Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) in Children and Adolescents: Diagnosis and Treatment

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Oppositional Defiant Disorder (ODD)

What is it?

ODD is a psychiatric disorder that is really just the far end of the stubbornness spectrum. The line that divides being just difficult and stubborn from ODD is a set of diagnostic criteria. The criteria for ODD are:

A pattern of negativistic, hostile, and defiant behavior lasting at least six 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 misbehavior

6. is often touchy or easily annoyed by others

7. is often angry and resentful

8. is often spiteful and vindictive

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

How often is "often"?

All of the criteria above include the word "often". But what exactly does that mean? Recent studies have shown that these behaviors occur to a varying degree in all children. These researchers have found that the "often" is best solved by the following criteria.

Has occurred at all during the last three months-

8. is spiteful and vindictive

5. blames others for his or her mistakes or misbehavior

Occurs at least twice a week

6. is touchy or easily annoyed by others

1. loses temper

2. argues with adults

3. actively defies or refuses to comply with adults' requests or rules

Occurs at least four times per week

7. is angry and resentful

4. deliberately annoys people

What causes it?

No one is every going to discover the "cure" for ODD because there isn't just one cause. It takes quite a few risk factors to develop the disorder. The more risk factors, the more chances the child will have it. No one factor will cause it. ref

Biologic Risk Factors

Genetics- Being oppositional is a strongly inherited trait.

Pregnancy- It turns out smoking during pregnancy is a significant risk factor for ODD. This alone should stop every women from smoking! (30) Fetal alcohol Syndrome is another common risk factor for ODD.

Psychologic Risk Factors

Living in an abusive home, not having two biologic parents, multiple separations, and poor attachment to your parents are known risk factors

Social Risk factors

Poverty, lack of community, uninvolved parents, lots of violence, child abuse, substance abuse, and inconsistent parenting are a few

How can you tell if a child has it?

ODD is diagnosed in the same way as many other psychiatric disorders in children. You need to examine the child, talk with the child, talk to the parents, and review the medical history. Sometimes other medical tests are necessary to make sure it is not something else. You always need to check children out for other psychiatric disorders, as it is common the children with ODD will have other problems, too.

Diseases that look like ODD and Conduct Disorder

It is fairly easy to miss a rare disease that is causing Conduct Disorder. Children with brain tumors, problems metabolizing certain chemicals, strokes, head injuries, epilepsy, and a host of other diseases can make children act badly. In suspicious cases, neurologists, geneticists, endocrinologists may all be involved along with a host of lab tests and other investigations.

Does every misbehaving child need all that done?

Definitely not. There are some warning signs that should maybe this behavior that looks like ODD or CD (see below) is really something else.

1. Recent onset in later childhood or adolescence.

ODD and CD do not usually start after age 8. A perfectly behaved child who lives in a happy family and starts to seriously misbehave at age 12 needs a careful examination. There are a number of other medical, psychiatric, and neurologic disorders to consider.

2. ODD or CD with worsening abilities to think, remember, and understand.

Of course, street drugs would be a more likely case of having more trouble thinking. A child who never had learning problems until age 12 should be checked out much more carefully than a child who always had learning problems.

3. ODD or CD along with a major medical or neurologic problem.

Sometimes it is just chance, but if your child has some serious illness or had some serious illness in the past, this might be related to their behavior now and needs checking out.

4. ODD or CD with signs of disinihibition.

Disinhibition means that the usual control we have over our desire for food, sexual contact, possessions, and social approval are loosened. Children with CD often have sexual symptoms involving disrespect. When the main symptoms involve these basic drives, other neurologic signs and symptoms need to be checked out.

5. Major problems with sleep.

There are a number of sleep disorders which can look like ODD or make it worse. This information is in the a separate pamphlet. Click here to go there.

Who gets ODD?

A lot of children! This is the most common psychiatric problem in children. Over 5% of children have this. In younger children it is more common in boys than girls, but as they grow older, the rate is the same in males and females.

ODD rarely travels alone - Comorbidity

It is exceptionally rare for a physician to see a child with only ODD. Usually the child has some other neuropsychiatric disorder along with ODD. The tendency for disorders in medicine to occur together is called comorbidity.

Common patterns of comorbidity

ODD plus ADHD

If a child comes to a clinic and is diagnosed with ADHD, about 30-40% of the time the child will also have ODD (1). Here are some examples of how this looks across ages.

Pre School Marianne

Marianne is now 4 years old. Her parents were very excited when she turned four that perhaps that would mean that the terrible twos were finally over. They were not. Her parents are very grateful that the Grandparents are nearby. The grandparents are grateful that

Marianne's aunts and uncles live nearby. Marianne's Aunt is grateful that this is her niece, not her daughter. Why? Marianne requires an incredible combination of strength, patience, and endurance.

Marianne begins her day by getting up early and making noise. Her father unfortunately has mentioned how much this bothers him. So she turns on the TV, or if that has been mysteriously disconnected, bangs things around until her parents come out. Breakfast is the first battleground of the day. Marianne does not like what is being served once it is placed in front of her. She seems to be able to sense how hurried her parents are. When they are very rushed, she is more stubborn and might refuse it altogether. It would be a safe bet that she would tell her Mom that the toast tastes like poop. This gets her the first “time out” of the day.

In the mornings she goes to pre-school or goes off with her grandmother or over to her aunts. Otherwise Marianne's mother is unable to do anything. Marianne can not entertain herself for more than a few moments. She likes to spend her time purposefully annoying her mom, at least so it seems. Marianne will demand over and over that she wants something. For example, playdough. She knows it must be made first. So her mom finally gives in and makes it. Marianne plays with it about one minute and says, " Let’s do something" . Her mother reminds her that they are doing something, the very thing that Marianne has been demanding for the last hour. " No, Lets do something else"

So after Marianne's mother screamed so hard she was hoarse when her husband came home, Marianne gets to go out almost every morning. At preschool she is almost perfect, but will not ever do exactly what the teacher wants. Only once has she had a tantrum there. Marianne gets along with the other children as long as she can tell them what to do.

Her grandmother and Aunt all follow the same “time out” plan. This means she goes to a certain room until she calms down. The room is empty now at Marianne's grandmother. Marianne broke the toys, and they were removed. She banged the furniture around and it was removed. What sets Marianne off is not getting to do what Marianne wants. She screams, tells people she hates them, and swings pretty hard for a four old. After a half hour it is usually over, but not always. Marianne will usually tell her mom or Grandmother about these tantrums. The story is always twisted a little. For example, Marianne will tell her Grandmother that her mom locked her in her room

because she was watching TV. Her grandmother used to believe these stories, and Marianne could tell the whole story of how she was watching this show, and her mom just came in and dragged her to her room. Now it turns out that Grandma doesn't think much of TV anyways, and so this made a certain amount of sense to her. This led to more than one heated argument between the Grandma and her mom. Of course there was almost no truth to this at all. It took the tables being turned for the Grandma to really believe that her Granddaughter could set up an argument like this. Marianne came home and told her mom that Grandma let her eat four cookies and an ice cream cone for a treat and that she was very full. Marianne's mom doesn't think much of treats, and could see how this might happen and thought she would have to talk to her mom. Finally they both realized what Marianne was doing.

Most of the afternoon with Marianne is spent chasing her around trying to wear her out. It doesn't seem to work, but it is worth a try. When she is at her aunts, she tries to wreck her cousin’s stuff. When is she good? When there are no other cousins around and she has the complete attention of her Aunt or Grandpa.

Marianne loves the bedtime battle. She also loves to go to the Mall. But she never gets to go there or hardly anywhere else. She acts up so badly that her family is very embarrassed. Her mother shops and visits only when Marianne goes to preschool. It is hard to know who is more excited about Marianne going to school next year, her mother or Marianne!

Elementary School Ryan

Ryan is 10. Ryan's day usually starts out with arguing about what he can and can not bring to school. His mother and his teacher have now made out a written list of what these things are. Ryan was bringing a calculator to school and telling his teacher that his mother said it was alright. At first his teacher wondered about this, but Ryan seemed so believable. Then Ryan brought a little (Ryan's words) knife. That lead to a real understanding between the teacher and Ryan's mother.

Ryan does not go to school on the bus. He gets teased and then retaliates immediately. Since it is impossible to supervise bus rides adequately, his parents and the school gave up and they drive him to school. It is still hard to get him there on time. As the time to leave approaches, he gets slower and slower. Now it is not quite as bad because for every minute he is late he loses a dime from his daily

allowance. Once at school, he usually gets into a little pushing with the other kids in those few minutes between his mother's eyes and the teacher's. The class work does not go that badly now. Between the daily allowance which is geared to behavior and his medicine, he manages alright. This is good for everyone. At the beginning of the school year he would flip desks, swear at the teacher, tear up his work and refuse to do most things. Looking back, the reasons seem so trivial. He was not allowed to go to the bathroom, so he flipped his desk. He was told to stop tapping his pencil, so he swore at the teacher.

Recess is still the hardest time. Ryan tells everyone that he has lots of friends, but if you watch what goes on in the lunch room or on the playground, it is hard to figure out who they are. Some kids avoid him, but most would give him a chance if he wasn't so bossy. The playground supervisor tries to get him involved in a field hockey game every day. He isn't bad at it, but he will not pass the ball, so no one really wants him on his team.

After school was the time that made his mom seriously consider foster care. The home work battle was horrible. He would refuse to do work for an hour, then complain, break pencils and irritate her. This dragged 30 minutes of work out to two hours. So, now she hires a tutor. He doesn't try all of this on the tutor, at least so far. With no home work, he is easier to take. But he still wants to do something with her every minute. Each day he asks her to help him with a model or play a game at about 4:30. Each day she tells him she can not right now as she is making supper. Each day he screams out that she doesn't ever do anything with him, slams the door, and goes in the other room and usually turns the TV on very loud. She comes up, tells him to turn it down three times. He doesn't and is sent to his room. She calculated that she has made about 1500 suppers since he was five years old. Could it be that they have gone through this 1500 times? She decides this is not a good thought to follow through. After supper Ryan's dad takes over and they play some games together and usually it goes fine for about an hour. Then it usually ended in screaming. So Ryan's grandmother had the bright idea of inviting them over for desert at about 8:00 pm most nights. But what about days when there is no school? Ryan's parents try very hard not to think about that.

