Oppositional Defiant Disorder Treatment and Best Practices – 2 hr.

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Learning Objectives

- List five diagnostic criteria for oppositional defiant disorder (ODD).
- Define the three components of oppositional defiant disorder.
- Identify two of the most common comorbid disorders.
- List three common risk factors in developing oppositional defiant disorder.
- Explain how genetics may play a role in the development of oppositional defiant disorder.
- Name three assessment tools used to diagnose ODD.
- List three evidence-based practices for treating ODD.
- Explain two ways parents give power away, according to strategic family therapy.
- Discuss four theoretical assumptions of solution focused therapy.
- List at least two tasks assigned in solution focused therapy.
- Outline the role of the reflection team.
- Identify the best treatment by age group for oppositional defiant disorder.

Brandon

Brandon is a fourteen-year-old boy who is in the seventh grade. He failed last year in school because he never completed his homework, argued with teachers, and received numerous in and out of school suspensions. Recently, Brandon was arrested for possession of marijuana while out with friends at a bowling alley. He routinely breaks property at home, sneaks out of the house at night, argues with his parents, and gets into fights with his peers in the neighborhood and at
school. Brandon’s parents took him to therapy and told the therapist that they have tried everything that they can think of to help him. For instance, they bought him an Xbox to encourage him to act appropriately. They hoped to use the video game console as leverage — something they could take away as punishment and use as a reward if he complied with the rules. When Brandon’s father took the Xbox from him after his arrest for marijuana possession, Brandon did not seem to care. Later that week, his father found that someone took the Xbox from the master bedroom and broke it. Brandon’s father accused Brandon who denied it and blamed it on his brother. Brandon recently discovered that another boy “ratted him out” and told the police officer that Brandon had marijuana at the bowling alley. When Brandon found out, he waited for the boy after school and beat him up.

**Brittany**

Brittany is a ten-year-old girl who argues constantly with her parents. She refuses to clean her room, she will not eat her dinner and cries and tantrums until her parents relent and cook her favorite food, pizza, for her every night. Brittany calls her mother and father names. She has extreme tantrums in which she throws objects, and screams at her parents that she hates them over simple requests, such as taking her turn at unloading the dishwasher. Her parents and younger sister feel as if they are “walking on eggshells” at home with her and have stopped asking her to do chores or go to bed at a set time in order to avoid conflict. However, at school, Brittany is a good student and her teachers praise her for being cooperative and well behaved.

**Cody**

Cody is a three-year-old boy who tantrums constantly and refuses to follow directions at home and in preschool. He is very defiant and stubborn. His mother is raising Cody alone, but she
struggles with a substance abuse issue and works a demanding job. Cody spends a great deal of his day in daycare and his mother is frustrated with his behaviors. She admitted to Cody’s family therapist that she never wanted to have a baby and that she feels very detached emotionally from Cody. Cody’s mother feels guilty about her feelings, so she buys Cody a lot of toys to “make up” for being gone a good deal and also because of her guilty feelings about not really wanting him.

In these vignettes, all three of these children have behavioral issues. It is hard to say just based upon the information given if these three are actually oppositional defiant. Brandon appears to be symptomatic of the three. Brandon exhibits behavioral issues at home, at school, and in the community. He engages in some criminal activity, violence towards others, and vindictive behaviors; shows immunity to normal forms of praise and punishment; and defies authority in many realms of life.

Brittany shows a milder form of oppositional defiant disorder in that she has issues only in one realm, which is at home. She does fine in school. It is possible that Brittany does not meet the criteria for oppositional defiant disorder and that, instead, there may be a parent-child relationship problem, or impaired parenting with her mother and father. However, in the milder forms of oppositional defiant disorder, it is not unusual to see a child do well at home, but constantly get in trouble at school, or vice versa.

Cody may be a young child with emerging oppositional defiant disorder, and he has problems at home and school. However, his mother is not well bonded with him and does not know how to provide structure and discipline. Cody may just be acting out in response to spending too much time away from a primary caregiver, as well as needing a caregiver who provides him with the warmth and consistency that he craves.
Oppositional defiant disorder is a common issue for which parents of children and adolescents seek help. The refusal to follow basic requests, the resistance to the usual rewards and praise to which other children respond, and the constant sense of walking on eggshells waiting for the next explosion, are all common feelings for parents of these children.

