Deconstructing Oppositional Defiant Disorder: Clinic-Based Evidence for an Anger/Irritability Phenotype

Deborah A.G. Drabick, Ph.D., and Kenneth D. Gadow, Ph.D.

Objective: To examine risk factors and co-occurring symptoms associated with mother-reported versus teacher-reported anger/irritability symptoms (AIS) of oppositional defiant disorder (ODD) in a clinic-based sample of 1,160 youth aged 6 through 18 years. **Method:** Participants completed a background history questionnaire (mothers), school functioning questionnaire (mothers, teachers), and *DSM-IV*–referenced symptom checklists (mothers, teachers). Youth meeting AIS criteria for ODD were compared to youth with ODD who met criteria for noncompliant symptoms (NS) but not AIS and to clinic controls. **Results:** Compared with NS youth, youth with AIS were rated as exhibiting higher levels of anxiety and mood symptoms for both mother- and teacher-defined groups, and higher levels of conduct disorder symptoms for mother-defined younger and older youth. The remaining group differences for developmental, psychosocial, and psychiatric correlates varied as a function of informant and youth's age. **Conclusions:** Evidence suggests that AIS may constitute a more severe and qualitatively different ODD clinical phenotype, but informant and age of youth appear to be important considerations. J. Am. Acad. Child Adolesc. Psychiatry, 2012;51(4):384–393. **Key Words:** ODD, anger, irritability, risk factors, *DSM-5*

Oppositional defiant disorder (ODD) is characterized by a pattern of negativistic, hostile, and defiant behavior toward adults and can co-occur with numerous psychiatric disorders, including attention-deficit/hyperactivity disorder (ADHD), conduct disorder (CD), and anxiety and mood disorders.[1-6] Although for many individuals ODD is relatively stable over time and predictive of later-onset CD, the anger/irritability symptoms (AIS) that, in part, define ODD may be more differentially associated with anxiety and mood disorders.[7-11] Given this possibility, the *DSM-5* ADHD and Disruptive Behavior Disorders Workgroups recommended distinguishing between the "emotional" (loses temper, is touchy or easily annoyed, and is angry or resentful) and "behavioral" (e.g., argues, defies, annoys, blames others) features of ODD (www.dsm5.org).

The findings of several studies served as the basis for this study. Stringaris and Goodman[10,11] created three a priori subgroups of ODD symptoms, which they labeled as irritable, headstrong, and hurtful, and examined their prognostic significance in a large mental health survey of youth aged 5 to 16 years. The three-item irritable dimension (loses temper, is angry and resentful, is touchy or easily annoyed) predicted parent- and teacher-reported depressive and anxiety disorders at both baseline[11] and 3-year follow-up.[10] The headstrong dimension (argues, defies, deliberately annoys, blames others) was associated with parent- and teacher-reported ADHD at baseline[11] and 3-year follow-up.[10] All three dimensions were associated with parent- and teacher-reported CD at baseline; however, at 3-year follow-up, only the headstrong and hurtful (i.e., vindictive) dimensions predicted CD.[10] Using epidemiological data from the Great Smoky Mountains study, Rowe *et al.*[6] used factor analysis to identify an "irritable" factor identical to that of Stringaris and Goodman[10,11] and a "headstrong" factor comprising the remaining five ODD symptoms. They reported that both dimensions predicted CD and depressive disorders, but that only the irritable dimension predicted anxiety disorders. Conversely, Mick et al.[12] found that, although a three-item irritability cluster (same items as Stringaris and Good-

man[10,11] and Rowe *et al.*[6]) was common among youth with co-morbid ADHD, it was not associated with increased risk of mood disorders.