High School Tasha

Tasha is 15. She is in ninth grade and from her marks, you would say there is no big problem. She is passing everything, but her teachers

always comment that she is capable of much more if she tried. If they gave marks for getting along with others, it would be a different story. Tasha's best friend is currently doing a 6 month sentence for vandalism and shoplifting. Tasha and Sylvie have been friends since fall, if you can call it that. Since Tasha has almost no other friends, she will do anything to be Sylvie's friend. At least that is what her parents think. Tasha thinks it is "cool" that Sylvie is at the Shelbourne Youth Centre. One sign of this friendship was that Tasha almost always gave her lunch money to Sylvie. Why? Because Sylvie wanted it. Tasha thought that Sylvie was her friend, but everyone could see that Sylvie was just using her. What seemed saddest to Tasha's parents is that Tasha could not see this at all. But this was nothing new. She would make a friend, smother them with attention, and that would be the end of it. Or, the friend would not do exactly what Tasha wanted and there would be a big fight, and it would be over. But mostly Tasha complained that everyone bugged her. What seemed to save Tasha was the nursing home. Somewhere along the way Tasha got involved working there. To hear the staff there talk about her, you would never guess it was the same girl. Helpful, kind, thoughtful - they couldn't say enough good about her. In fact her parents joked that maybe if they all moved to the nursing home, it would stop the fighting at home. They figured it out when another teenager volunteered to help one of the same afternoons as Tasha. Unfortunately the "other" Tasha came out. She was tattling, annoying, disrespectful and hard to get along with. Tasha could get along with any one, as long as they weren't her age, a teacher, or a relative!

These examples stress some of the common features of this comorbid combination. Extremely major social problems with relatively little academic problems are not uncommon. Recent research suggests that all things being equal, girls with ODD plus ADHD have significantly worse social problems than boys with ODD plus ADHD (2). Tasha in the above example illustrates this.

ODD plus Depression/Anxiety

This is the other common combination with ODD. If you look at children with ODD, probably 15-20% will have problems with their mood and even more are anxious. (1) Here are some examples of how this can present

Preschool -Arriane

Arriane is 4. She has not been an easy child. Her mom does not like to compare children, but it is hard not to! Her brother is easy to get along with, excited, and energetic. She expected to have arguments with Arriane about doing a chore or task, but she ends up having an argument with Arriane about doing something fun! Arriane's first response to almost any activity is "No, I don't want to". Her mother has learned that if she can get Arrianne out the door and to pre-school, for example, she does quite well once she is there. That is, as long as everything is going her way. It does not take much of a problem for Arriane to lose her temper. Two days ago she was called to preschool when another boy bumped Arriane and she dropped her cheese and cracker on the carpet. Arriane belted the child and screamed "I hate you, I hate this place, I hate it!" until her mother came. Of course the next day she was back again and things were going alright. Arriane's mother has some unusual memories, or at least she thinks so. She remembers last fall when they took Arriane horseback riding for the first time. Arriane's face showed true joy for a whole hour. Her mother did not know whether to cry or not, as she could not remember such an expression on her child's face before for more than a few moments. That memory makes her hopeful that somehow she can bring that joy back to Arriane.

It is not an easy task. The combination of being irritable and oppositional tests everyone's patience. She did not realize how stressful it was until she started bringing Arriane to a babysitter so she could go out and visit her friends. Finally she did not have to be thinking about how to keep Arriane from losing it every minute. She is finally coming to the decision that try as she might, she can not make Arriane's life as smooth as Arriane wants it.

Elementary School Rick

Ricky is 11 years old. Ricky spends a lot of time in his room doing legos and making models. Then, all of a sudden there is a scream and stuff gets thrown around. If his parents are so unwise as to go up there, they will get to hear Ricky say that he hates this world, hates legos, and hates this stupid model. Then he will usually look up and say something awful to his parents. That is why they just leave him up there. He comes home from school crabby and throws his homework down and goes up plays in his room. His parents realize that he needs to get out and do something, but the only thing they can ever get him to do is go lift weights at the YMCA. Ricky's father has absolutely no interest in lifting weights, but he has done a pretty good job of convincing Ricky that he likes to go. That gets him out of the house

about three times a week. As far as playing with other kids, unless his cousins come over, he won't play with anyone. His parents used to ask why and the answer was because no one likes me. Sad to say, it is not hard to figure out why Ricky would have that idea. When a friend comes over, he is so demanding and insists that the child do things just the way Ricky wants. Usually Ricky ends up sulking part of the time when he doesn't get his way. So now, his mom invites friends over for Ricky, but she plays right along side of the friend and Ricky. At least they aren't scared off that way. At school, it is even worse. Everyone seems to know how easy it is to get Ricky to loose his temper. It happens almost every day. He bangs the desk, takes a swing at someone, swears, or kicks them. He is usually caught, and since he is so irritable anyway, the teachers hear a fair amount of defiance. Amazingly, he does pretty well in school once he gets going on something. This year he has changed classes. His old teacher was humble enough to admit that Ricky had pushed her too far and she could not take it any longer. She said she just could not remain professional. Ricky's mom knows how that could happen. Sometimes she just takes off for a walk when Ricky is driving her nuts. She knows she shouldn't leave him alone at home, but she figures if she doesn't go out in the woods for a walk there would be far greater dangers awaiting Ricky at home than if he was there alone. Ricky mostly wishes people would just stop bugging him. Once in awhile, right before bed, Ricky will ask him mom if it hurts to die or what it is like to be dead. She can't tell if he means it or is just saying that to bug her. She is afraid to even think about it.

High School Justin

Justin is now 18. Things are going great for Justin this year. He is back in school, off drugs, and actually is getting along with his parents. In fact, he actually missed them when they went away. He has been helping his Dad put up dry wall after school. Both he and his parents are grateful for his recovery, but they wished they could have picked it up earlier, like when he was 12 or 13. That's when things really started to get worse. Justin had always had a hot temper and still does, but then it was unreal. At age 12 his parents would not let him go to a dance. He broke all the windows in their car. He lasted two months in 8th grade before he was suspended for fighting. Justin lost the few friends he had by getting kicked off the hockey team. He swore at a judge during a probation hearing and got two months in the Youth Centre which was extended to six months after he tried to attack a guard. All the while he was so irritable and never happy. When he came home from the Youth centre he wanted to be able to

drive. They said no, and he decided that was it and went out to hang himself in the barn. His parents still remember those words, "You'll all be f-ing better off without me and if you come after me I'll f-ing kill you, too". That horrible day was the turning point. It took five mounties to get him to go to the hospital. It took a careful evaluation to figure out that he wasn't just oppositional , stubborn, and hot headed. He was very depressed, too. Now after 6 months of medical and non-medical interventions, he is 100% better. Justin admits that if he had to go back to living the way he was, he'd start thinking of suicide.

These examples show how very difficult the combination of ODD and depression can be for the family and the child. Often the depression gets mixed in the midst of dealing with the aggression and defiance. I commonly run across children like Justin who have been oppositional and depressed but no one ever notices the depression until they make a suicide attempt. Looking for depression in ODD youth is very important, (see treatment section)

What happens to children who have this when they grow up?

There are three main paths that a child will take.

First, there will be some lucky children who outgrow this. About half of children who have ODD as preschoolers will have no psychiatric problems at all by age 8.(19)

Second, ODD may turn into something else. About 5-10 % of preschoolers with ODD will eventually end up with ADHD and no signs of ODD at all. (19) Other times ODD turns into conduct disorder (CD). What predicts a child with ODD getting CD? A history of a biologic parent who was a career criminal, and very severe ODD.

Third, the child may continue to have ODD without any thing else. However, by the time preschoolers with ODD are 8 years old, only 5% have ODD and nothing else.

Fourth, They continue to have ODD but add on comorbid anxiety disorders, comorbid ADHD, or comorbid Depressive Disorders. By the time these children are in the end of elementary school, about 25% will have mood or anxiety

problems which are disabling. (14) That means that it is very important to watch for signs of mood disorder and anxiety as children with ODD grow older.

Will children with ODD end up as criminals?

Unfortunately, severe and early onset ODD does predict getting conduct disorder in adolescence, and some of those become criminals. In other words, if you take 100 children in grade 1 with ODD, roughly 30 will have conduct disorder as teenagers, and about 10 will be criminals as adults. (31)

What is the difference between ODD and ADHD?

ODD is characterized by being oppositional, but not impulsiveness. In ODD people annoy you purposefully, While it is usually not so purposeful in ADHD. ODD signs and symptoms are much more difficult to live with than ADHD. Children with ODD can sit still.

What difference does it make if you have ADHD or ADHD plus ODD?

A lot! Children and adolescents with ADHD alone do things without thinking, but not necessarily oppositional things. An ADHD child may impulsively push someone too hard on a swing and knock the child down on the ground. She would likely be sorry she did this afterward. A child with ODD plus ADHD might push the kid out of the swing and say she didn't do it.

My child has been diagnosed with ODD. I don't like to say this, but no one can stand him. Is this common?

Unfortunately, it is quite common. In comparison to ADHD alone, children and adolescents with ODD plus ADHD or just ODD are much more difficult to be with. The destructiveness and disagreeableness are purposeful. They like to see you get mad. Every request can end up as a power struggle. Lying becomes a way of life, and getting a reaction out of others is the chief hobby. Perhaps hardest of all to bear, they rarely are truly sorry and often believe nothing is their fault. After a huge blow up, the child with ODD is often calm and collected. It is the parents who look as they are going to lose it, not the child. This is understandable. The parents have probably just been tricked, bullied, lied to or have witnessed temper tantrums which know no limits.

My father in law says the whole problem is my husband and I. My daughter convinced him that she is a victim of uncaring parents. How often does this happen?

Too often! Children and adolescents with ODD produce strong feelings in people. They are trying to get a reaction out of people, and they are often successful. Common ones are: inciting spouses to fight with each other and not focus on the child, making outsiders believe that all the fault lies with the parents, making certain susceptible people believe that they can "save" the child by doing everything the child wants, setting parents against grandparents, setting teachers against parents, and inciting the parents to abuse the child. I frequently see children with ODD in which teachers and parents and sometimes others are all fighting amongst each other rather than with the child who is causing all the turmoil in the first place.

Conduct disorder

In some ways, conduct disorder is just a worse version of ODD. However recent research suggests that there are some differences. Children with ODD seem to have worse social skills than those with CD. Children with ODD seem to do better in school. (1). Conduct disorder is the most serious childhood psychiatric disorder. Approximately 6-10% of boys and 2-9% of girls have this disorder.

