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ODD AND CONDUCT DISORDER

Oppositional Defiant Disorder (ODD) is described as a severe and persistent, recurrent pattern of negativistic, defiant, disobedient and hostile behavior beginning in childhood or adolescence with a duration of six months or more. Symptoms that are specific to ODD are: irritable or angry mood, argumentative and defiant behaviour, being easily annoyed by others, aggression and vindictiveness, a refusal to comply with rules, the deliberate annoyance of others and blaming others for their own mistakes. It is well established that ODD is a precursor for Conduct Disorder.

Conduct Disorder (CD) occurs predominantly amongst male youths. They display at least four of the following behaviours:

- Aggression towards others including physical altercations and physical cruelty to animals
- The use of a weapon to harm others
- The perpetration of a forced sexual act on another
- Property destruction by arson or any other means
- Criminal acts such as breaking into a property or theft or shoplifting or mugging
- Truancy, running away from home and a refusal to comply with the rules set by parents and/or other adults.

These individuals also show a lack of remorse, no empathy towards others and seem callous and unconcerned by the nature of their behavior. Callous and unemotional behaviour strongly suggests the potential progression towards Antisocial Personality Disorder or habitual adult criminality. The rate of this progression is as high as fifty percent.

For both conditions there is well established co-morbidity and pre-morbidity with Attention Deficit Hyperactivity Disorder (ADHD). ODD is a comorbid diagnosis in 60% of minors with ADHD. The combination of the diagnoses indicates a worse prognosis, earlier age of onset with more functional impairment, increased risk of developing anxiety, depression and progression to conduct disorder and more delinquency than either disorder alone. ADHD is a treatable condition. Therefore, diagnosis and successful treatment of ADHD is critical factor in reducing the potential progression to ODD and CD.

Risk factors for the development of ADHD, ODD and CD include:

- Antenatal maternal smoking and postnatal adversities
- Family history of ADHD, ODD or CD
- High levels of family conflict
- Parental psychopathology, substance abuse and maladaptive parenting styles including harsh parenting
- The absence of fathers/positive male role models
- The experience of any form of abuse

Specific risk factors contributing towards CD are:

- The inability to self-regulate combined with rapid activation of the fear and anger centres as a result of neurological malfunction in the amygdala and the orbito-frontal cortex
- Low verbal IQ
- Lack of economic opportunity
- Frequent unoccupied and unsupervised time
- Rejection by more prosocial peers and an association with delinquent peers and the gang system

Fifty to seventy percent of referrals to Child and Family units in the Western Cape are for male minors presenting with unmanageable behaviour, extreme impairment in functioning and the creation of significant distress in both patient and family, as a result of this diagnostic combination. This combination of diagnoses tells the sad tale of family structures that have collapsed. Fathers are usually absent; mothers are overwhelmed or are abusing substances and

grandmothers are left to try and raise their grandchildren - a momentous task.

Attending school can be an opportunity for these children to experience structure, leadership, encouragement and healthy outlets like sport. However, our schools are overburdened and under-resourced. Most schools don't provide after-school programmes which leaves youths unsupervised and less likely to make pro-social choices. Communities offer another opportunity to provide support to youths. Community cohesion and prioritisation of the needs of youth (exposure to positive role models, access to sports coaching, extramural activities, leadership programmes) would help this precious developmental phase to realise a successful outcome.

Diagnosis of these conditions requires an in-depth assessment of disruptive behaviour symptom profiles. A focus on family history of possible ADHD, ODD and CD as well as antenatal and postnatal events is necessary. Family functioning, family challenges, family substance abuse and parenting practices must be assessed. The minor's schooling history, level of academic functioning or cognitive ability and behaviour in the school environment provide essential information. Screening for mood, anxiety and trauma related psychopathology is necessary. An assessment of risk factors with regards to the patient and the family members should also be done.

The occurrence of ODD, left untreated, which progresses to CD is a tragic development of disorders that carries significant negative consequences.

The cost to the individual includes sexually transmitted diseases, risk of serious injury, failure of education, isolation from family and friends and involvement with the juvenile justice system. Consequences for parents include self-blame, shame, anxiety, social embarrassment, interruption of work, escalation of family discord and theft of their property. Cost to communities and society are significant. Often these youths are drawn into the gang system and a cycle of criminality with significant risk to self and others begins. Substance abuse is a frequent comorbid disorder, further aggravating dysfunctional behavior and criminality. The economic cost per individual per annum, runs into the hundreds of thousands of rands.

Treatment of this symptom dimension includes early intervention, maximising the pharmacological management of ADHD, augmentation with other pharmacological options and psychological or behavioural interventions. Successful treatment and behavioural change are possible where interventions are implemented before the age of eight years. The primary form of intervention is parental guidance. Parents are guided to encourage the use of house rules, problem-solving, structure in the home environment, sympathy and empathy. Working solely with the individual child is ineffective without the additional parenting interventions.

Prevention programmes are typically initiated in grade one or two of the school years. The fundamental purpose is to teach prosocial behavior and correct antisocial behavior. The components of the programmes are communication of clear expectations of behaviour and limit setting, modelling appropriate behaviour, ignoring offensive behaviour, the use of quality time, practice and feedback and specific praise and rewards to reinforce correct behaviour. Well-resourced countries implement targeted programmes including psychosocial interventions such as parent-training, family therapy and child social skills training. More intensive interventions include a nurse-family partnership where parent training is done in the home environment over a period of six to nine months. Adolescents presenting with ODD and CD require a multidimensional approach including social services intervention, social skills training, parent training, family therapy, educational support and the involvement of the juvenile justice system. Minimal preventative or targeted programmes are currently active within South Africa.

Among the medications used for the treatment of ADHD, psychostimulants have the most efficacy in the treatment of oppositional behavior. The use of polypharmacy to stabilise disruptive behavior is restricted for highly problematic behaviour. The approach should always be step wise. A time frame should be used to trial medications and careful management of the side effects of medication is crucial. The combination of stimulant and risperidone is beneficial. The combination of atomoxetine and olanzapine is beneficial. The combination of stimulant and citalopram, aripiprazole or fluoxetine is effective in the reduction of irritability, anxiety and depression.

Early intervention is the cornerstone of treatment for a good outcome. The prognosis is poor in patients presenting over the age of eight years. Adolescents with problematic behaviour often require placement in long-term, highly structured, inpatient behaviour modification programmes. Application for placement in these programmes is done through state social workers. Within the private sector, referral for behaviour modification is done to the adolescent programme of the 'Healing Wings' organisation. The Department of Social Development has created a six week ROAR programme as a targeted intervention for ODD.

Criminal activity will eventually lead to the involvement of the juvenile justice system. Parents are often hesitant to report violence, destructive acts and theft but should be encouraged to do so for their own safety and the possibility of earlier intervention, even if that means involving the criminal justice system.

Other avenues for intervention come through sport focused organisations like 'Waves for Change' which use the positive and healthy benefits of sport activity to enhance confidence, self-belief and prosocial behavior. The youths of today are the adults of the future. Valuing their talents, providing structure and opportunities, nurturing their education, allowing them to develop surrounded by support and healthy boundaries ensures healthy adult functioning. Ignoring these needs and abandoning our youths to the chaos of broken families, communities and society is an oversight with tragic and appalling consequences.

References available on request. MHM