All children have difficult behaviors at times. Many children enter phases that are relatively short-lived in their lives, which can be difficult for them and for their caregivers, but these behaviors appear to be transitional stages and not long lasting. Sometimes, telling the difference between transitions and the actual diagnosis of oppositional defiant disorder can be difficult. As noted in the examples above, oppositional defiant disorder can consist of many different behaviors, which makes it harder to identify and diagnose than one would expect.

Any therapist or social worker who has worked with children and adolescents faces these situations of intense acting out, extreme frustrations on the part of parents who feel they have “tried everything,” as well as parents threatening to send these children to jail, to their grandparents, or to a residential treatment facility. Many of these children end up in the juvenile court system for being “ungovernable” or “unruly.” Oftentimes, their behavior can be truly shocking, with tales of oppositional defiant disorder children and teenagers hitting their parents, cursing at elderly relatives, throwing tantrums in which they destroy property that is precious to others, just to name a few examples. Some cases of oppositional defiant disorder are less dramatic, but they stress out parents and siblings greatly and lead everyone in the family to feel tense, unhappy, and on edge. Oftentimes, strangers and relatives alike will tell parents that the child “just needs a good spanking.” Other people give dirty looks or tell the parent something like, “I would never let my child speak to me that way!” Parents of oppositional defiant children are told by their own parents, “You would have never gotten away with that in my house! Send
them to me and I’ll straighten them out!” Comments like this leave parents feeling inadequate, guilty, frustrated, and powerless. Teachers and other authority figures feel angry, burned out, and frustrated in dealing with the demanding nature of these children and their refusal to comply with simple requests. Oftentimes, teachers and parents end up blaming each other for misbehavior, especially if the child only acts out at school.

This course examines what oppositional defiant disorder actually is and what it is not. It also explores the various dimensions of oppositional defiant disorder. Next, the course examines comorbid disorders and risk factors. Lastly, students will learn about the various evidence-based practices, as well as more traditional approaches to therapy.

**Diagnostic Criteria**

The Mayo Clinic notes the following in order for a child to meet the criteria for a diagnosis of oppositional defiant disorder, or ODD, “DSM-5 criteria for diagnosis of oppositional defiant disorder, show a pattern of behavior that:

- Includes at least four symptoms from any of these categories — angry and irritable mood; argumentative and defiant behavior; or vindictiveness.
- Occurs with at least one individual who is not a sibling.
- Causes significant problems at work, school, or home.
- Occurs on its own, rather than as part of the course of another mental health problem, such as a substance use disorder, depression, or bipolar disorder.
- Lasts at least six months.

DSM-5 criteria for diagnosis of oppositional defiant disorder includes both emotional and behavioral symptoms.
Angry and irritable mood involves someone who:

- Often loses their temper.
- Is often touchy or easily annoyed by others.
- Is often angry and resentful.

Argumentative and defiant behavior includes someone who often:

- Argues with adults or people in authority.
- Actively defies or refuses to comply with adults' requests or rules.
- Deliberately annoys people.
- Blames others for their mistakes or misbehavior.

Vindictiveness:

- Is often spiteful or vindictive.
- Has shown spiteful or vindictive behavior at least twice in the past six months.

These behaviors must be displayed more often than is typical for a child’s peers. For children younger than five years, the behavior must occur on most days for a period of at least six months. For individuals five years or older, the behavior must occur at least once a week for at least six months.

Oppositional defiant disorder can vary in severity:

- **Mild.** Symptoms occur only in one setting, such as only at home, school, work, or with peers.
- **Moderate.** Some symptoms occur in at least two settings.
- **Severe.** Some symptoms occur in three or more settings.
For some children, symptoms may first be seen only at home, but with time extend to other settings, such as school and with friends” (2015). Therefore, based upon the diagnostic criteria above, a child could exhibit these behaviors, but if a child has only been acting out for three months, the child would not meet the diagnostic criteria for oppositional defiant disorder.

One of the interesting issues in diagnosing oppositional defiant disorder is the reluctance of parents to see it as a true mental health disorder. Many parents see oppositional defiant disorder as a phase or just a lack of maturity (AACAP, 2012).