Here is the Definition.

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major society rules are violated. At least three of the following criteria must be present in the last 12 months, and at least one criterion must have been present in the last 6 months.

Aggression to people and animals

often bullies, threatens, or intimidates others

often initiates physical fights

has used a weapon that can cause serious physical harm to others (a bat, brick, broken bottle, knife, gun)

physically cruel to animals

physically cruel to people

has stolen while confronting a victim (mugging, purse snatching, extortion, armed robbery)

Destruction of property

has deliberately engaged in fire setting with the intention of causing serious damage

has deliberately destroyed other's property other than by fire setting

Deceitfulness or theft

has broken into someone else's house, building or car

often lies to obtain goods or favors or to avoid work

has stolen items of nontrivial value without confronting a victim (shoplifting, forgery)

Serious violations of rules

often stays out at night despite parental prohibitions, beginning before 13 years of age

has run away from home overnight at least twice without returning home for a lengthy period

often skips school before age 13

B. The above problem causes significant impairment in social , academic, and occupational functioning.

Does every child who breaks society's rules have Conduct Disorder?

Definitely not. If the brain of a child is injured in a certain way, they are much more likely to do some of the same things mentioned above. Exposure to alcohol in the womb can make people have very little self control. Concussions and head trauma can also cause people to have less control over their actions. Drugs, medications, toxins in the environment such as lead, epilepsy, and a host of rarer problems also can give rise to antisocial behavior.

How can you tell if it is Conduct Disorder?

The medical and prenatal history are helpful. Sometimes other tests are necessary. However, an easy rule of thumb is that these other causes of antisocial behavior are more related to disinhibition and impulsiveness.

So how are ODD and CD related?

Currently, the research shows that in many respects, CD is a more severe form of ODD. Severe ODD can lead to CD. Milder ODD usually does not. The common thread that separates CD and ODD is safety. If a child has CD there are safety concerns. Sometimes it is the personal safety of others in the school, family, or community. Sometimes it is the safety of the possessions of other people in the school, family or community. Often the safety of the child with CD is a great concern. Children with ODD are an annoyance, but not especially dangerous. If you have a child with CD disorder in your home, most likely you do not feel entirely safe. Or, you do not feel that your things are entirely safe. It is the hardest pediatric neuropsychiatric disorder to live with as a sibling, parent, or foster parent. Nothing else even comes close. It is worse than any medical disorder in pediatrics. Some parents have told me that at times it is worse than having your child die.

Conduct Disorder and comorbidity

It has been common in the past for people to think that conduct disorder is just the beginning of being a criminal. Up until the last few years, children with conduct disorder were often "written off". It is now clear that this is true only with a minority of cases. It is very easy to focus on the management of the CD child and forget to check the child out for other neuropsychiatric disorders. A careful examination of children with CD almost always reveals other neuropsychiatric disorders. Some of the most exciting developments in this area of medicine involve understanding these phenomena. It is called comorbidty, that is the tendency for disorders to occur together.

It is very common to see children with CD plus another one or two neuropsychiatric diagnoses. By far the most common combination is CD plus ADHD. Between 30-50% of children with CD will also have ADHD (1). Another common combination is CD plus depression or anxiety. One quarter to one half of children with CD have either an anxiety disorder or depression (3). CD disorder plus substance abuse is also very common. Also common are associations with Learning Disorders, bipolar disorder and Tourettes Syndrome. It is exceptionally

rare for a child to present for evaluation by a pediatric psychiatrist to have pure CD. Here are some examples of the comorbid presentations.

Looking for comorbid disorders in every child with conduct disorder is absolutely essential. Many of the treatments of these children depend on what comorbid disorder is also present.

CD plus substance abuse

Sadly, this is very common. In my clinic, every child with CD is assumed to be abusing substances until proven otherwise. Compared with children who do not have CD, children who have CD are three times more likely to smoke cigarettes, 2.5 times more likely to drink, and five times more likely to smoke pot. As far as having a problem from drug use, children with CD a 5.5 times more likely to be addicted to cigarettes, six times more likely to be alcoholics, 7 times more likely to be addicted to pot. (16)This is certainly the most common comorbidity and often goes along with the one's below.

Terry

When Terry was 9, he told his mom that he wanted to buy lunch instead of bring it. His mom at that point still believed that some of what Terry said was innocent of any other purpose, and so she let him. She did notice that he was very hungry when he came home from school. He said the lunches were small and for an extra 75 cents he could get seconds. She believed this. Two weeks later the principal called to report that Terry was caught with cigarettes on the playground. Terry's mom was amazed, as she did not smoke and neither did her husband. Not only that, but he had a whole pack. Well, it took a lot of "interrogation" to get the story out. The lunch money went to buy cigarettes from a boy in Jr. High. Terry then smoked a few of those and then sold the rest at a big profit. His parents remembered that two years later when he was found drunk in the locker room at Jr. High. Now his parents are lots wiser. Terry still thinks his parents are totally unreasonable. The rule is you get your allowance and phone privileges as long as those random urine drug screens are normal. If he doesn’t cooperate, then they are assumed to be positive. So he ended up poor and lonely for a few weeks, but now that is under control. As far as cigarettes go, if he can buy them, he can smoke them outside. If he is caught drinking or around people who are

drinking, good-bye allowance and phone. Terry hates it and can't wait until he moves out so he can finally do what he wants.

ADHD plus CD

When these two disorders are present, usually the ADHD symptoms are much more severe than when ADHD is present without CD (1) .

Stephen

Stephen is now 14. When his mother thinks back to his infancy, she could actually see it coming at age 18 months. At that age he got up in the middle of the night, put a chair up to the door, opened it and went walking outside. The Mounties found him a while later and brought him home. If only that had been his only contact with them!

Stephen's mother hated school almost as much as Stephen did. Almost every day there were calls from the school about Stephen. In grade primary he tried to stab a child with scissors. He was swearing at his teachers by grade one. On Grade two it was stealing lunch money. Every time they seemed to get one problem under control, he was into something else. Everyone seemed at a loss about what to do except her brother, who took him Irish mossing every chance he could. It didn't matter what the weather was like, Stephen was out there. His uncle said that by the time he was ten, he could do the work of a grown man. There was no fear in Stephen. Cold weather, big swells, nothing bothered him. He refused to do any homework from fourth grade on. Up until that grade, his teachers let him go out for a walk around the building every hour or so, but when a set of keys went missing and were "discovered" by Stephen a few days later, the walks ended. Still, compared to the last few years, this was easy.

Stephen was suspended from 7th grade after two weeks when he threw a match into a boy's locker. Why? The boy called him stupid. He was out for a week, then after only two more days, he was thrown out for making death threats against the teacher. His parents tried home school and they thought they were getting somewhere. Until they got a call from the bank. They were overdrawn. When it all came out Stephen had stolen the cash card and figured out the password and had taken out $500 dollars. They still don't know how he did it. Before they could even sort that out, Stephen was arrested for vandalizing the school. He would have only received probation, but after giving the judge the finger, he was sent to the Shelbourne Youth Centre. It was the staff there that finally figured it out. This guy could not sit still for

anything, he said the first thing that came to his mouth, and was constantly getting in bigger trouble for it. He saw the doctor, ADHD was diagnosed, and he was given medication for this in the Youth Centre. But what will happen in two months when he gets out? His mother spends a lot of sleepless nights thinking about that.

CD and depression

Charlene

Charlene is 14, too. Her life didn't start out quite so difficult. In fact, her mom swears that until she was almost 10, there were no problems. That is hard for everyone to believe now. Her mom remembers thinking that Charlene was certainly starting the teen years early. At age 11 she was having a tantrum about not being able to go out with her boyfriend who was 15. You could hardly blame her. By the time Charlene was 11, she looked like she was 15 or 16. Unfortunately, she did not have the maturity of a 16 year old. She ran away from home at age 12 for a week before they could find her. She brought a bottle of rum to school and got drunk. But more than this, she was absolutely unbearable to live with. She had become super defiant, and would fight her parents or anyone else for no reason at all. She never seemed happy, just angry. Unless she was with her friends, which by age 13 or 14 were 18 or so. Her parents kept asking themselves, "what had happened to their old daughter?" She was failing in school mostly because she was never there. She was never where she told her parents she said she was. The first clue came when she came home high on something and told her parents she was going up stairs to bed. They heard a crash and came in the bathroom to find her trying to cut herself with a broken mirror. Charlene wanted to die. Her boyfriend of two months had left her. For a few weeks she just hung around the house and lay on her bed and listened to music. Her parents let her out one night to go to her girlfriend's house. They got a call later that night that Charlene had admitted to taking a half a bottle of Tylenol.

It is not uncommon that a mood disorder along with CD gets missed. There are usually so many pressing problems to sort out and so many different stressors, that it isn't until suicide is tried or talked of that many families, physicians, and other health professionals consider comorbid depression. Recent studies of teenagers who have committed suicide have found that these children are about three times more likely to have CD and 15 times more likely to abuse substances.(15) Suicide is worth worrying about in CD.

CD plus Tourettes, OCD, and ADHD

Marc

Marc is now 12. He has seen more doctors, nurses, and psychologists than most people will see in a lifetime. His father worried that maybe his son could have Tourette's like him, but he never dreamed it could get like this. When he was 4 he was thrown out of pre-school for fighting. Because of his reputation, he was the first child where the school approached the parents about getting a teacher's aide in grade primary rather than the parents approaching the school. Lucky for Marc, he never seemed to have all of these problems at once. Usually he would have a tic, especially blinking, which would last a few weeks or so. Then he would have to touch things, and then that might go away, too. The tics and OCD were nothing compared to his behavior. His temper was incredible. The usual pattern was that the excitement of being around other kids would get him so wound up that he was literally bouncing around. This usually led to pushing, fighting, and punishment. He resisted this and usually ended up being sent home as they could not deal with him. He attacked him sister. He attacked his mother and broke her arm. That led to living with different relatives and now a foster home. No one seemed to be able to manage him. The new foster parents were actually being bothered the most by his poor sleep and a nearly constant vocal grunting tic. They brought him to yet another doctor to see if they could do anything about this. He was placed on some medicine for the tic and amazingly, he behavior improved quite a bit. For the first time his parents are hopeful that maybe he can come home again.