Additional research has considered affective (angry/irritable) and behavioral ODD symptoms, but has used items for constructing ODD symptom groups that differ from those described by the *DSM-5* Workgroups and the studies referenced above.[6,10-12] For example, Burke *et al.* used factor analysis to identify a "negative affect" (touchy, angry, spiteful) and "behavioral" (argues, defies, loses temper) dimension of ODD among clinic-referred boys[8] and among a separate sample of nonreferred girls.[7] The behavioral dimension predicted CD (both samples), whereas negative affect predicted major depressive disorder (MDD, both samples) and CD (white girls). Last, Leibenluft *et al*.[9] reported that "chronic irritability" defined a priori by four items ("arguing a lot" at home and school and "temper tantrums" at home and school) measured in early adolescence prospectively predicted ADHD in late adolescence and MDD in early adulthood. It should be noted that, although all studies include "loses temper" in constructing their respective AIS group, only Leibenluft *et al*.[9] included "argues" in the AIS construct. Collectively, the aforementioned studies provide preliminary evidence for a distinction between AIS versus primarily noncompliant symptoms (NS) of ODD.

An important conceptual and methodological issue to consider is the use of data from multiple informants when defining caseness.[13,14] For example, symptom severity, impairment, levels of comorbidity, and psychosocial correlates differ depending on the informant whose evaluations serves as the basis for establishing ODD status.[3,4,15,16] Some evidence suggests that compared with parents' reports, teachers' ratings have better predictive power for the diagnosis of ODD,[17] are more strongly related to peer-reported impairment criteria,[16] and have greater specificity for predicting co-occurring symptoms.[4,15] Three studies that compared different strategies for considering parent and teacher data found that source-specific classifications demonstrated better internal and differential validity than grouping strategies based on combining data from multiple informants.[3,15,18]

To further examine the validity of AIS and NS as ODD clinical phenotypes, we compared associated clinical, developmental, and psychosocial features of referred youth with ODD with AIS, ODD with NS, and non-ODD clinic controls. The present study expands on prior research by examining a wider range of psychosocial validators of group differences, as well as informant-specific classification strategies. The primary focus was co-occurring symptoms previously found to be differentially associated with AIS.[6,10-12] We hypothesized that youth with AIS would have more severe symptoms of anxiety, depression, and mania than youth with NS, but that these groups would not differ in terms of ADHD or CD. We also examined additional variables associated with ODD,[1,3,4,19,20] but that heretofore have not been studied in terms of their potential differential associations with AIS (e.g., "difficult" temperament, academic and language difficulties, familial stressors, parental discipline, treatment history). Findings have implications for nosology and, more specifically, *DSM-5* Workgroup recommendations.

METHOD

Participants

Participants were parents (primarily mothers) and teachers of 1,160 youth who were consecutive referrals to a university hospital child psychiatry outpatient service that serves an ethnically and economically diverse clientele. Given the well-established developmental differences in the emergence of psychiatric symptomatology, we divided the sample into a younger (6-11-year-olds; $n = 546$; 72.7% males) and older (12-18-year-olds; $n = 614$; 67.1% males) cohort (full sample mean = 12.1, SD = 3.4 years; 69.6% males). Caregiver-identified ethnicity was as follows: European-American (n = 977; 84%), African-American (n = 81; 7%), Hispanic-American (n = 127; 11%), Native-American (n = 12; 1%), Asian-American (n = 30; 3%), and Other (n = 11; 1%). Most youth lived with their biological mothers (84%) and fathers (62%), and in 65% of families, parents were married. Maternal and paternal education, respectively, was as follows: without high school diploma (6.9%, 9.5%); high school graduate without college education (23.5%, 26.4%); some college education (26.0%, 27.3%); and degree from 4-year college or more (43.6%, 36.8%). With regard to family income, 12% of families reported income of less than $20,001/year, 15% reported income from $20,001 to $40,000/year, 23% reported income from $40,001 to $70,000/year, and 50% reported income greater than $70,001. The two most common clinician-assigned diagnoses were ADHD and ODD, and almost all youth with ODD were also co-morbid for ADHD. This retrospective chart review study was approved by a university Institutional Re-

Download English Version:

https://daneshyari.com/en/article/325366

Download Persian Version:

https://daneshyari.com/article/325366

Daneshyari.com