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Abstract

This paper is a review of the literature on Oppositional Defiant Disorder (ODD) in children and adolescents. Included in this review is information on the history of changes through which the diagnosis of ODD has gone, a comparison of children with ODD to "normal" children in terms of development, gender differences, co-morbidity, etiology, and treatment interventions.

OPPOSITIONAL DEFIANT DISORDER (ODD) IN CHILDREN AND
ADOLESCENTS

A Research Paper

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Master of Arts

by

Maria J. Garlie

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Abstract

This paper is a review of the literature on Oppositional Defiant Disorder (ODD) in children and adolescents. Included in this review is information on the history of changes through which the diagnosis of ODD has gone, a comparison of children with ODD to "normal" children in terms of development, gender differences, comorbidity, etiology, and treatment interventions.

Oppositional Defiant Disorder (ODD) in Children and Adolescents

This paper will cover a review of literature on Oppositional Defiant Disorder (ODD) in Children and Adolescents. This review will include information on the history of changes through which the diagnosis of ODD has gone, a comparison of children with ODD to "normal" childhood development, gender differences, comorbidity, etiology, and treatment/interventions.

The diagnosis of Oppositional Disorder was originally introduced in the DSM-III (American Psychiatric Association, 1980) in the category Disorders Usually First Evident in Infancy, Childhood, or Adolescence. It required that two of the following five behaviors be present for a diagnosis: (a) violation of minor rules; (b) temper tantrums; (c) argumentativeness; (d) provocative behavior; and (e) stubbornness.

Since that time, much debate has taken place regarding the distinctiveness and co-occurrence of the disruptive behavior disorders Oppositional Disorder and Conduct Disorder (CD) (Paternite, Loney, & Roberts, 1995). Some have questioned whether ODD was a mental disorder at all and whether it could be distinguished from "normal" childhood behaviors or if it was simply a milder form of Conduct Disorder (Rey, 1993). Other clinicians and researchers have favored the use of one diagnostic entity for both CD and ODD and have debated the utility of separate diagnoses (Loeber, Lahey, & Thomas, 1991).

Seven years later, the DSM-III-R (American Psychiatric Association, 1987) changed the name to Oppositional Defiant Disorder, and it was classed with Conduct Disorder and Attention Deficit Hyperactivity Disorder under Disruptive Behavior Disorders. The diagnostic criteria were increased to nine. In addition to

the behaviors described for Oppositional Disorder in the DSM-III (American Psychological Association, 1980), the authors of the DSM-III-R included: (a) blames others for his or her own mistakes; (b) is touchy or easily annoyed; (c) is angry and resentful; (d) is spiteful or vindictive; and (e) swears. Stubbornness was removed, and the remaining original four were reworded as (a) loses temper, (b) often argues, (c) actively defies, and (d) bullies. The number of criteria required for a diagnosis was also increased to five. These changes were implemented in response to the criticism that ODD could not be distinguished from the behavior of many normal children, and these changes were well-accepted in the mental health profession (Rey, 1993).

In the progression from the DSM-III-R to the DSM-IV, there has been a continued tightening of the criteria for ODD. In the DSM-IV (American Psychological Association, 1994), ODD and CD still are conceptualized separately, but it has now been postulated that the two lie along a developmentally staged severity dimension, with the least severe level of CD being ODD (Paternite, Loney, & Roberts, 1995). The DSM-IV (American Psychological Association, 1994) stated: "to qualify for Oppositional Defiant Disorder, the behaviors must occur more frequently than is typically observed in individuals of comparable age and developmental level and must lead to significant impairment in social, academic, or occupational functioning" (p. 91).

The authors of the DSM-IV (American Psychiatric Association, 1994) described ODD as a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that is accompanied frequently by the following: losing temper, arguing with adults, defying or refusing to comply,

deliberately annoying others, blaming others for his/her own mistakes or misbehavior, being touchy or easily annoyed by other, being angry or resentful, or being spiteful or vindictive.

Oppositional Defiant Disorder (ODD), along with Conduct Disorder (CD), is considered to be among the most common psychiatric disorders seen in children and adolescents (Kronenberger & Meyer, 1996). It has been estimated that approximately 10 million children and adolescents are in need of mental health services in this country. Of these 10 million, some experts suggest that as many as two-thirds (6.5 million) have ODD or the more severe diagnosis of CD (Windell, 1996). Parents of ODD children are more likely to use child mental health services than parents of children diagnosed as having Conduct Disorder, Major Depression, Attention-Deficit Hyperactivity Disorder, or Overanxious Disorder (Rey, 1993).

