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LETTERS TO THE EDITOR

The Many Faces of Oppositional Defiant Disorder

Dear Editor:

The clinical heterogeneity within oppositional defiant disorder (ODD) is gaining some face validity with new research identifying two symptom factors within the eight DSM ODD symptoms. An "irritable/negative affect" symptom cluster is associated with internalizing disorders and a "headstrong/oppositional" cluster is differentially predictive of disruptive disorders (Stringaris & Goodman, 2009; Burke, Hipwell, & Loeber, 2010). *This research is exciting as it suggests there may be more than one group of ODD children who would benefit from differential identification and provision of treatments.* Gadow and Drabick (2012) identified groups who had predominantly irritable as opposed to disruptive ODD symptoms in their large clinical sample. The youth so identified did have some significant differences in comorbidity in the hypothesized direction (i.e. more internalizing disorders). However, the irritable group had more comorbidity overall, suggesting irritable youth with ODD are more globally impaired. Whether this group is a clinical subtype requiring a different treatment approach is unknown. In respect of this important work, I would like to suggest a clinical typology for ODD that may be of clinical use as it incorporates contextual and developmental information that we typically collect in practice.

The typology consists of three types: **Stimulus Dependent** ODD, **Cognitive Overload** ODD and **Fearful** ODD. Youth with **Stimulus Dependent** type ODD have noticeably impairing attention deficit/hyperactivity disorder (ADHD) and have ODD behaviours in multiple settings. Oppositionality improves when ADHD is treated (Connor, Steeber, & McBurnett, 2010). Oppositionality reflects low dopaminergic tone hence low arousal and reward sensitivity, behavioural disinhibition and impaired behavioural learning, a phenotype alluded to by Matthys and colleagues (Matthys, Vanderschuren, Schutter, & Lochman, 2012). *This group would arguably be high in "headstrong" in relation to "irritable" scores.* The second group **Cognitive Overload** ODD, struggles with learning, language and social processing difficulties far in excess of ADHD, and usually meets criteria for learning disability and anxiety disorder not otherwise specified. This group has poor executive functioning skills even under low demand conditions and their oppositionality appears for no clear reason beyond resistance to change. They have poor social perspective taking abilities, and are socially awkward. These challenging youth require multimodal, staged treatments targeting anxiety and attention, but success is limited without psychoeducational testing to direct supports at home and school. *They would have high levels of all types of oppositional symptoms.* Finally, the **Fearful** type constitute highly aroused and stress reactive children, who can do well in many contexts, but present with ODD symptoms when threat of loss or shame is present, typically with caregivers. Often these children have histories of trauma and mistrust authority; indeed their behaviours reflect a profile of anxious/ambivalent attachment. Garland (2001) discussed the clinical phenomenon of "rages and refusals" in anxious teens, and Storch et al. (2012) recently reported on rage attacks in obsessive compulsive disorder OCD. Otherwise, the place of anxiety in mediating ODD symptoms has not been a focus of study, yet of great clinical importance. *This group is likely highest on the irritability factor as described above.*

The proposed clinical typology of ODD is premature because it is untested. However, these clinical types may be relevant to ongoing debate regarding the heterogeneity of ODD in the DSM-V and emphasize the importance of considering context, relationship functioning and brain developmental differences that most certainly contribute to variation in oppositionality. In many respects the typology can be mapped on to the factors identified in research, yet acknowledge that the factors are not independent of each other in individual children. I hope these ideas may spur clinical colleagues to consider whether their patients with ODD conform to the proposed typology and whether the approach to providing care does or does not effectively target their ODD symptoms.

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