Supporting Indigenous Youth With Behavior & Conduct Challenges: Oppositional Defiant Disorder & Conduct Disorder

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Jeremiah D. Simmons, PhD (Yankton Sioux/Navajo) is a Post-Doctoral Fellow in the Department of Psychiatry & Behavioral Sciences in the School of Medicine at Stanford University. Jeremiah, a native New Mexican, was raised on the Mescalero Apache Indian Reservation in Mescalero, NM. While he associates himself with the Mescalero Apache Indian Reservation, his family originates from the Yankton Sioux and Navajo tribes. Jeremiah graduated with a B.A. from Stanford University, a M.S in Clinical Psychology from the University of New Mexico, and a Ph.D. in Clinical Psychology from the University of New Mexico.

From a clinical practice perspective, Jeremiah currently works Native American populations with co-occurring mental health and substance use problems and ensures that empirically-supported interventions are culturally centered and linguistically appropriate. His research activities are broadly focused on adolescent health disparities with an emphasis on mental and behavioral health, behavioral health policy, and co-occurring substance use and mental health disorders.
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The views expressed in this presentation are those of the speaker and do not necessarily represent the views, policies, and positions of the Indian Health Service (IHS), or the U.S. Department of Health and Human Services (HHS).
Personal Disclosures

- I am a cisgender male of Native American (Yankton Sioux/Navajo) descent
- I have a family history of mental illness and substance abuse
- I have sought out and received my own mental health care
We recognize that Stanford sits on the ancestral land of the Muwekma Ohlone Tribe. This land was and continues to be of great importance to the Ohlone people. Consistent with our values of community and inclusion, we have a responsibility to acknowledge, honor and make visible the university’s relationship to Native peoples.

STANFORD LAND ACKNOWLEDGMENT
Learning Objectives

At the end of this presentation, participants will be able to:

• List the key features of Oppositional Defiant Disorder and Conduct Disorder

• Describe disorders with similar presentations that must be differentiated from oppositional defiant disorder and conduct disorder

• Evaluate racial/ethnic disparities in diagnosis for Native Youth
In your culture/community of origin, how is oppositional defiant disorder (ODD) and conduct disorder (CD) discussed/perceived?
Disruptive, Impulse-Control, & Conduct Disorders

- Conduct Disorder
  - Antisocial PD
- Oppositional Defiant Disorder
- Kleptomania
- Pyromania
- Intermittent Explosive Disorder
- Difficulty Regulating Behavior
- Difficulty Regulating Emotions
Oppositional Defiant Disorder Criteria
Characterized by a child that is defiant/argumentative, angry/irritable, and vindictive, and has shown this pattern of behavior for at least six months.

• Angry/irritable mood:
  – Often loses temper
  – Is often touchy or easily annoyed
  – Is often angry and resentful

• Argumentative/defiant behavior:
  – Often argues with authority figures or, for children and adolescents, with adults
  – Often actively defies or refuses to comply with requests from authority figures or with rules
  – Often deliberately annoys others
  – Often blames others for his or her mistakes or misbehavior

• Vindictiveness:
  – Acted spiteful/vindictive at least 2x within the past 6 months

(APA, 2022)
**Conduct Disorder Criteria**

Repetitive & persistent pattern of behavior that violates basic rights of others OR major age-appropriate societal norms/rules violated, with at least 3 behaviors being present in the past 12 months, and one behavior being present in past 6 months:

- **Aggression to People & Animals**
  - Physical cruelty, bullying, physical fighting (initiates), use of weapons, confrontational theft, forced sex etc.

- **Destruction of Property**
  - Deliberate destruction (not including fire setting) of property of others, intentional fire setting to cause serious damage.

- **Deceitfulness or Theft**
  - Breaking and entering, conning others, shoplifting, etc.

- **Serious Violation of Rules**
  - Nonadherence to curfews at age <13, >2 occurrences of running away overnight, school truancy at age <13

(APA, 2022)
Differential Diagnosis

ODD:
- CD
- Adjustment Dx
- PTSD
- ADHD (often comorbid)
- Disruptive Mood Dysregulation Dx
- Intermittent Explosive Dx
- Intellectual Development Dx
- Language Dx
- Social Anxiety Dx
- Depression & Bipolar Dx’s

CD:
- ODD
- Adjustment Dx
- ADHD (comorbid)
- Intermittent Explosive Dx
- Depression & Bipolar Dx’s

(APA, 2022)
Prevalence, Risk Factors, & Disparities

• ODD: 1%-11% (3% avg)
  — Difficulties in differential diagnosis and cultural insensitivity
  — Western culture: 🧑‍👨 for Boys (Demmer et al., 2017)
  — Non-Western culture: no difference

• CD: 2%-10% (4% avg)
  — 👵 prevalence in Western cultures
  — Adolescent-onset: 👵 assoc. w/psychosocial stressors (ie., socially oppressed/facing discrimination)

• Risk Factors:
  — Adverse Childhood Experiences (ACEs; Petrucelli et al., 2019)
    • Highly correlated with development of these disorders
      — Harsh parenting more associated with ODD in girls than boys
  — At-risk for later mood disorders (Cameron et al., 2007; Fadus et al., 2020)

Disparities in Misdiagnosis

Abuse
1. Physical
2. Emotional
3. Sexual

Neglect
4. Physical*
5. Emotional*

Household dysfunction
6. Substance abuse
7. Mental illness
8. Domestic violence
9. Incarceration
10. Parental separation*
References


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