The authors of the DSM-IV (American Psychiatric Association, 1994) suggested the prevalence rate for ODD is between 2 and 16 percent of the child and adolescent population. In a review of studies, Barkley and Benton (1998) found 4.9% of 6 to 17 year olds, 3.2% of 5 to 14 year-old boys, 5.7% of 11 year olds, and 1.7 to 2.5% of adolescents were diagnosed with ODD. Despite the different prevalence rates presented for various ages of children and adolescents, ODD is found across a wide age range and affects a significant amount of children and adolescents. It typically becomes evident before the age of 8 and usually no later than early adolescents, with the onset being gradual, usually occurring over the course of months or years (American Psychiatric Association, 1994).

ODD versus Normal Childhood Development

Oppositional Defiant Disorder symptoms often resemble typical childhood behaviors such as tantrums, arguing with adults, refusing to listen, and blaming mistakes or behaviors on others. Due to this factor, parents may be unaware that the behavior of their child could qualify their child for a psychiatric diagnosis. It is important to understand what constitutes a "normal" amount of oppositional behavior and where the boundary of "normal" ends.

Oppositional Defiant Disorder behaviors differ from typical childhood disobedience in severity and frequency. In general, these children have a drive to defeat adults that assumes exaggerated proportions (Riley, 1997). They may be found to push limits, defy rules, and display verbal and physical outbursts, all in an attempt to get what they want. Another important difference is that, with ODD, these behaviors are recurrent and a part of the child's everyday life.

Many symptoms of ODD are considered developmentally appropriate and normative during a child's preschool years. Temper tantrums usually reach their peak when children are 2-3 years of age. "Normal" children may also display negativism which can result in angry outbursts and conflict on matters such as toilet training or possessions at the age of 2 and tidiness at age 5. Destructiveness, bullying, and fighting may also be present, but typically decrease after the preschool years (Rey, 1993). It is when these behaviors persist and become more severe that a diagnosis of ODD should be considered.

The beginning stages of ODD for preschoolers may be observed in frequent, severe temper tantrums, and intolerance of frustration. If parents give in to the child's demands, the child learns that the escalation of the power struggle can

result in the gratification of his/her needs (Kronenberger & Meyer, 1996). Thus, the child is encouraged in future conflicts to engage the parent(s) by refusing to give in during an argument, yell, swear, or throw a tantrum because the end result is the child gets what he/she wants.

During adolescence, talking back, swearing, arguing, passive-aggressive refusal to comply, and rebelling are typical behaviors. Adolescents' behaviors are considered pathological when the magnitude, inflexibility, or persistence continues at later developmental periods when other children have outgrown them (i.e., middle to late childhood) (Rey, 1993). For example, if the temper tantrums, destructiveness, and aggressive behavior that were seen during the preschool years, continued to persist and are incorporated into power struggles with the parent(s) this would be indicative of ODD behavior. Oppositional and defiant children often use threats, appear to be provoking, and are described as touchy, stubborn, argumentative, and provocative (Kronenberger & Meyer, 1996). The important thing to remember when comparing ODD children to "normal" children is that the behavior of ODD children is far more severe and frequent.

Gender Differences

Evidence on gender differences in children with ODD is inconsistent and minimal. Males are diagnosed approximately three times as often as females (Kronenberger & Meyer, 1996). According to the DSM-IV (American Psychiatric Association, 1994), ODD is more prevalent in males before puberty, but occurs with equal prevalence in girls after puberty. In a review of epidemiological surveys, Rey (1993) found that diagnosis of children 12 years and younger showed a prevalence of ODD that was more than double for boys as compared to girls,

while adolescent studies showed a higher rate of prevalence for ODD in girls. Differences between males and females are large in 4 to 5 year-olds, moderate in 9 to 12 year-olds, and small in college age students (Rey, 1993). Studies typically do not include enough girls to provide separate data analyses, or girls are completely exempt altogether. Thus, obtaining adequate samples of girls with ODD to examine differences in gender is likely to continue to be a problem and studies with females subjects will be underrepresented in the literature (Carlson, Tamm, & Gaub, 1997).

