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REVIEW ARTICLE

ODD: behavioural perspectives and their association with ADHD and CT

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Abstract

Oppositional Defiant Disorder (ODD) is characterized by impulse and conduct control disorders and aggressive behavior. It is often associated with other disorders, especially conduct disorder (CT) and attention deficit hyperactivity disorder (ADHD). This is an integrative review of medical literature of a qualitative nature, which aims to present what are the perspectives for a patient with OCD and its main associations: CT and ADHD. These psychopathologies directly influence the personal and professional relationships of individuals and are associated with a greater propensity to aggression, crime and theft when not controlled. Therefore, it is essential to diagnose these disorders and promote the necessary interventions.

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INTRODUCTION

Childhood is the period of greatest individual and social transformation of an individual, and during this period, many develop and manifest psychiatric disorders. Disruptive, impulse control and conduct disorders are characterized by verbal and physical aggression against people and property and/or conflicts with norms and authority figures, caused by difficulties in emotional regulation and poor social skills[1]. Among these disorders, oppositional defiant disorder (ODD), also known as oppositional defiant disorder, is characterized by hostile and purposeful opposition to any authority figure, such as parents, caregivers and teachers, by the constant denial of everything that is asked of them[2-4].

Children and adolescents with ODD show rapid, intense and inconsequential reactions with a low threshold to frustration, characteristics that appear early in cognitive development. Aversion to waiting and impulsiveness exacerbate these characteristics. In some cases, rule-breaking and antisocial behavior is well engineered, and often associated with coldness[1]. This disorder is considered one of the main precursors of psychopathology in adulthood[5].

Family factors strongly contribute to the development of TOD characteristics[6]. Children exposed to intense negative emotions, physical, verbal and sexual aggression, punitive methods and lack of care for their emotional and cognitive development on the part of those responsible manifest highly impulsive and irritable temperaments. Gestational and hereditary factors may also be related, such as gestational stressors and low birth weight[1]. Biological factors, such as abnormalities of the prefrontal cortex and amygdala, nervous and hormonal transmission[7] and the development of the empathic system promote great susceptibility to the condition[1].

This irritability, anger and aggression in the face of negative emotional situations involve two systems, the " bottom-up " and the "top - down ". The first is composed of subcortical structures responsible for basic emotions such as those mentioned, while the second has prefrontal cortical structures and involves mechanisms of inhibitory control and information processing from more primitive structures, which allows for action planning[5].

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) presents as diagnostic criteria for the disorder an angry or irritable pattern of questioning and defiant behavior, or a vindictive nature lasting at least six months with at least one individual except a brother[7,8]. Thus, the clinical presentation can range from violence and impetuosity to manipulation and revenge. ODD patients usually justify their behavior based on the situations to which they were submitted, covering up their true characteristics[7].

Three dimensions underlying TOD were identified: "irritable", which comprises the symptoms of being angry or resentful, frequently out of control and easily being bothered by other people; "headstrong", which encompasses symptoms of arguing with adults, defying or refusing to follow adult rules and requests, purposely bothering others and blaming them for their misconduct; and " hurtful ", composed of vengeful or mean attitudes[5].

More common in males at a ratio of 3:1, the prevalence of ODD among children aged 7 to 14 years can reach 3.2%, based on national studies. Evidence points to a higher percentage of cases belonging to children from families with low socioeconomic conditions[1]. In addition, ODD is present, in many cases, in association with other disorders[2], such as conduct disorder (CD) and attention deficit hyperactivity disorder (ADHD)[9].

In view of this introduction, the objective is to present the two main psychiatric associations of ODD, TC and ADHD, the way in which these associations determine the prognosis of the carrier, and what are the prospects for a patient with ODD.

LITERATURE REVIEW

This work was a bibliographic research through an integrative review of the medical literature of a qualitative nature. The search for scientific productions was carried out in the following databases: Scientific Electronic Library Online (SciELO), PubMed and Latin American and Caribbean Literature in Health Sciences (LILACS). Medical textbooks of great relevance in the field of psychiatry were also used. The inclusion criteria defined for the selection of articles were: 1) articles published in the last ten years; 2) articles published in Portuguese, Spanish and English; and 3) articles that addressed the signs and symptoms of oppositional defiant disorder, associated with neurophysiology and psychology. Articles published in years prior to 2010, which focused on health areas other than neurology and psychiatry, which had discrepant titles, and which did not show associations with the target disorder, were excluded. The Health Sciences Descriptors (DeCS) "Attention Deficit Disorders and Disruptive Behavior", "Antisocial Personality Disorder", "Attention Deficit Hyperactivity Disorder" and "Attendance Disorder" were used to search for articles. Conduct" , their synonyms and their corresponding words in English and Spanish. The articles selected for analysis were then copied from the virtual libraries and organized according to the order of selection.