**Differential Diagnosis**

As with any psychiatric or emotional disorder, the diagnostic process for ODD is difficult. Oppositional defiant disorder can often be misdiagnosed. According to Linda Spiro, PsyD, some of the more common disorders that can be mistaken for oppositional defiant disorder include:

- **Anxiety:** When a child is anxious, the desire to get away from situations that provoke intense anxiety can cause a child to become oppositional. For example, a child who has severe anxiety about going to school may refuse to get up in the mornings, or refuse to get out of the car at school. When the anxiety is treated, these oppositional behaviors go away.

- **ADD:** Children who have attention deficit disorders (ADD) can act very impulsively and engage in behaviors that look oppositional on the surface, such as not staying in their seat at school. However, it is not so much deliberate defiance as it is the failure to understand how to delay gratification, and to understand how their behaviors affect others that are more of the issue with ADD.
• Learning Disorders

Some children with learning disorders may try to avoid being in a class that makes them feel inadequate and frustrated. They may refuse to go to class, or they may act disruptive in a class due to frustration. Again, this behavior can appear to be the result of oppositional defiant disorder, but it is more situational in nature.

Definitions of Oppositional Defiant Disorder

For many years, there has been controversy about what oppositional defiant disorder actually is and how common the disorder is. The prevalence of oppositional defiant disorder is hard to estimate. Quay (1999) attempted to review the body of literature on oppositional defiant disorder to come to a conclusion for this question. His comprehensive review indicated that the studies to date had so many inconsistencies in measurement and sample size that the prevalence of oppositional defiant disorder varied tremendously based upon many factors in each of the studies reviewed. The tools used to measure the disorder, whether it was parent- or child-reported behaviors, and how oppositional defiant disorder was defined all factored into the number of cases found in the general population. Such variability was also noted by different studies, such as Munkvold et al. (2009) who found in their study that 2 percent of boys and less than 1 percent of girls had oppositional defiant disorder, whereas others studies have shown rates of 3 percent for boys and 2 percent for girls (Costello et al, 2003). Other studies have indicated that as many as 20 percent of school-aged children have the disorder, but that estimate is called into question (U.S. National Library of Medicine, 2014).

Furthermore, there has always been controversy in behavioral health research over whether or not oppositional defiant disorder is the same as conduct disorder (Quay, 2013). Some
interesting findings from his review noted that while oppositional defiant disorder was not a great predictor of conduct disorder, some symptoms of conduct disorder were highly predictive of oppositional defiant disorder. These symptoms were cruelty to people, cruelty to animals, staying out late at night, and starting fights. However, after an exhaustive analysis of the literature, it was determined that while conduct disorder and oppositional defiant disorder did share some common symptoms, there was enough validity of difference in the two diagnoses to support the two distinct diagnoses. It is important to note, however, that some of the symptoms of both disorders are strongly age related. As Quay notes, a presubber is not going to commit crimes, such as armed robbery, breaking and entering a home, or use of weapons, and therefore, would not meet the criteria for a diagnosis of conduct disorder. However, despite some misgivings initially, Quay concluded that oppositional defiant disorder and conduct disorder were closely related, but separate disorders.

It interesting to note that despite the common factors in oppositional defiant disorder and conduct disorder, most children who have a diagnosis of oppositional defiant disorder do not go on to develop conduct disorder (Rowe, et al., 2002).

Many questions remain about the diagnosis of oppositional defiant disorder, but a few key themes have emerged over the years of research that has been carried out related to this disorder. In general: (a) there has been a pattern of oppositional defiant disorder across geographic regions and social constructs that show a cross-cultural pattern for this disorder, (b) those children diagnosed with oppositional defiant disorder tend to have more difficult adolescent years, and (c) there is a significantly increased risk of conduct disorder developing in those children and adolescents diagnosed with oppositional defiant disorder (Frick and Nigg, 2012). However, as
the authors point out, it is hard to know if a child is experiencing true oppositional defiant disorder or just a difficult period of adjustment in childhood or adolescence.

Frick and Nigg note:

As a result, it is not clear if oppositional defiant disorder is simply a nonspecific marker for problems in adjustment or if it is an indicator of a meaningful and unique clinical construct. In short, there are concerns that oppositional defiant disorder overpathologizes a normative behavior pattern and that, unless it is accompanied by another disorder (e.g., ADHD, CD), it is transient and benign and should not be considered as a separate disorder (p. 77).

