the disorder.
- Inconsistent, harsh, or unpredictable discipline teaches the child that escalation works and that compliance is optional.
- The irritable dimension predicts later depression and anxiety, while the defiant dimension predicts later conduct problems and delinquency.

DIFFERENTIAL & COMORBIDITY

- Disruptive mood dysregulation disorder requires severe recurrent outbursts plus persistently irritable mood between outbursts.
- Undiagnosed **ADHD**, language disorder, learning disorder, anxiety, or trauma exposure frequently masquerades as willful defiance.
- **ADHD** co-occurs in 40-60%, while anxiety and depressive disorders each appear in roughly 15-20% of clinical cases.
- Assess for maltreatment, domestic violence, parental substance use, and parental depression, all of which sustain the behavior pattern.
- Untreated ODD raises risk of conduct disorder, substance use, school exclusion, and adult antisocial and mood outcomes.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication is FDA approved for ODD, and psychosocial intervention remains first line at every level of severity.
- Treat comorbid **ADHD** with stimulants first, since oppositional symptoms improve substantially in many children once attention improves.
- **Risperidone 0.25-2 mg/day** reduces severe aggression in the short term but requires metabolic, prolactin, and movement monitoring.
- Treat comorbid depression or anxiety with SSRIs, since irritability driven by a mood episode often resolves as the episode resolves.
- Avoid polypharmacy and long-term antipsychotic maintenance without documented target symptoms, dose review, and taper attempts.

PSYCHOTHERAPY

- **Parent management training** is first line under age 12, including **PCIT**, Incredible Years, or Triple P across 10-20 sessions.
- Effect sizes for parent training run about 0.5-0.8, and gains depend on attendance, home practice, and consistent follow-through.
- **Collaborative and Proactive Solutions** targets lagging cognitive skills and unsolved problems rather than motivation alone.
- **Problem-solving skills training** and anger coping groups directly help school-age children and adolescents regulate conflict.
- **Multisystemic therapy** or functional family therapy suits older adolescents with broader school and community system involvement.

ADJUNCT & SUPPORTIVE

- **Vanderbilt**, **ECBI**, and **SDQ** rating scales completed by parent and teacher track severity and response to treatment.
- School-home daily report cards align contingencies across settings and reduce the cross-setting inconsistency that sustains defiance.
- Address sleep deprivation, screen and gaming conflict, and chaotic household routines, which reliably fuel outbursts.
- Treat parental depression, substance use, and marital conflict, since untreated caregiver problems strongly predict treatment dropout.
- Escalate to intensive in-home services or day treatment when safety, school placement, or living arrangement stability is threatened.

CLINICAL PEARLS

- Parent training beats child-directed therapy under age 12; treat the dyad, not the child alone.
- Treat ADHD first; much apparent defiance is untreated inattention and impulsivity.
- Chronic irritability between outbursts points toward DMDD or a mood disorder.

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NOTE

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