A total of 43 articles were found in the Latin American and Caribbean Literature on Health Sciences and in the Scientific Electronic Library Online, of which 30 were eliminated due to non-correspondence with the subject in question and the absence of objective information. After reading the 13 works in full, 11 of them were selected because they met all the current inclusion criteria.

DISCUSSION

Attention Deficit Disorder With Hyperactivity

ADHD is a neurodevelopmental disorder defined by harmful levels of inattention, disorganization and/or hyperactivity-impulsivity that has a substantial clinical presentation

during childhood[7,10]. It is known that individuals with ADHD may have learning difficulties in 19 to 26% of cases, being the main reason for consultation of school-age children with a pediatric neurologist[1].

In addition, individuals with ADHD tend to be interpreted as lazy and irresponsible, directly influencing their personal and professional relationships. The way and intensity that affects their interpersonal interactions are linked to the form of their manifestations. Predominant inattention is associated with academic deficits, school problems and peer neglect, while peer rejection and, to a lesser extent, accidental injuries are more prominent with marked symptoms of hyperactivity or impulsivity when severe, the disorder affects adaptation in social spheres. family and school/professional[7].

Children with ADHD usually have other clinical or psychological comorbidities such as specific disorders, oppositional defiant disorder, antisocial behavior, anxiety disorder and mood disorder[1]. In childhood, ADHD often overlaps with disorders generally considered "externalizing", such as oppositional defiant disorder and conduct disorder[7].

Some studies consider that about 30% of children with ODD have ADHD. Many indicate that the symptoms of both develop in parallel[4]. In these cases, they are associated with unstable mood, with easy irritability, may have tantrums[1]. The association between the two disorders may be the result of shared temperamental risk factors[7].

Conduct Disorder

ADHD and ODD are common in individuals with conduct disorder (BD), and this correlation is a predictor of worse outcomes[7].

Conduct disorder is characterized by inappropriate social behaviors that violate laws and escape the rules of the social environment in which one lives. HT is more common in children over ten years of age and in males[11,12].

It includes as diagnostic criteria actions related to the aggression of people or animals, destruction of property, forgery or theft and serious violations of rules in the last 12 months. Furthermore, it has subtypes according to the period of onset of symptoms (childhood, adolescence or unspecified), which may occur in mild, moderate or severe forms[7].

In childhood-onset BD, male individuals usually present physical aggression against other people[13], have troubled relationships, may have had ODD early in childhood and many also have attention deficit disorder or other neurodevelopmental difficulties concomitantly[7].

The correlation between TC and TOD occurs because both present symptoms that put the individual in conflict with adults and authority figures (parents, teachers, bosses). Generally, TOD behaviors are of a less serious nature than TC and do not include aggression towards people or animals, destruction of property, pattern of theft, or deceit. Furthermore, ODD is related to emotional dysregulation problems, such as irritable and angry mood, which are not included in the definition of conduct disorder.

Studies show that although most children with ODD do not progress to BD, in some situations this phenomenon occurs, and that in adulthood, they will continue to antisocial personality disorder[11].

Perspectives of Social Behavior

The circle of facts that is present in the daily life of children with ODD is made up of provocations, which generate complaints and criticism, and which turn into low self-esteem, increasing the need for retaliation[2]. Aggression, manipulation and constant breaking of rules causes withdrawal from their social interactions[1]. They may consider any type of human relationship as unsatisfactory[8].

In the school environment, this circle does not only affect the student's school performance, but also the whole class, which starts to question the teacher's authority, and if the child with ODD is a leader among the other students, he can set bad examples[2]. When there is no presence of other associated disorders, they have enough intelligence to perform well in school. However, they refuse to interact with colleagues and teachers, resist certain school tasks and insist on solving their problems alone[8]. Also in this sphere, according to a cross-sectional study carried out in Mexico by Albores- Gallo et al. (2011)[14], children who express the behavior of victims and aggressors in the bullying phenomenon often have ODD and ADHD, or other disorders externalizing.

When left untreated during childhood, the patient can progress to antisocial disorders that affect their daily lives, their family and professional relationships, and thus, they become problematic adults[8], carrying other diagnoses such as schizophrenia, psychosis and antisocial personality disorder[13]. In extreme cases, extremely radical acts can be committed, such as robberies, violation of private property and group crimes, which can start in adolescence[15].

CONCLUSION

The studies analyzed demonstrated the main signs and symptoms of Oppositional Defiant Disorder and the social and individual importance of early diagnosis. Not only the professional aspect of the carrier will be harmed, but also all their relationships. The absence of psychiatric, occupational, psychological and family treatment will promote the development of new disorders and increasingly aggressive behaviors. Monitoring communication and learning is necessary to assess the need for speech therapy intervention and correct possible delays. Not least, the differentiation or association of ODD with ADHD and BD is fundamental for the patient's prognosis and for understanding the causes and consequences of these disorders.

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