Diagnosing Conduct Disorder

Conduct disorder is diagnosed like all things in pediatric psychiatry. The child and the caregivers will be interviewed together and separately to go over the history and check out all other possible comorbid conditions. Usually there are school reports, too. The child is examined to look for signs of many disorders. This usually includes some school work, some parts of the physical exam, and getting the child's perspective on things. Occasionally, there are lab tests and x-rays to do. Unfortunately, is no lab test that proves a child has Conduct disorder.

Prognosis and Course of Conduct Disorder

Perhaps about 30% of conduct disorder children continue with similar problems in adulthood. It is more common for males with CD to continue on into adulthood with these types of problems than females. Females with CD more often end up having mood and anxiety disorders as adults. Substance abuse is very common. About 50-70% of ten year olds with conduct disorder will be abusing substances four years later. Cigarette smoking is also very frequent. A recent study of girls with conduct disorder showed that they have much worse physical health. Girls with conduct disorder were almost 6 times more likely to abuse drugs or alcohol, eight times more likely to smoke cigarettes daily, where almost twice as likely to have sexually transmitted diseases, had twice the number of sexual partners, and were three times as likely to become pregnant when compared to girls without conduct disorder (6).

Looked at from the other direction, by the time they are adults, 70% of children no longer show signs of Conduct disorder. Are they well? Some are, but what often happens is that the comorbid problems remain or get worse. That is, a girl with CD and depression may end up as an adult with depression, but no conduct disorder. The same pattern can be true of CD plus bipolar disorder and other disorders. Here are some examples that illustrate this.

EXAMPLES

Trisha- ADHD plus CD as a child which eventually disappears

Age 4-12 Classic problems with aggressiveness towards others, hyperactivity, and impulsiveness along with running away and shoplifting

Age 12-16 ADHD symptoms become less prominent. Continued fights with teachers, shoplifting, and lying

Age 16-24 Fighting decreases, returns to school and succeeds.

Age 25-35 No sign of psychiatric problems.

Reggie- ADHD plus Conduct Disorder leads to similar problems as an adult (the minority of cases)

Age 3-7 Reggie shows lots of aggression and hyperactivity.

Ages 7-12 Besides being hyperactive, Reggie lies, cheats, steals, and eventually forces a child to take of their clothes

Ages 13-18 In and out of trouble with the law, and more involved with alcohol, Reggie quits school at age 16.

Age 18-24 Reggie has spent two years of the last six behind bars. He successfully stays off drugs and alcohol, but meets old friends, quits his job, and is back bootlegging again.

Sarah - CD with more and more signs of mood disorder. Eventually CD disappears

Age 4-12 Sarah slowly gets into more and more trouble with everyone. She starts to get irritable

Age 12-18 Sarah continues to have troubles with gambling, shoplifting, and vandalism. Occasional thoughts of suicide

Age 18-24 Sarah is hospitalized twice for depression, eventually recovers and seems to settle down

Age 24-50 A few more hospitalizations for post partum depression but no CD features.

Mitchell -Learning problems, CD, and drug abuse leads to schizophrenia

Age 4-12 Trouble in School, zero social skills, and constant conflict with family and peers

Age 13-18 Using drugs and occasionally hears voices and sees things. Goes away when he is clean

Age 18-30 Slowly but surely he gets the substance abuse under control. The hallucinations and unusual thoughts continue on and require medical treatment.

Jeff - CD plus ADHD leads to mania

Age 4-11 typical ADHD.

Age 12-14 Totally out of control. Assaults everyone, gets drunk, pulls fire alarms, attacks father, steals a car all in the space of a week. Diagnosed by a psychiatrist who visits the youth prison as manic.

Age 14-20 At least 10 episodes of mania and or depression. Hyperactivity and CD not present except while manic.

Long term outcome of ODD/CD

ODD/CD and Personality Disorder

This is one of the "labels" psychiatry uses to describe people who have traits in their personality that cause them major problems. These are not things that come and go but last for years and even decades. A person's personality starts to form as a teenager, and that is when we see personality disorders start to form. We have all met people with these types of problems. They fit into a few big categories that have lots of different names.

One group is people who are strange, different, and keep to themselves. This is called cluster A. Another group is people who are dramatic, have lots of mood problems, are forever getting into trouble, and whose lives are quite mixed up. This is called cluster B. They are often very difficult to get along with over the long run. Another group are people who are withdrawn, scared, and have to do things a certain way. This is called cluster C. When any of these problems screw up people's relationships, ability to work, get them in trouble with the law, or make them miserable, we call it a personality disorder.

Recent studies have shown that children who have certain psychiatric problems are much more likely to get personality disorders as adults. Children who have multiple psychiatric problems are even more at risk. Children who have ODD are about four times more likely to have a personality disorder when they grow up, that is about a 15% chance. If they already have some signs of personality disorder as a young teenager, they are 25 times as likely to have a personality disorder as adults. What this tells us is that the longer these problems go on in childhood and as teenagers, the more likely they are to lead to personality disorders as adults. (17)

There are two types of Personality Disorder in Cluster B which are especially associated with ODD/CD. These are Borderline Personality Disorder and Antisocial Personality Disorder.

Borderline Personality Disorder is called this because patients have many traits from different psychiatric disorders. They have very unstable moods, like bipolar disorder. They often have strange experiences, like people with schizophrenia. Their relationships with others are usually quite unstable. They often don't have much of a sense of who they really are or where they are going. They often cut themselves. Most of the people with this problem are female. If you have ODD/CD and are female, you have approximately a 15% chance of getting this. (24)

Antisocial Personality Disorder is basically a continuation of Conduct Disorder. People with this problem continue to not respect the rights of others or their property. They continue to get in fights or worse. They often are stealing or cheating. Usually they are involved with the law. They have extremely high rates of substance abuse and high rates of suicide and other unnatural causes of death. This is primarily a male diagnosis. Almost 20% of teenagers with ODD/CD with have Antisocial Personality Disorder as a result. (24)

How bad are Personality Disorders?

If you have a personality disorder as a teenager, by the time you are a young adult, here are the chances that these bad things will happen to you:

1. Make a suicide attempt- 6-10%
2. Serious assault on another 25-35%
3. Not get as far in school as you should have been able to 25%
4. Difficulties with interpersonal Relationships 20-30%
5. Ending up with other Psychiatric problems 35-40%
6. Having at least one of the above bad outcomes 70-80%
7. Having at least two of the above bad outcomes 50% (25)

This seems really bad. Do people with personality disorders ever get better?

Yes, some personality disorders are much more likely to improve over time. After 15-25 years, only about 10% of adults who had Borderline Personality Disorder continue to have it. That means 90% got over it. Antisocial Personality disorder tends to improve, too. However, about 25% of people with Antisocial Personality Disorder die prematurely. Of those that do not die, most are better, but few have recovered completely.(26)

-ODD leading to personality disorder

Tina

When Tina was four or five, she pretty much controlled the house. Somehow she had figured out exactly what she could get away with. She also was able to figure out where her parent's weak points were. More amazingly, she figured out where the weak points in their marriage were. This got so bad that her parents went to marriage counseling and finally adopted a policy of "united we stand, divided we fall" in regards to Tina. This certainly helped keep Tina in line in her elementary school years. Tina also had ADHD, but it was never too severe. She only had to take medication for a few years at the end of elementary school. As she became a teenager, she began to have problems. The loss of a boyfriend led to cutting her wrists. She always was in some sort of turmoil with her friends or the youth group. People were always trying to "save" her. The school counselor and the youth group leader both "knew in their hearts" that Tina needed a lot of attention and special care and encouraged her parents to be more understanding on her sensitive nature. Tina's grandfather said that he "knew in his heart" that Tina needed a swift kick in the rear. As the teenage years went on, these problems just continued. She got involved in some minor crimes like shoplifting, tried vomiting to lose weight, and smoked pot. Each time she made such a big deal about the whole thing that her parents could hardly stand it. When she was 18, she moved in with an older guy who she thought "really understood her". They have been separated about six times so far. Her life continues in turmoil.

This points out the fact that sometimes, even with great parenting, things don't turn out so well. However, many times with aggressive intervention things go more like this-

Richard -

Richard was always hyper and always quite the con artist. The neighborhood moms never really trusted him. He got referred after he hit the teacher hard enough to knock her down in second grade. We did everything. He took medications for his ADHD. The parents followed through with every type of intervention for ODD. He was very involved in cadets as a teenager. When he was about 19, I met his mother in a store. She wanted to tell me how well he turned out. He was still a bit of a hot head and was still on meds for ADHD, but he

was working and had a steady girlfriend. He was hoping to join the militia. Richard had turned out just fine.

Families and CD

It is not unusual to see signs of stress in the parents and other siblings when a child has CD. One of the hardest questions is figuring out whether or not difficulties in the family are causing CD or whether the stress of CD is causing family problems. Often it is impossible to determine this or there are reasons to suggest both the CD is casing the family problems and the family is causing the CD to be worse. . CD is a very difficult problem to live with. It would be very unusual to see a family where it was not causing grave distress. This obviously needs to be addressed in any treatment plan.

Some of the things parents have told me about their conduct disordered child are noted below.

"If you have a child with CD, everyone will initially assume it is your fault. You will be blamed by everyone for what the child does. You may know all about Family and children services, probation, youth court, residential homes, RCMP procedures, and mental health services. "

"You will often have the feeling that no one knows what they are doing with your child and they are just trying to pass the buck to someone who does. "

"You can end up divorced, depressed, alcoholic, hopeless, or all of these from dealing with such a child. It will often make or break your faith in yourself and your faith in God."

"You can see yourself where the child's problems are leading, but can be unable to do anything about it or find anyone else who can do anything about it."

Don't give up! There is a lot to that can be done!

What can be done?

Over the last decade, many new strategies, both medical and non-medical) have been investigated for treating ODD and CDThere are hundreds of psychological techniques which have been tried, but none have been found to be always successful. They involve behavior modification, working with families, and tight supervision. the best results have been found with what is called multisystem therapy. What that means is, do a lot of different things at the same time. As far as this pamphlet goes, it means you should not rely on just one type of intervention. Ideally, you should use a little of all of them. Overall, since CD is usually just a very severe form of ODD, all of the below can be useful in CD. At the end of this section are some other suggestions for CD.

Treat Comorbid disorders

CD plus ADHD

Treating the comorbid disorders is absolutely key. Recent studies have shown that treating CD plus ADHD with stimulants helps the conduct disorder and the ADHD symptoms. This effect appears independent of how bad the ADHD is (4) Since 60-70% of children who go to a clinic for help with CD also have ADHD, this is extremely important. Serious consideration should be given to medically treating all children with CD plus ADHD. Although this type of medical intervention does not make the children "normal", it can make a big difference. It often means that the non-medical interventions will work much better.