Comorbidity

It is common for ODD to coexist with other disorders. It is estimated that, among clinic-referred youth who are diagnosed as conduct disordered, 84% to 96% also meet the diagnostic criteria for ODD (Sommers-Flanagan & Sommers-Flanagan, 1998). The authors of the DSM-IV (American Psychiatric Association, 1994) specified that, in cases where both ODD and CD are present, "diagnosis of Conduct Disorder takes precedence and Oppositional Defiant Disorder is not diagnosed" (p. 93). This is supported in a review by Loeber, Lahey, and Thomas (1991) who found that most children with CD have early histories of ODD. Despite the information reviewed by these authors, empirical evidence of ODD being a precursor of CD is scarce, and Loeber, Keenan, Lahey, Green, and Thomas (1993) suggested two reasons why it is important to clarify the degree to which ODD predicts CD:

First, if a substantial proportion of youths with a diagnosis of ODD experience the onset of CD later, ODD can be more clearly considered a risk factor for CD. This link can then be extended to some cases of CD eventually qualifying for a diagnosis of antisocial personality disorder.

Second, it could well be that, depending on the selection of symptoms, ODD will vary in its ability to forecast which youths will later meet the criteria for a diagnosis of CD. (p. 379)

Results from a study (August, Realmuto, Joyce, and Hektner, 1999) that examined the developmental progression of ODD in a community-based population of 7,231 children from 22 suburban elementary schools failed to provide much evidence to show that ODD acted as a precursor to CD. There were 43 children with a baseline diagnoses of ODD, and only 1 had CD at the follow-up. The results do suggest that ODD, in some cases, appears as a prodrome to CD. All 10 children with CD diagnosed at baseline and one new case of CD at follow-up were codiagnosed with ODD.

ODD has also been found to coexist in as many as 35% of children with Attention-Deficit Hyperactivity Disorder (ADHD) (Kuhne, Schachar, & Tannock, 1997). When these two disorders co-occur with one another, both diagnoses should be made (American Psychological Association, 1994). Furthermore, children who display concurrent ODD and ADHD appear to be at a heightened risk for developing severe antisocial behavior compared to children with either single-disorder category (Webster-Stratton, 1993).

Etiology

It is widely accepted that there are a multitude of influences and factors that contribute to the development and maintenance of ODD in children and adolescents. This section will include various child and parental factors such as: child temperament, child cognitive and social skills deficits, parenting skills deficits, and parent psychological factors.

Child Factors

The way in which a child approaches and reacts to people and situations can have an impact on his/her oppositional and defiant behavior. The type of temperament and cognitive/social skills deficits that a child may possess can be related to ODD and will be discussed here.

Temperament. There are three patterns of temperament found in children: easy, difficult, and slow-to-warm-up. Children with difficult temperaments are more irritable, more intense in expressing emotions, reacts to frustrations with tantrums, and displays intense and frequent negative moods (Papalia & Olds, 1992). Barkley (1999) suggested that adolescents who have difficult temperaments are more prone to display coercive/aggressive behavior and be noncompliant than other teens. He further explained that adolescents who are easily prone to emotional responses, are often irritable, have poor habit regulation, are highly active, and/or are more inattentive and impulsive (have ADHD), appear more likely to display disruptive behavior disorders, and therefore more likely to demonstrate defiant and coercive behaviors than teens without these negative temperamental characteristics.

Another suggestion is that a temperamentally difficult child needs to be "trained" to become oppositional and defiant (Windell, 1996). This could occur when the parents continue to give rewards, privileges, and reinforcements despite unmanageable and oppositional behavior. Children such as these present a great challenge to their parents. When parents attempt to curb the stubborn and defiant behavior, they use discipline methods that lead to more behavior problems which in

turn cause stress in the parents, who are then even less able to provide effective discipline.

Despite the suggestions above, it has also been stated that "no temperamental pattern confers an immunity to behavior disorder, nor is it fated to create psychopathology" (Webster-Stratton, 1993, p. 439).

Cognitive and social skill deficits. It has been suggested that ODD children who have cognitive and social deficits may generate fewer alternative solutions to social problems, seek less information, define problems in hostile ways, and anticipate fewer consequences for aggression (Webster-Stratton, 1993). The child's perception of hostile intentions from others may encourage negative, defiant, disobedient, and hostile behavior to be displayed by the child. All of these behaviors are patterns seen in children with ODD.

Matthys, Cuperus, and Engeland (1999) described Dodge's model which proposes that when children are faced with a social situational cue they engage in 4 mental steps before enacting competent social behaviors: encoding of situational cues, representation and interpretation of these cues, mental search for possible responses to the situation, and selection of a response. Skillful processing at each step will lead to competent performance within the situation, whereas deficient or biased processing will lead to deviant behavior. Oppositional Defiant Disorder children are found to encode fewer cues, attribute hostile intentions to peers, generate fewer possible responses to situations, and they are more prone to engage in aggression and expect that it will come easily for them.