Just as Quay (2013), concluded before them, the authors do note that despite some misgivings, there is empirical support that oppositional defiant disorder does exist as an independent diagnosis in some ways. They do note, however, a strong relationship between oppositional defiant disorder and conduct disorder. They elaborate on this by stating that the two disorders share many common risk factors. They also note that while significant numbers of children with oppositional defiant disorder do develop conduct disorder, many children do not go on to develop conduct disorder. Furthermore, they believe that the two disorders may be similar enough to have oppositional defiant disorder as a subtype of conduct disorder, in that children with oppositional defiant disorder are merely those who have a subtype of conduct disorder that is marked by issues with emotional regulation.

Frick and Nigg make a compelling argument that oppositional defiant disorder may not be a behavioral disorder, but rather an emotional disorder, citing that irritability and anger are more emotional issues and are two of the key symptoms of oppositional defiant disorder. They note
that the symptoms of oppositional defiant disorder have three dimensions: mood, defiant behavior, and vindictiveness, similar to the symptoms from the DSM-5 mentioned earlier.

Angry, irritable mood involves someone who:

- Loses their temper often.
- Is irritable.
- Is annoyed easily by others.

Defiance:

- Argues with authority figures.
- Defies requests from authority.
- Purposely annoys others.
- Blames others for own actions.

Vindictiveness:

- Seeks revenge and acts spiteful.

These clusters of symptoms are very highly correlated, meaning that if one group of symptoms exists, then the others are also likely to exist as well. However, it is interesting to note that the occurrence of being highly stubborn can be found without the anger and irritability, though it is rare to find the angry dimension of oppositional defiant disorder without the ensuing mood and anger problems as well. Other interesting findings were that the anger and irritability dimension appeared highly related to emotional issues later in life, the defiance dimension related strongly to ADD, and the spiteful and vindictive traits tended to relate to issues of callousness. However,
all three dimensions were highly related to developing conduct disorder in later life (Frick and Nigg, 2012).

Oftentimes, parents report that a child is well-behaved at home and only exhibits these behavioral traits at home. Other times, a child will behave at school and act out severely in the home. In order to be diagnosed with oppositional defiant disorder, a child does not have to display the behaviors in more than one setting. There is a growing concern among professionals in the field, however, that a child who only shows problems at home may not suffer from a true disorder, but instead may be in a situation with a parent that relates more to a parent-child relationship issue, or is dealing with a parent with their own emotional health issues. There is a valid concern that a child in one of these situations receives a mental health diagnosis when the real problem might only be situational in nature (Frick and Nigg, 2012). The DSM-5 does include pervasiveness of oppositional defiant disorder in more than one setting as a way to determine the severity level of the disorder. Indeed, Frick and Nigg note that pervasiveness across settings is also associated with more severe symptoms overall.

There is growing support for the idea that oppositional defiant disorder is more a problem of emotional issues than behavioral, as was mentioned in the Frick and Nigg study. Cavanagh (et al., 2014) determined based on their study of the underlying factors related to the disorder that while there was a pretty clear separation of conduct disorder and oppositional defiant disorder, there was not a clear separation of oppositional defiant disorder and emotional dysregulation. Copeland et al., (2009) found that adult depression was a frequent diagnosis for young adults who had oppositional defiant disorder as children. However, depression as a young adult was not associated in any significant way for those who were diagnosed with conduct disorder when they
were younger. This seems to lend further support to the idea that oppositional defiant disorder is an emotional issue, rather than a behavioral issue.

In addition, genetic studies have found links between those adolescents who report higher levels of irritability with their oppositional defiant disorders, and depression. Additionally, more headstrong and stubborn characteristics of oppositional defiant disorder link with adolescents who had genetic markers that also linked to delinquent behaviors (Stringaris et al., 2012).

**Comorbid Disorders**

Although oppositional defiant disorder can be mistaken for other disorders and vice versa, oftentimes, certain disorders can appear along with oppositional defiant disorder. In fact, about one-third of all children with ADD have a comorbid disorder of oppositional defiant disorder (Qian, Wang, Guan, and Faraone, 2009).

Oppositional defiant disorder is found to be comorbid with a number of other disorders, in particular, with depression. Copeland and his colleagues (2009) examined those with oppositional defiant disorder and discovered that having this disorder in childhood was a strong indicator of developing depression as a young adult.

Burke et al. (2005) did note linkages between oppositional defiant disorder and anxiety and depression, as well as with later diagnoses of conduct disorder, finding that oppositional defiant disorder is often comorbid with any of these diagnoses.