CD plus depression

Recent work also suggests that treating depression in the context of CD be effective (5)While Prozac was used in this study, most likely other drugs in that same family would be effective. See details depression and its treatment in the Depression handout.

CD plus Substance abuse, movement disorders, bipolar disorder, psychosis, Pervasive Developmental Disorders

Although there is not as much data on these areas, it is a good idea to always vigorously treat any disorder comorbid with CD. The importance of treating comorbid conditions can not be overstated.

Non-Medical Strategies for ODD and CD

Containment

The essence of this group of interventions is to make it impossible for ODD to "work." That is, it is a way of making sure all these attempts to irritate and annoy others and to cause fighting between others are not as successful. There are four elements to this.

1. Come together

Children and adolescents with ODD convince mothers that fathers have mistreated them. They convince parents that the teachers are treating their child unfairly. They convince teachers that the parents are bad, etc. You have to come together and never believe anything the child with ODD tells you about how others treat them. In order to do this, all parties need to talk directly with each other without the child as an intermediary. Mothers need to talk face to face with fathers. Parents need to talk with teachers and with principals. Sometimes Parole officers, parents, teachers and others have to all sit down together for the purpose of making it impossible for the child to play one person or group off against another. Here are some concrete suggestions.

Ask to sit down with the principals and teachers regularly.

Make it school and home policy to never rely on information your child with ODD gives you about what others have done.

Do not include the child in these discussions.

Sit down with all caregivers (grandparents, uncles, baby-sitters, parents, etc.) to make sure they understand ODD and they follow the above policy.

2. Have a plan

That is, a plan to deal with all of this oppositional and defiant behavior. If you react on the spur of the moment, your emotions will guide you wrongly in dealing with children and adolescents with ODD. They will work to provoke intense feelings in everyone. Everyone needs to agree on what happens when the child with ODD does certain things. What do we do if she disrupts class, annoys others incessantly, fights, has a major temper tantrum, states she is going to kill herself or run away?

You need a behavior modification or management plan.

Is that what "1-2-3 Magic" is?

Yes, that is a good example. For behavior modification to work, the program must have certain properties:

1.A few important behaviors need to be targeted. Rather than targeting "being good," you might try no hitting and no swearing.

2. The behavior must be clear cut and not fuzzy. Things like "listen when I tell you something" won't work, because it is too unclear. A better idea would be, "Sit down and look at me when I ask you to listen."

3. It must be consistent. There is no bending of rules in this sort of thing: no difference between the baby-sitter, mom, or dad.

4. The rewards and punishments need to be geared to the individual.

5. The rewards should not be money or things that are bought, but rather should be privileges which you can grant or activities which the child can do. Behavior Modification should not require a bank loan.

6. There needs to be an even mix of negative and positive reinforcers. The program should not be like candyland, but it also should not be out of Dorchester Prison. A typical positive reinforcer would be a later bedtime on the weekend or a choice of dinner. A typical negative one would be going to your room or no TV.

7. It should be simple and straightforward so that your child easily understands it. If your child can read, it should be written down. If possible, your child should sign it and agree to it.

Almost every book on ADHD contains many good examples of these programs. I have some, all the family resource centers do, and so do libraries and book stores.

Here are some examples of good and bad behavior modification programs:

Jim never comes home when he is supposed to. This drives his parents nuts and they would like to kill him when he finally does come home. The behavior they want is to have Jim come home on time.

The good parents

The positive reinforcer (the carrot) would be if he comes home on time for 5 days, he can have a friend stay over and they can stay up late. The negative reinforcer (the stick) would be that if you are more than 5 minutes late, you will not be able to go out by yourself the next day. You will have to go out with the parent when it is convenient for the parent.

The Candyland parents

If you come home on time, we will pay you five dollars or you will be able to stay up as late as you want at our house that night. If you don't come home, nothing bad will happen.

The Dorchester Prison Parents

If you are one minute late, you will be grounded for a week to your room.

I tried all of these. It worked for a while and then it stopped working. What happened?

Behavior Modification doesn't work for everyone. Sometimes you have to keep changing it all the time. It works best when you find the perfect reinforcers, positive or negative. A lot of people just do not have anything they are willing to try that hard for. Also, some people are so severely impaired they just can not benefit from this.

3. Decide what you are going to ignore

Most children and adolescents with ODD are doing too many things you dislike to include every one of them in a behavior management plan. The key caregivers have to decide ahead of time what sort of thing will just be ignored.

4. Try very hard not to show any emotion when reacting to the behaviors of children and adolescents with ODD.

The worst thing to do with a kid with ODD is to react strongly and emotionally. This will just make the child push you that same way again. You do not want the child to figure out what really bugs you. You want to try to remain as cool as possible while the child is trying to drive you over the edge. This is not easy. Once you know what you are going to ignore and what will be addressed through Behavior Modification, it should be far easier not to let your feelings get the best of you.

If these interventions work, then hopefully the dialog can proceed like this:

Ann comes in and says, as she watches you folding the wash, "I need my red sweater washed and dried by 7:30 tonight"

You do not reply but think a moment. This was the sort of thing you and your husband decided to ignore. You respond, "Are you hungry?"

or this:

Ann comes in and says, as she sees you folding the wash, "Aren't you done with that yet? I need that sweater right NOW!" Ann throws her books on the floor and knocks over a glass of milk.

You respond, "let's see, that sure sounds like being disrespectful to me. I guess "the plan" says that means no internet tonight."

instead of this:

Ann comes in and says, as she sees you folding the wash, "Aren't you done with that yet? I need that sweater right NOW!" Ann throws her books on the floor and knocks over a glass of milk.

Mom throws the clothes down, glares at Ann, and replies the way she really feels, "Why you inconsiderate #$%*! Take this sweater and wash it yourself! (Throws sweater at Ann) and these socks! (throws socks at Ann) and these pants!" (throws them, too).

Dad comes home later and Ann tells him that Mom "lost it" when she just asked about how the wash was coming!

The Good of Containment

especially helpful for dealing with less aggressive behavior.

Supports all who are dealing with child

Can lead to the child abandoning his efforts at annoying others and choosing to do more reasonable things with his time.

The Bad of containment

Time consuming

Must have a lot of patience

Doesn't work as well with severe aggressiveness

Make sure that you are as healthy and strong as you can be

Children and adolescents with ODD will find the weakness in the family system and exploit it. Is there tension between father and mother? They will aim to worsen this. Trouble with the in-laws? These children and adolescents will try to exploit this. Are you out of shape and exhausted after work? That's when they will be most trying. Are you worried or depressed about something? They will try to figure it out and torment you. Dealing with a child with ODD is very exhausting and trying. It will take about 1/3 to ¼ of all your emotional, mental, and physical resources. If you knew that you would be chopping wood for four hours every day, You would make sure you got enough rest, a good diet, and had plenty of time to relax. The same holds double for dealing with ODD in the long term. You have to take care of yourself in ways you would not have to if your child did not have ODD. This includes things like:

1. Find a baby-sitter and go out weekly away from this child and your home with your spouse or significant other.

2. Make sure you have plenty of time to piss and moan about the difficulty of this to your spouse or friends.

3. Get adequate exercise. There is nothing better to blow off steam than exercise that is fun.

4. Get enough sleep

5. Eat well and don't try to go on a big diet.

6. Don't try to do too much. Remember, caring for a kid with ODD is a big job!

7. Get help if your marriage is in trouble

8. Do everything you can to stop drinking if you or your spouse has a drinking problem

9. Make sure you have some hobby you enjoy and can do when things get rough.

Limit Television

Television is a major force in our lives. Study after study has shown that Television is filled with violence, drug and alcohol use, and sexuality. The average child spends at least 2-3 hours a day watching this stuff. Many children spend 4-6 hours a day watching this. It should not be any wonder then that children who watch a lot of TV are more violent, are more likely to do drugs, and are preoccupied with sex. In a child with a problem like ADHD or ODD, this is clearly something that needs to be done. The American academy of Pediatrics recommends the following: (16)

Limit all media use to no more than 1 to 2 hours per day.

Monitor their children's use of the media.

Co-view television with their children.

It also goes without saying that it is impossible to limit children's viewing if the parents are watching Television or playing video games all day and night. Turning off the TV is the most effective but radical solution to a host of child psychiatric problems. My advice is to be radical and do it!

Eliminate or reduce video and Computer games

Anyone who has ever seen a child play Nintendo can see that there is a very potent force at work here. Unfortunately, the vast majority of computer and video games are violent and are becoming more graphic, not less, in their depiction of violence. As mentioned above, large amounts of television viewing can cause increased psychiatric

problems for children. Although there is a less research on games, the same trend is there.

Most children play computer or video games. As anyone who has a child knows, these games can be very addictive. One out of five children from grades 5-8 are as addicted to computer games as an alcoholic is to alcohol. (10) The earlier children start playing these games, the more likely they are to get addicted. Children who play lots of video and computer games aren't as nice to others. Children who play violent games are more physically aggressive and are not as intelligent.(12) Unfortunately, the question remains whether or not children who are aggressive and have problems are attracted to these games or whether the games make them that way. With TV, the evidence suggests that violence on TV makes more violent kids. Given that video and computer games are a much more powerful medium than TV, I think it is quite safe to assume that they are having a detrimental effect on children.

But how can I get my child off video games? The withdrawal would be horrible!

With any addiction, there are a few strategies, none of which is without short term pain for long term gain.

"Going Cold Turkey" approach

In this approach a child is told when they come home from school that all the video games, internet games, and hand held games have been removed from the house. Most children who are addicts go beserk for a few days. If there parents are made of steel, they can tough it out and things will usually calm down in 2-4 weeks. The problem is that most parents are not that tough, especially if they have been worn down by behavior problems.

"Methadone Clinic" approach

Because heroin is so hard to get off of, there are clinics that heroin addicts can go to get their fix, but instead of heroin, they get methadone. In order to get their fix, they have to behave. For video addicts the approach is that you can get your fix of video game time based on your behavior. For younger children, every 3-4 three hours that you meet the behavior goals gets you a 20-30 min fix of video games. For older children, compliance, homework, and respect gets you internet privledges for a certain amount of time.