Parent Factors

All major psychological theories of the origin of conduct problems in children state that parent and family functioning play key etiological roles (Frick, Lahey, Loeber, Stouthamer-Loeber, Christ, & Hanson, 1992) in the development and maintenance of childhood and adolescent disorders like ODD. Parent skills deficits and parent psychological factors will be covered in this section.

Parent skills. Certain parental characteristics can have a negative impact on a child's behavior and effect quality of the relationship between the two . Harsh discipline and poor supervision were found to be related to ODD and CD symptoms (Atkins & McKay, 1996; Rey, 1993). Kronenberger and Meyer (1996) explained that harsh, physical punishment of children can cause anger, reduced attachment, and provide a model of aggression. This model of aggression can be seen where the child is rewarded for escalating behaviors until the parents give him/her what he/she wants; the child then learns to escalate the pattern of defiant, aggressive and destructive behavior in order to be rewarded and get his/her way. Reinforcement of oppositional behavior is achieved when the child gains attention and control as a result of this negative behavior. Symptoms of ODD are likely to continue if the child is receiving attention, control, and gratification as a result of the oppositional behavior.

There is also evidence that parents of noncompliant and defiant children have less effective problem-solving skills than parents of children who are not noncompliant and defiant, particularly when performing tasks that involve conflict. These parents are more likely to criticize, belittle, and blame their children in

conflict-resolution instead of accepting any responsibility and using problem-solving skills (Rey & Walter, 1999).

Rey and Plapp (1990) conducted a study with 490 adolescents to determine if there was a relationship between parenting style and the development of CD or ODD. The authors compared ratings on a self-report measure of perceived parenting (Parental Bonding Instrument) by "normal" adolescents and by adolescents with CD or ODD. It was found that adolescents diagnosed as having either ODD or CD reported more parental overprotectiveness and less parental caring than a normal control group.

Parent psychological factors. It has been said that families with children who have a diagnosis of ODD tend to reveal higher rates of parental depression, substance abuse, and Antisocial Personality Disorder (APD) than those families with other clinic-referred children (Kronenberger & Meyer, 1996). The level of maternal depression and maternal and paternal psychopathology (Antisocial Personality Disorder or criminality) are considered to be significantly associated with risk for childhood and adolescent oppositional and aggressive behavior and later teen delinquency (Barkley, Edwards, & Robin, 1999).

In a 3-year longitudinal study of 177 boys aged 7-12 years old, Frick, Lahey, Loeber, Stouthamer-Loeber, Christ, and Hanson (1992) examined the association between conduct problems in children, parental adjustment, and several dimensions of family functioning. The authors of this study failed to find a direct relation between parental depression and ODD. They suggested, instead, that parental depression was a characteristic of families of clinic-referred children in general and not specific to conduct problems.

They did find that families of children with ODD had a higher rate of parental substance abuse and APD than other clinic-referred children. This higher rate of parental substance abuse and APD was primarily due to the high rate found in the father and not the mother. Analyses were conducted to determine how the risk factors of having a biological parent with APD outside of the home and having a mother in the home with poor parenting behavior might interact with putting a child at risk for ODD or CD. The results suggested that the biological parent with APD outside the home poses the greatest risk. The importance of APD as a risk factor for ODD or CD suggests that future research should focus on understanding the link between parental APD and child ODD/CD, whether it is a psychosocial mechanism or genetic predisposition.

Treatment/Interventions

There are many treatment approaches or interventions used in working with children who are diagnosed with ODD, as well as in working with the parents/families of such children. This section will cover parent training, family therapy, medication, and hospitalization.

Parent Training

This section will cover the procedure of Parent Management Training (PMT), the parent training program developed by the Oregon Social Learning Center, and two studies. One evaluates the effectiveness of parent training through a Head Start program; the other evaluates through the use of the Behavior Management Flow Chart (BMFC).

Kazdin (1997) described Parent Management Training as a procedure used to train parents in how to help improve their child's disruptive behavior at home.

This approach is based on the view that defiance and noncompliance are inadvertently developed and/or maintained by maladaptive patterns of parent-child interactions. Treatment is conducted primarily with the parent(s) and lasts anywhere from 6-25 weeks depending on the severity of ODD. The parent(s) meet with the therapist who teaches them to use specific procedures to alter interactions with their child, to promote prosocial behavior, and to decrease deviant behavior by training the parents to identify, define, and observe problem behaviors in new ways. Some of the other parent training programs described in the literature will be covered here.