One of the more interesting findings about anxiety in relation to oppositional defiant disorder is that children tend to develop oppositional defiant disorder as a reaction to their already existing anxiety. Oppositional defiant disorder somehow helps these children cope with anxiety (AACAP, 2012).
ADD is the most common comorbid disorder for those with oppositional defiant disorder. Children with both of these disorders tend to have more difficult behaviors than those with just oppositional defiant disorders. These children tend to be more aggressive, have more problems in school and more family conflict.

**Risk factors.** There appear to be three general risk factors for the development of oppositional defiant disorder. According to the Mayo Clinic (2015), the three general factors include temperament, parenting issues, and other family issues. Temperament includes such things as a child who has problems with frustration or is naturally very reactive. Parenting issues can include parents who are abusive, inconsistent, or neglectful. Other issues in the family can include substance abuse or mental health problems with a parent.

Other studies have indicated somewhat similar risk factors. Boden, Ferguson, and Horwood (2010) identified some different risk factors from their review of the literature including maternal smoking during pregnancy and poverty, in addition to individual cognitive abilities, association with negative peer groups, parental mental illness, and family violence. They examined a cohort of children in New Zealand and determined in their sample that each of these predictors were significantly associated with the development of oppositional defiant disorder.

A study completed by Harvey, Metcalf, Herbert, and Fanton (2011) identified similar risk factors. Their study found that the factors of over-reactive parenting, marital conflict, maternal depression and lower socioeconomic status were all associated with higher rates of oppositional defiant disorder in later years.

One recent study was designed to identify early childhood risk factors associated with the development of oppositional defiant disorder in later childhood and adolescence. In general, it
was found that boys were at greater risk of developing oppositional defiant disorder when they came from families with higher levels of conflict and adversity. It also found that children who were rated as physically aggressive, hyperactive, and oppositional by their teachers, and who had mothers who scored lower on measures of warmth and control over their children, were significantly more likely to develop oppositional defiant disorder. These risk factors were identified as areas for intervention in order to hopefully prevent the development of full-blown oppositional defiant disorder (Tremblay, Duchesne, Vitaro, and Tremblay, 2013).

The American Academy of Child and Adolescent Psychiatry, or AACAP, (2012) also notes environmental factors, such as poor nutrition, exposure to environmental toxins, and having a mother who smoked while pregnant. External risk factors included were uninvolved parents, abuse, chaotic environments, poverty, and a lack of supervision.

Quy and Stringaris (2012) note several other risk factors that appear to play a role in the development of oppositional defiant disorder. They note in their literature review that negative peer influences play a role in the increased risk of developing oppositional defiant disorder; however, this relationship may be bidirectional. Other risk factors include the neighborhood in which a child lives, as poorer neighborhoods and more violent neighborhoods are associated with increased risk of developing oppositional defiant disorder.

Some research indicates that genetics plays a stronger role in the development of oppositional defiant disorder than was previously thought. In their literature review of the link between genetics and oppositional defiant disorder, Quy and Stringaris (2012) cite studies (Eaves et al., 1977) which indicate that as much as 50 percent of cases relate to genetic factors.
AACAP (2012) notes several biological risk factors for the development of oppositional defiant disorder, including parents with a history of oppositional defiant disorder, conduct disorder, or ADD; and parents with a mood disorder, such as depression or bipolar disorder.

Despite such studies, genetics are often not understood for the role that they play in disorders such as oppositional defiant disorder. And while genetics do play a role in the development of oppositional defiant disorder, it is only one part of the analysis of all the possible risk factors and should not be overrated as a risk factor. A recent study indicated that genetics are often overlooked, to some degree, as one such risk factor, but genetics intertwine in very complex ways with psychosocial factors in the development of any psychiatric disorder, including oppositional defiant disorder (Lavinge, et al., 2013).

The authors note the strong body of research with twins and the development of psychiatric disorders, such as depression, anxiety, and oppositional defiant disorder. They note that many previous studies have shown empirical support for the interaction of genetic factors and psychosocial factors. In particular, they cite the extensive literature review that examined the development of psychiatric diagnosis and the contextual risk factors that was completed by Smeekens, Riksen-Walraven, and van Bakel (2007), whom they note, “identified four domains of risk: (a) contextual characteristics (e.g., stress), (b) parental characteristics (e.g., psychopathology), (c) parenting (e.g., hostility), and (d) child characteristics (e.g., temperament)” (p. 558). The author noted that these risk factors do not just result in oppositional defiant disorder, but in other diagnoses such as depression and anxiety in children.