“Planned obsolescence” approach

Since games cost a lot of money, and so do computers, make sure the addict never gets games for presents of cash that can be turned into games. Do not replace your home computer, and if possible, change to dial up internet. The advantage to this is that it is slow and most children never realize they are being weaned off computer games. Of course it takes two years to completely work.

Medical Interventions

ODD and CD are usually co-morbid with other problems. If your child has another co-morbid condition, you should look at the handout for information on the medical and non medical treatment of that disorder

When do you consider medications?

There are three reasons to consider this

1. if medically treatable Co-morbid conditions are present (ADHD, depression, tic disorders, siezure disorders, psychosis)

2. If non-medical interventions are not successful.

3. When the symptoms are very severe.

Which drugs do you use?

In choosing drugs for ODD, I look for drugs that have been proven safe in children, have no long term side effects, and have been found in research studies to be effective in extremely aggressive children and adolescents or in Comorbid conditions which children with CD often have. Each drug has certain problems that need to be watched for. The current medical literature suggests three basic principles when using psychiatric drugs in children. 1) Start low, 2) Go slow, and 3) Monitor carefully

What do you mean by Start low?

This means that you do not start any of these drugs at the usual dose, or the maximum dose. When you have pneumonia, it can be a real emergency. You want to give people plenty of medicine right away, and if there are problems, then you reduce it. Unfortunately, many people use this same strategy in the medical treatment of ODD. The problem is that big doses can cause big problems, and when the problems affect your mind and personality, this usually means trouble for the person taking the medicines. So I start with the lowest dose possible. For example, if I use a drug called Risperidal, for a boy about 60 lb., I know that the dose that will probably work for most boys that size is two pills a day. If I gave him that to start out with, I might win and it would work. But if he happens to be sensitive to that drug, he could have big problems. Although they would be reversible problems, it would probably make most children and adolescents and or parents never want to take the drug again. So what do I do? I start with a half of a pill a day, about 25% of the usual dose. That way if the child is sensitive to the drug, it causes little problems. I also find that many children respond to drugs at very low doses, far below the usual recommendations.

What do you mean, go slow?

ODD is not an acute illness. Less than 10% of the people I see with this need to be treated very quickly. Most people whom I see with this problem have had it for years. As a result, there is no need to increase the dose quickly. By going slowly, it is a lot easier to manage any side effects because things don't happen suddenly. Also, it is easier to find the lowest effective dose.

What do you mean, monitor?

For each of the medical treatments for ADHD, there are specific side effects which need to be checked regularly. Some common ones (see individual drugs below) are monitoring weight so that people are gaining weight, watch for tics, watch for depression, checking blood pressure and pulse, checking blood tests and EKGs, and making sure parents know what the side effects are of the different medications. In this way, if there is a problem, we can pick it up early and avoid the horror stories, some of which are true, about the medical treatment of this problem.

If the child has any diagnosis besides CD or ODD first try the drugs for that condition, If that fails, or they don’t have a comorbid disorder then-

Drugs which are used for Violence, Oppositionality, and aggression regardless of diagnosis

These are drugs which have been tested in adults and children who are violent and aggressive for a variety of reasons - from ADHD to brain damage, to Conduct Disorder, and of course ODD.

First choice-

Atypical Antipsychotics

These drugs were first used for schizophrenia, and that is how they got this name. They are now commonly used for many conditions where people are not psychotic. As you can see, these are not benign medications. All of them can have serious side effects. As a result, they are not used for small problems.

Risperidone (Risperidal)

This drug was initially developed to be a safer drug for adult schizophrenia. It was then found to be effective in children with schizophrenia and other psychoses. Then it was found to be helpful in some children with Tic disorders. Based on those findings it has been used in Conduct Disorder and aggression. (20) These studies are probably the most exciting news for the medical treatment of CD in 20 years. Risperidone is called Risperidal and comes in a variety of sizes; .25mg, .5 mg, 1mg, 2mg and liquid. It also helps Tourettes and psychosis. Usually this is given twice a day. This drug usually shows an effect within hours of a dose. There are more studies done on this drug than all the other atypical antipsychotics combined.

Olanzapine (Zyprexa)

This drug was recently approved for mania in adults. It has been studied less in children. However the early reports are positive. (14) The usual dose is about 5-15 mg a day. It comes in 2.5 mg, 5mg and 10 mg. It is also called Zyprexa. It is more expensive than Risperidone and in adults is associated with more weight gain. This can be given once a day.

Quetiapine (Seroquel)

This drug is a little different than the above drugs as it seems to cause very little problems with things like tremor and stiffness. In

adolescents it can lower the blood pressure so the dose has to be increased slower. The dosage range is 200-800 mg a day. There are only a few articles on its use in children and adolescents, but these have been quite positive for mood disorders. (15) I do not know of any study on using in CD. It comes in a 25mg and 100 mg size and has to be given twice a day. It is called Seroquel.

Side Effects of the Atypical Antipsychotics

Weight Gain.

This is the biggest problem with these drugs in children. Not all kids gain weight, but a fair number can get 10-30lbs or more. Obviously this is something we watch very carefully. Overall Zyprexa causes the most weight gain, then Seroquel, followed by Risperidal. This is sometimes very hard to manage. It is key to weigh children everytime and start with a diet at the first sign of weight gain. There should also be a weight above which alternative drugs are tried. There is some data to support the use of a drug called Topamax for this. This is covered in the Bipolar handout. (click here)

Stiffness, restlessness, and tremor –

These occasionally happen with these drugs, too, but to a much less extent than with the others. This is called drug induced Parkinsons. This is reversible if the dosage is reduced or the drug is stopped. Overall it is most common with Risperidal, then Zyprexa, and least common with Seroquel.

Elevated Cholesterol and Triglycerides

It was thought that only those people who were gaining weight got this, but now it is clear that it can happen with children who do not gain a lot of weight. Zyprexa is the most likely to cause this, followed by Seroquel, and least likely is Risperidal.

Diabetes

This can come out of the blue or be worse on these medications. Zyprexa is the most likely to cause this, followed by Seroquel, and least likely is Risperidal.

Tardive Dyskinesia

Sexual Side effects

Risperdal (risperidone) can increase a hormone in the body called Prolactin. This hormone is normally involved in breast feeding. As a result it can lead to breast enlargement (called gynecomastia), a milk like substance coming out of the breasts (called galactorhea), and irregular periods. While only girls get galactorrhea and mentstral problems, boys can get gynecomastia.

This sounds horrible! How often does this happen?

In a recent study of 504 children ages 5-15 who took Risperdal for a year, 22 boys and 3 girls developed gynecomastia, or about 5%. (21)

That sounds like a lot!

The problem is that gynecomastia is quite common in adolescent boys normally. It occurs in about 1/3 of boys. (22)

Does it go away?

In this study, the gynecomastia disappeared while the child was on risperidal in 8 of the 25 who had this side effect. Usually, when the medication is stopped, the gynecomastia disappears, but there have been rare cases where it doesn't. (21)

Galactorrhea sounds bad, too

Only one of the 85 girls in this study developed galactorrhea. This always resolves when the drug is stopped. The menstral irregularities also usually return to normal if the drug is stopped. (21)

What about the other drugs?

Other drugs in the category almost never cause this side effect.

How can you tell who is going to get this?

You can't. Even measuring the prolactin level doesn't predict who will get this. (23)

The bottom line……..

Sexual side effects are pretty rare, not medically serious, but psychologically devastating to children if they occur and have not been told about it before hand.

Neuroleptic Malignant Syndrome

This is a rare reaction to antipsychotic medication where people are very ill and have a fever, stiffness, and they are not thinking clear. It can be very serious and has even caused deaths. But it is very rare.

With the older drugs, it was found in about 3-4 cases out of 1000. With the newer drugs it is harder to say. Risperidone is the most prescribed antipsychotic for children and adults in Canada. In all the world's literature, there are 8 clear cases of Risperidone causing this syndrome in adults (6) I am not aware of any cases in children or adolescents with the newer drugs, but there have been cases with the older drugs. Since the 1960's, 77 cases in children with the older drugs have been published. That would make it very, very, very rare, and rarer still with the newer drugs (7) However, if a child is suddenly started showing these changes while taking these medications, it should be considered.

Psychiatric symptoms

These drugs can make a child very anxious, depressed, and even can make them more violent. This is all reversible upon stopping the medication. No drug is more or less likely to do this. My experience is that it affects younger children more often.

How are these drugs really used?

Joey is a terror!

At age 4 Joey was thrown out of two preschools for biting and hitting. Grade Primary started off bad with a suspension in the first month for throwing rocks and at a child's face. He is involved with anger management at school, family therapy through the mental health centre and yet there are still major problems. Like it is dangerous to take him anywhere children are. It isn't so dangerous for Joey, just for the rest of humanity. Joey was put on Risperidal and within a few days he was a lot less violent. He eventually gained 5 lbs, but that was manageable. Every summer I try to cut it down and within a few days, he is unmanageable. This is a typical case - some side effects, but a good effect.

Alysha inflates

At age 12, Alysha had been on Ritalin for 5 years already for her ADHD. She wasn’t moody, but was becoming more and more violent with other kids. The stimulants didn’t help, nor did all the parenting. She was in a foster home three days out of seven and even they couldn’t handle her. She started on Risperidal. When the dose got up to 1mg a day, her foster mom and her biological mom agreed that it was true, Alysha was actually worse on this drug. When I mentioned

how the drug could make her worse, they told me Alysha couldn't be worse. Now she was super irritable, smashing even more and hoarse from screaming. So we stopped the drug and Alysha went back to her old very violent self. So we tried Zyprexa instead. It worked wonders. No one could believe the difference. Alysha gained a pound a week for 6 months. That's over 25 pounds. That is a lot when you only weighed 80 to start with. No diet was helping. After discussing the case with her family, we switched to Seroquel. It did nothing. Now she is back on Zyprexa and is taking a new drug, Topamax, to help her lose weight. Here the benefit barely outweighs the side effects.

Jonathan looks like Grandpa

Jonathan is now 11. He has Tourettes, but the tics have never been that bad. He always had a hot temper but this year it is unbelievable. He smashed his hand in the sink over nothing. He threw a shovel through a car window. At anger management class, he got mad and trashed the office. So, since something had to work right away and he had tics, we started him on Risperidal. It worked like a charm, in three days he was back in school actually using the strategies properly that he learned in anger management. But he slowed down. His gait was shuffling a little, he fell easily, and his hands shook. His teacher said he sat "like a statue". When I examined him, he was stiff and had all the signs of drug-induced parkinsons. Cutting down the dose improved the stiffness, but his temper got worse. Now on Seroquel, there is no stiffness, and less temper, but still not as good as on Risperidal. Here it takes some changes to get a good balance between side effects and benefit.