One of the most influential parent training programs was developed by Patterson and colleagues at the Oregon Social Learning Center (Webster-Stratton, 1993; Kronenberger & Meyer, 1996). This program was based on research indicating that oppositional and defiant behaviors are learned and maintained primarily through family interactions. Through the process of social learning within the family, the child is reinforced for escalating defiant, aggressive, and antisocial behaviors, which coerce parents into yielding to the child's demands. Behavioral change occurs when the coercive interchange is broken and the focus of family interaction changes from coercive, antisocial behavior to prosocial behavior, family communication, and mutual social problem solving. This is accomplished through a series of six steps: (a) psychoeducation on ODD concepts; (b) observation and monitoring of behaviors at home; (c) reinforcement of prosocial behavior; (d) discipline of unacceptable behavior; (e) supervision and monitoring of the child at all times; and (f) learning effective communication strategies (Kronenberger & Meyer, 1996).

One study (Webster-Stratton, 1998) focused on 394 mothers of Head Start preschool children. The purpose of this study was to evaluate a comprehensive, multifaceted theory-based prevention program. During the 8-9 week training program, parents were taught positive discipline strategies, effective parenting skills, and ways to strengthen their children's social skills and prosocial behavior through weekly parent meetings and viewing videotapes of modeled parenting skills. The results show that, whether parenting competencies were evaluated through parent self-reports of discipline technique, general parenting style, independent observers' general impressions of mother discipline style, or observations of discrete parenting behaviors and techniques, all forms of assessment showed significant short and long-term improvements in parenting competence among the intervention mothers. The mothers also demonstrated significantly fewer critical remarks and commands, less harsh discipline, and more positive remarks and competent behavior in their parenting when compared to control mothers. The children of the mothers involved in the intervention were observed to exhibit significantly fewer conduct problems, less noncompliance, less negative affect, and more positive affect than control children. Improvements were maintained at a one-year follow-up.

Danworth (1998) conducted a study on the outcome of parent training using the Behavior Management Flow Chart with 8 mother/child dyads. The purpose was to determine the effects of parent training on the mothers' behavior and on the oppositional behavior of their children. The BMFC is a flow chart based on the task analysis of the child behavior management steps that are taught to adults. The flow chart synthesizes the research into a cohesive unit that allows a clear-cut

portrayal of child behavior management steps. The primary target behavior of the BMFC is noncompliance. Multiple outcome measures suggested that training mothers of ADHD/ODD children according to the BMFC reduced children's oppositional behavior, improved parenting behavior, and reduced maternal stress. Parent ratings of child misconduct and direct observations at the 6-month follow-up were relatively stable.

Family Therapy

In general, family therapy helps parents learn why the child became oppositional through therapy sessions that include the child. Although there are several approaches to family therapy, they are all similar in that the problem is viewed as having been developed within the family and that the solution involves all the family members working together (Windell, 1996). Two types of family therapy, functional family therapy and family preservation services, will be discussed.

Functional family therapy. One form of family therapy is functional family therapy, which is based on a blend of strategic and behavioral theories. The purpose of functional family therapy is to reduce the child's defiance and noncompliance by increasing reciprocity and positive reinforcement among family members, fostering the establishment of clear communication, helping to clarify behaviors that family members desire from each other, and identifying solutions to interpersonal problems (Rey & Walter, 1999). Functional family therapists assume that most family behaviors are attempts to become more or less intimate and, through reframing, can help family members see each other's behaviors in a new

way. Families are also helped to set up contingency management programs to help them achieve the behavior changes more directly (Nichols & Schwartz, 1998).

Family preservation services. Family preservation services have been recommended by clinical child psychology and mental health services researchers as a desirable alternative to the use of restrictive and expensive placements of youths with behavioral and emotional problems. Family preservation is a 4 to 6 week model of service delivery through which a variety of counseling and concrete service interventions are implemented in the homes and communities of referred families such as skills-building techniques (e.g., parent-child conflict resolution and parent behavior management). Children are seen as better off being reared by their natural families. The family is seen as a source of strengths, and the objective is to empower the family to meet their needs in the future (Quay & Hogan, 1999).