Medications for Brandon

Brandon is 10. His life has been hard since conception. Exposed to alcohol and smoking in the womb, exposed to abuse as a preschooler, plagued with ADHD and learning disabilities, his biggest problem is that he will not stop bugging people and if he doesn't get his way, he "flips" which means things wrecked and people get hurt. Stimulants did nothing. Risperidal only sedated him. Zyprexa made him, as he said, "crazy for food", but no better. Seroquel did nothing. So he was started on the next class of medications - mood stabilizers.

Second Choice

Older Mood Stabilizers

(Epival, Lithium)

These drugs were all used initially for bipolar illness. They have since been tried in people who are violent from brain damage, personality disorders, and children with ODD and CD. Lithium has been tested the most. There are only a few studies using Epival. If there are signs of bipolar illness or a strong family history of bipolar illness, these are the drugs to start with. Otherwise, they are for when the atypical antipsychotics don't work or are not tolerated. (20)

Lithium can prevent suicide (click here to go to the details of this in the Suicide handout)

Lithium

Although we refer to lithium as a drug, it is actually a naturally occurring element. In some places in the world it is present to a significant degree in the drinking water. It has been used in adults for bipolar illness for almost 40 years. Approximately 80% of adults with bipolar illness will respond. The response is less when there is a mixed picture or rapid cycling. In some children and adults, it can make a normal life possible again. This drug will often stop or reduce cycling, get rid of mania and hypomania, and sometimes get rid of depression, too. It is not clear exactly how it affects the different parts of the brain to accomplish this. However, it is not an easy to use drug. It has numerous side effects. It has been used in children for a number of years.

Nuisance side effects

Occasionally this drug can cause nausea, vomiting, diarrhea, shakiness, and balance problems.

Psychologically serious but medically non serious side effects

This drug can cause or worsen acne. It can cause weight gain. It can, in some cases cause bedwetting. It can cause or worsen psoriasis.

Medically serious side effects -

Lithium can damage the kidneys. The most common problem is that it makes a person make lots of weak urine, so they need to urinate all the time. Other changes can also occur more rarely. To be used safely, blood tests for the kidneys and urine

tests are done on a regular basis. With regular monitoring, these changes can almost always be detected before they become serious.

Lithium can affect the thyroid glands. It can make the thyroid gland reduce the amount of hormone it puts out. This is another thing that can be managed by monitoring blood tests. If it is severe, and the drug is helping a lot, then a person can be given thyroid pills.

Lithium, at high levels, can affect the brain. If a person has high levels of this drug in them, it can make them confused, cause coordination to be poor, and make thinking slower. For this reason, the level of the drug needs to be monitored regularly.

If you become dehydrated from the flu, diarrhea, or other causes, and you keep taking your lithium, your body will save it up and the level will go higher and higher. This is the main danger of this drug. Anyone who is taking this drug needs to talk to the prescribing physician if they are getting dehydrated so they can figure out what to do. Usually, the drug is stopped temporarily.

Certain drugs can make the amount of lithium in your blood go very high.

You should not take Lithium if you are planning on getting pregnant. It has been reported to cause certain defects in the heart of the fetus.

So why would you ever give this drug?

1. Because what you are treating is a lot worse than the above. You don't treat mild conditions with Lithium. Bipolar disorder is not mild. If it has worked in other family members it is especially worth considering.
2. Because most people do not have any of these major side effects.
3. Because if people know what can go wrong, and the doctor knows, and things are carefully monitored, you can pick up any problems before they get serious.
4. Lithium can save a child's life from suicide.

Lithium comes in a couple of forms and sizes. The blood level determines the dose. So you have to take it for a few days, then check the blood level, adjust the dose, and check the blood level again. Once the level is in the proper range, then it is usually only checked every month.

When the drug works, it is usually within 2 weeks for mania or 4-6 weeks for depression. However, sometimes it takes much longer to see the full effect. It is very cheap.

Here are some examples from the bipolar handout

Example:

Annette is 14. She has been admitted for depression following a week of hypomania. She has had one previous admission for depression. Her pediatric psychiatrist wants to treat her depression without risking her switching into mania. So he feels Lithium is a good choice. Before he starts the drug, blood tests for kidney function and thyroid function are checked. She starts taking 150mg twice a day and after a few days of this it is increased to 300 mg twice a day. Four days later a blood level is checked. It is .4 . The level should be .8-1.0. The doctor increases the dose to 450 mg twice a day and checks a level in another five days. It is .9. Annette has a little nausea and a tiny bit of tremor, but otherwise has no side effects. After four weeks, she is still very depressed. An antidepressant, Paxil, is added. Over the next two weeks she recovers from her depression. For the first month, she gets her lithium level checked weekly. Then it is twice a month for a few months, then every month. After she has been on the drug 3 months, other lab tests are checked. Annette takes the drug for 6 months, but at that point feels that she no longer needs it and thinks it is causing her acne. Against everyone's advice, she stops it. One month later she is again hypomanic, but her acne is better.

> This example points out the reality of Lithium use in pediatrics. The medical side effects are a breeze to manage compared to compliance issues. Many children with bipolar illness do not have a lot of insight into their illness. Frequently after a few months they become non-compliant. Usually it is for trivial reasons from an adult's perspective. The biggest problem with lithium is that people don't like to take it long term. In fact, a big part of the counseling for this disorder is devoted to just this issue.

Jordan is 12. He first started to show signs of mania when he was 8 or 9. At 10 he got very depressed and was given an antidepressant. He became quite manic and almost had to be hospitalized. Now he is swinging from being depressed to mania every few days, and sometimes every few hours. He can't stay at school. He talks, writes, and sings about suicide. Since he almost took a fatal overdose of Tylenol last month, his parents are watching him very closely. He still wants to die sometimes, but not right now. Everyone in the family says he is just like his Uncle Terry. His uncle suicided at age 20. His aunt from BC called Jordan's mom to tell her about how well she did on Lithium.

> With strong suicidal urges, a bipolar disorder, family history of a good response to lithium, and manic symptoms on an antidepressant, Jordan is a good candidate to try Lithium.

Valproic Acid, Divalproex, (Epival)

This mood stabilizer has been used for years to treat epilepsy. Over the last five years it has been found to be very effective in bipolar illness in adults, especially in mixed bipolar illness and rapid cycling bipolar illness. It is not clear how this, or other anticonvulsant drugs work for bipolar illness. It has been tested some, but not a whole lot, in pediatric bipolar illness.

Nuisance side effects

Occasionally this drug will cause nausea, tremor, vomiting, or diarrhea. It can be sedating in some people. It can affect balance. It can make a person temporarily lose some of their hair, but that will come back.

Medically serious side effects -

Ovaries

-Teenage women who have bipolar illness or epilepsy and take this drug are more likely to have cysts on their ovaries. They also may be more likely to have a disorder called Polycystic Ovary Syndrome. This means you have irregular periods (or none), extra hair, and sometimes obesity and acne. The male hormones are elevated. This disorder can make people infertile.

So does Epival cause Polycystic Ovary Sydrome?

.One group of researchers found that 80% of women under age 20 who were put on this drug developed Polycystic Ovary Syndrome (1).However it is not exactly clear. This is because women who have Polycystic Ovary Sydrome and are not on Valproate can show features of bipolar disorder, too. Nevertheless, there is a good chance that Epival can cause Polycystic Ovary Syndrome, especially in women under age 20. (2).

What can you do about this possible Risk?

The fact is, unless everything else has been tried, it is not justifiable to be giving young women valproic acid for psychiatric indications.

Some people recommend that any teenage girl who is going to be put on Epival should have a pelvic ultrasound done first along with some blood tests for male hormones. These tests should be repeated in a year. If there is no change, you can be quite positive that the child is not developing Polycystic Ovary Syndrome. (2).

Weight gain

- In women under age 20 with epilepsy, 82% gained a substantial amount of weight. The same question comes up as before. Is it the epilepsy or the drug? In this case, it is more clear. Probably it is the drug.

Liver –

this drug can damage the liver in rare cases (2 out of 100,000) so the liver tests need to be checked regularly, like every four months or so.

Blood-

this drug can rarely reduce blood counts (2 out of 10,000) (10)

Pregnancy

- It can cause serious birth defects if it is taken during pregnancy.

The drug comes in 250mg and 500 mg pills called Divalproex. You can start taking nearly the full dose right away. The dose in milligrams is usually ten times the weight in pounds each day. Blood levels are checked at regular intervals.

Overall, this drug is much, much easier to use than Lithium. The side effects, outside of weight gain, are usually mild. If there are mixed features, signs of epilepsy or brain damage, it is my first choice.

Note

> None of the mood stabilizers are as safe as we would like. When weighing the risks of the medication you need to balance the risk of the untreated condition versus the risk of the medication. In severe cases, the risk of the disorder far exceeds the risk of the medication. In very mild cases, it is best to try to get by without these drugs. In between requires a lot of thought and conversation between families and doctors.

And when mood stabilizers don't work, even when added to atypical antipsychotics -

Third line drugs for ODD/CD

Clonidine

This drug was originally developed for treating blood pressure and it is very safe. It turns out to be useful for a lot of things. Tics, severe ADHD, detoxifying Heroin addicts, menopausal flushing, and sometimes autism with hyperactivity or severe aggression are the usual indications. The good thing about this is that it never aggravates tics, works when autism is present, and works in very aggressive children and adolescents who never sleep. It is safe for pre-schoolers and comes in a pill called dixarit that is sweet tasting and looks exactly like smarties. As a result, children and adolescents will easily take it. It also comes in a larger size. It is also used in autism, preschoolers, and very aggressive children and adolescents with ADHD and insomnia.

And the bad side?

About one out of every 10 to 20 people who take this will become depressed. It comes on within about 3-4 days and after the drug is stopped, it can take 3-4 days to clear. However, if you are not watching for this, you might think the child is depressed for another reason, and never stop the drug, thus leaving the child depressed. With careful monitoring, you will always pick this up if it appears.

This drug also has an effect on the heart. It can lower the pulse and blood pressure. To be cautious, I check an EKG before I start the drug

and once the child is on it. I also check their blood pressure and pulse at every visit.