Medication

There is a wide range of medications that include stimulants, antidepressants, antipsychotics, lithium, anticonvulsants, clonidine, benzodiazepines, and beta-blockers that have been used with children who have behavior problems (Rey & Walter, 1999). The effects of stimulants on children with ODD vary from significant improvement to no improvement at all. Thus, the overall benefit for stimulant medication is made on an individual basis (Kronenberger & Meyer, 1996).

Currently, the use of antidepressants in children is being investigated because there are few antidepressant medications for children that are FDA approved (Quay & Hogan, 1999). Because little is known about the treatment response for ODD to psychotropic agents Rey and Walter (1999) suggested that

medication in these patients should be used only in cases where there is a comorbid disorder that responds well to drug treatment. Overall, there is no one pharmacological treatment that is widely accepted for ODD. Based on each individual child's presentation, multiple medications can be used to treat severe symptoms (Kronenberger & Meyer, 1996).

Riley (1997) warned parents that it is unlikely for any medication to be developed that specifically treats oppositional behavior because it is not considered a disease and many insurance companies do not view it as a "real medical disorder." Thus, parents may be limited to behavioral interventions as the ones described earlier.

Inpatient Hospitalization

Some children's defiance and the impairment it causes, warrants more intensive interventions than parent training and family therapy. If children's behavior, safety, and psychological status are substantially deteriorating in the home environment, short-term inpatient or longer-term residential treatments should be considered. The most common are hospitalization, partial hospitalization (day treatment), and residential care.

Hospitalization. These settings provide the child the opportunity to be removed from the stresses of their environment and to implement a new behavioral plan in a safe milieu. These plans generally target compliance, following rules, and prosocial behaviors. They reward children's compliance through privileges, praise, and access to favored activities (Kronenberger & Meyer, 1996).

Other authors feel that there is no evidence that inpatient treatment is effective for children with ODD and it carries the risk of patients becoming

dependent on the institution, becoming accustomed to the "sick role," and possibly learning more dysfunctional coping styles or serious antisocial behaviors from other residents (Rey & Walter, 1999). Further, hospitalization should be reserved for cases of ODD where outpatient treatment has failed, problem behaviors escalated, a tense family situation needs to be defused, the family lives in a remote area with no access to mental health services, and there is a comorbid disorder which indicates inpatient treatment (Rey & Walter, 1999). Most often, a combination of treatment/interventions is the best approach (Barkley & Benton, 1998).

Day treatment. These programs provide an intensive outpatient experience lasting 5 to 8 hours a day, 5 days a week, where the child spends nights and weekends at home. Treatment includes education, activities, individual therapy, group therapy, family therapy, and behavior programs to encourage behavioral and psychological change. They are found to be effective in improving social skills, self-perceptions, and family functioning (Kronenberger & Meyer, 1996).

Residential treatment. Children and adolescents with the most severe ODD are sometimes placed in a residential treatment setting, where the child will reside there until treatment is completed. Settings with a therapeutic base may include components of cognitive-behavioral interventions and behavior-management programs (Kronenberger & Meyer, 1996).

There has been debate on the removal of children with ODD from their home environments. Removal of children from the home may harm already fragile attachment made with others. When placed in an environment where the only attachments to be made are with a predominantly antisocial subculture, this provides

a negative model and an education in antisocial behavior (Kronenberger & Meyer, 1996).

No matter what type of treatment or intervention is being used, it is important to consider the effects that socioeconomic disadvantage, marital discord, high parental stress, low social support, single parent families, harsh punishment practices, and parental antisocial behavior has on (a) who stays in treatment; (b) how much change there is among those who complete treatment; and (c) the extent to which change is maintained at follow-up (Kazdin, 1997).

Summary

Oppositional Defiant Disorder has gone through two revisions since its introduction in 1980 in the DSM-III. Despite all of the debate on whether ODD is simply a milder form of CD, it now stands separate from CD and is a widely accepted diagnosis of many children and adolescents by mental health professionals.

Evidence on differences between males and females remains minimal. However, ODD has been found to occur three times as often in males. Future studies should take into great consideration possible gender differences between males and females.

Oppositional Defiant Disorder also co-exists with many other psychiatric disorders, the most common one being Conduct Disorder. It is important to distinguish between the two diagnosis because the DSM-IV states that a diagnosis of CD takes precedence over ODD.

Causes of ODD range from child temperament, child cognitive and social skills deficits, parenting skills, and parent psychological factors. Treatment of

ODD can be found to target just the child (inpatient hospitalization and medication), just the parent(s) (Parent Management Training) or both (family therapy).

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