It will make some children sedated, but usually by cutting back the dose you can avoid this.

Stimulants

It turns out that even if a child does not have ADHD, stimulants can be helpful for ODD. See the ADHD handout for information on stimulants.

New and other mood stabilizerss

This includes three drugs at present, Gabitril, Tegretol Lamictal (Lamotrigine) Neurontin (gabapentin) and Topamax (Toprimate).

They are being used a fair amount in children as they have been tested for epilepsy in children. There is evidence that they are effective in adults with bipolar disorder but there are still no reports in the literature of careful trials of these drugs in children and adolescents. They are occasionally used in ODD/CD if all else fails. There are no good studies to show that they work.

So why use them?

Because nothing else has worked.

More non-Medical Interventions

Enlist others to help you

Caring for a child with ODD can take a lot out of anyone, especially if you are one of the main people the child is trying to aggravate. Some children with ODD and more children with ODD plus other psychiatric problems can require an incredible amount of patience, energy, and determination. Often this is more than any one or two human beings can provide. There is no natural law that states that all children can be managed by one or two reasonable parents. Many children are born who require three to five full-time parents. You may have one!

What you should do is everything you can to share the parenting.

First think who in your family can take care of this child reasonably well for an hour? a day? a weekend? a week? Often there are cousins, aunts, uncles, good friends, fathers, mothers, or Grandparents who can take a disturbed child for a while, but not a long while. By putting a few of these together, you can get a little breathing space. Obviously, all this is doubly true for the child with CD.

My family lives in New Brunswick, and my husband's family hates us.

The next step is to try what is available publicly. Daycare for little kids? After school programs for older children and adolescents? Big brother and big Sisters?

The last step is respite foster care on a regular basis. In some cases, this is the best way to go, as it will give you a chance to catch your breath and not go crazy.

The most common mistake people make in this situation is to think they should be able to do it all themselves. They then either end up giving up the child or getting so mad at the child that it would have been better if they had given it up the child to someone else. Don't be proud. Get some help.

Discover what your child is truly interested in.

Not what he is interested in for the sole purpose of aggravating people, but truly interested. Although some children do not have any interests, many do. If this can be encouraged, it can supply a direction for all the energy the child is putting into aggravating others. When you try to stop some of the ODD misbehavior, you want to make sure there is a direction you can push him in which he might enjoy. Children with ODD will often do their best not to wreck something they really like. That desire to want to have things work out is a great place to start, as it can be very hard to find things to praise in children and adolescents with ODD. It also might be a situation in which you can interact with the child in a setting that is far more rewarding than the usual show downs. The same holds true with CD. Obviously it requires a lot of supervision and creativity, but there often is something the child likes. In my experience with severe CD children on our ward and in the community, I am often quite touched by how normal they can be in certain settings. For example, a child may do just great swimming, but require 1:1 supervision in the locker room.

Hospitalize the child.

Some children with ODD plus a few other psychiatric diagnoses or CD are just totally out of control. They have everyone fighting with each other, are controlling the family, and are causing so much chaos that caregivers can only concentrate on surviving each minute. Sometimes putting the child in the child psychiatric ward can do wonders. You get some rest, and most importantly have some time to figure out what to do next with the assistance of the child psychiatric ward staff. The down side is that in Nova Scotia there is only one ward, and it is in Halifax. It is hard to get into and makes visiting and follow up care difficult.

Other non medical Strategies for CD

Safety

Before you can think about doing anything for the child, you and everyone else in the child's environment must feel safe. You can not say, "no" if you are afraid you might be seriously hurt if you do. A child will not learn to get along with others if the other children are so afraid of him they will not cross him or her.

A safe home

Every child deserves a safe home, but so does every parent! If your child is big enough to be dangerous and you can not enforce rules without fear for your safety, then the first thing to do is address this. Sometimes other interventions can make a big difference right away. Usually they will not. That means that at least for awhile, the child may have to leave your home. This might mean foster homes, hospitals, our residential centres. While this can be a hard thing to do, it is really the only choice at times. The rest of your family should not have to live in fear. The child should not learn the intimidation always works, which is often the lesson the child with CD is learning in a home where the parents are afraid.

A safe school

After a safe home, this is the most important thing. Other children and teachers need to feel safe in the presence of this child. This usually means lots and lots of supervision is necessary. Often it means expulsion and suspensions. Sometimes this can lead to out of home placement just so the child can be in a safe academic environment

A safe community

If the child with CD is committing crimes all over your town or village, that will also make any improvement in him impossible. Some parents, officers, and judges are eager to give a child many "chances". It is better to jump on these problems early and have an appropriately severe probation, etc., so that everyone is safe. This teaches the child that actions have consequences and gives people in the community confidence to work with the child.

Treating the child

In many children with CD, the safety issues are never resolved. Often it is because some person or group keeps wanting to give the child one more try or doesn't think that safety is the most important thing. All treatments will fail if everyone does not feel safe. Here are some principals of treatment.

Look at the whole picture

It is easy to get overly involved in one aspect of children such as these. The fact is, there are usually many parts of their problems.

Family - Many of these children have grown up in abusive homes and/ or may never have had a strong relationship with anyone. These issues can be addressed through counseling.

Learning - Children with CD frequently have learning disorders. They need to be assessed and appropriate extra help needs to be given with school work.

Neuropsychiatric - many children with CD also have some other major psychiatric problem. These need to be vigorously treated.

Social Skills - most children with CD have a very difficult time getting along with others. This needs to be addressed. . Click here to go to the section on this topic in the ADHD handout

If these problems are addressed, the child with CD has a chance to become one of those who grows out of it. Without intervening like these, the chances are far less.

Treating the caregivers

This is the most difficult psychiatric disorder of children. It is still often blamed on the parents or caregivers. The suggestions for taking care of yourself above need to be followed, but a few more are also necessary.

Full time parenting

If you are the full time parent with a child like this, it is a full time job. That means that either both parents/caregivers work part time or one works and the other doesn't. Don't expect to both work full time outside the home.. It won't work. You won't spend every minute with the child, but by the time you address all the needs of the child and yourself and your family, there will be no time for work, too. One of the most impressive changes in children with CD is when they go into a setting in which there is full time parenting (foster care, residential care, or hospital). There is often an almost instant improvement. Why is this? Children with CD need a huge amount of supervision and involvement from the person who is responsible for them. They frequently don't form close relationships easily, they don't do well without structure, and they need to be watched and watched and watched. While Baby sitters, groups, and relatives are great, they are not the same as the parent/principal care giver.

What if you can't afford to not work?

Between living with less, Government agencies, and family, nearly everyone can do this. I find that parents who say that they are going to stay home for their child with CD get a lot of support from families, agencies, and the community. Often money follows.

Someone to talk to

Whether it is your spouse, relative, friend, pastor, or a counselor, you need to be able to talk to someone with total frankness, especially if things go wrong. You can not do it yourself. Here are some of the common issues which come up.

- Having your child arrested for committing a crime in your home.
- Having people blame you for what the child has done.
- Having large amounts of money disappear and suspecting your child with CD

- Considering out of home placement
- Arranging schooling for a child with CD who has been suspended for the year.
- Having to tell the child he can not stay with you.
- Grieving the loss of the child you hoped you would have.
- Hearing about crimes and wondering if it was your child.
- Seeing the system write your child off.
- Sometimes admitting that you just can not cope with this child.

Putting it all together

Here are some recent suggestions which summarize the management of CD and ODD by John Werry, a psychiatrist in Auckland, NZ
Intervention should be as early as possible.
It should cover as much of the child's day as possible every day
It should include all caregivers
It should be consistent across all environments and across time
It should be maintained as long as needed (this may be years)
It should include many different types of interventions and not just focus on one aspect of the problem

It should address comorbidites such as depression, drug and alcohol abuse, and ADHD

ODD example

Jean is 8 years old. He has ODD, ADHD and a reading disability. The parents finally got help when Jean's mom was faced with a school suspension after only five days of school. After many battles, things are a little better. To start with, Jean's Dad and mom get a baby sitter three times a week. Sometimes they go out, and sometimes they take the child to the baby-sitter and just go back home. It is these every other day "dates" which see them through this. Jean's parents meet weekly with the school in person, along with a daily report card. Jean gets to use the computer at home only if he does well in school. Jean's Aunt helps twice a week with the reading, as Jean's parents just can not stand to do it. In exchange Jean's mom teaches her nephew piano. Jean takes medication for ADHD which helps, but it is no cure all. He is

in Karate, and scouts. About once a week, there is a "problem" in the neighborhood or school which Jean is usually at the center of. Jean wants a dog badly. Through an elaborate Behavior plan, he is slowly "earning" this. Jean feels like everyone is on his case for nothing. It is half true; he is watched closely. Jean's father prays each night that his child will not develop conduct disorder. So far, so good.

CD Example

Tony is 13 and has conduct disorder and depression. He is living with his Uncle and Aunt who have basically raised him since birth. Occasionally his mom comes by, but not on a regular basis. The father is unknown. Tony's Uncle and Aunt adopted him. They are the head of a "team" which cares for Tony. This includes respite foster parent's two weekends a month, Tony's other uncle one weekend a month, and his grandparents or his adopted parents the other weekend. At the moment, Tony is doing well. After the last sentencing, they were able to get better cooperation from their probation officer and a more workable probation agreement. Tony is supervised more than his adopted parent’s four year old. Last year he was hospitalized after he cut his wrist when he was caught drinking. Tony is now part of a group at school who are putting together a house. For once he is doing real well, except when he tried to steal an electric saw. But Tony's parents had warned the school to watch for this, and they did, and they caught him. The punishment? No electric guitar for four days. Every week or so while Tony is at school, his parents go through all his stuff. They have told Tony they will do this. Tony thinks it is mean and unfair. On the other hand, there have been no knives in the house for a month now. His parents call it "room service".

In summary,

ODD is one bad problem. There is no one thing that will probably fix it. Make sure you are not prematurely ruling out any of the possible interventions above. If you are not careful, it can destroy you long before it ruins the kid. If nothing is done, the outcome can be dismal. It is absolutely key to keep working to do everything you can to keep this problem from devastating your life and your child's.

CD is the worst medical or psychiatric problem there is to bear as a parent or caregiver. If you don't approach this problem with this view, it will most likely devour you. Even when everything is done right, a bad outcome is still possible. On the other hand, turning around a child

with CD is the most rewarding thing a parent or caregiver can do. Good luck!