In this study, the authors looked at a sample of 796 children in preschool who were four years of age. They measured psychosocial risk factors such as: 1) socio-economic status, 2) life stress, 3) family conflict, 4) caregiver depression, 5) parental support and hostility, and 6) parent support
for scaffolding, or completing tasks. In addition, several scales were used to measure both external and internal symptoms in children, including depression, anxiety, and behavioral acting out. Specific genetic tests were also completed based upon previous research that suggested that certain genes were involved with tendencies towards depression, anxiety, and oppositional defiant disorder. The study found that there were common psychosocial contextual factors present for children who developed oppositional defiant disorder and other psychiatric issues, such as anxiety and depression. These factors were stress, family conflict, caretaker depression, and caretaker hostility. However, conflict and caregiver depression were really not associated specifically with oppositional defiant disorder, at least not in this study with certain genetic combinations.

Assessment

Assessing for oppositional defiant disorder is typically completed through psychosocial history, interviews, and assessment tools. Some of the more common assessment tools include:

- Conners Child Behavior Checklist (Conners & Barkley, 1985).
- The Eyberg Child Behavior Inventory (Eyerg & Robinson, 1983).
- The Behaviour Assessment for Children (BASC-3; Reynolds & Kamphaus, 2015).

All of these instruments have strengths and weaknesses. Typically, professionals may use more than one of these in assessment.
Treating Oppositional Defiant Disorder

There are many treatment options for oppositional defiant disorder. There is no “one size fits all.” Some of the more common interventions are based in the social learning theory and fall under the broad category of parent management training (PMT). Social learning theory and how to change learned behaviors is one of the classic interventions for the disorder. The idea behind these forms of intervention is that problems in how parents and children relate is at the root of the oppositional behavior. The behavioral patterns that parents and children engage in lead to the emergence of the oppositional behaviors and serve to maintain these same behaviors. The intervention of parent management training focuses on teaching parents to consistently reward positive behaviors, and to intervene appropriately with negative behaviors. The common approaches that are widely used include:

- The Incredible Years (Webster-Stratton, 1981). This approach has been used with parents and teachers. This video-based program consists of several weeks of groups with parents, and the videos show both positive and negative ways to deal with children’s behaviors. The topics include setting limits, rewards and praise for behaviors, and positive interactions in general with children.

- The 4 Rs and 2 Ss for Strengthening Families Program. This is a program identified as an evidence-based program by the Substance Abuse and Mental Health Services Administration (SAMHSA), which is designed for families with children between the ages of seven and eleven who have oppositional and defiant behaviors. The goals are noted as: “1) provide family time to develop and practice communication and togetherness, 2) reduce stigma of mental health issues by normalizing the family’s experience within a group, and 3) promote continued learning outside the group.”
The format uses a manual and is designed to work with groups of six to eight families that meet with a therapist for one hour per week and lasts a total of sixteen weeks. However, the program can be adapted for use with one family, or to be held over eight weeks with two-hour sessions. The four Rs are: responsibility, relationships, rules, and respectful communication. The two Ss are stress and social support.

In terms of outcomes, the children in the study experienced significant reductions in oppositional defiant behaviors as compared to a control group. The outcome studies included lower-income youths from the New York City metropolitan area.

- **Kids in Transition to School (KITS).** KITS is used in several school districts in Oregon primarily and was found to have significant impacts on disruptive behaviors and antisocial behaviors in kindergarten-aged children. The program intervenes with social skills and self-regulation, as well as early literacy skills. Children attend two sessions a week for eight weeks during the summer before school begins, and one time a week for eight weeks after school begins. There are a total of twelve parent workshops which parents attend weekly in the summer and then every other week in the fall. Outcome studies indicated that teachers found significantly less aggression and opposition in the children who participated in KITS compared to those who did not attend the program. The program also demonstrated effectiveness in improving parenting skills.

- **The Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC).** This program is designed to intervene with a wide range of behavioral and emotional problems. The program utilizes worksheets, assessment tools, and handouts and involves a Web-based component that allows
providers to track client progress electronically. The modules in the program can be changed around to best suit the needs of clients.

Recent studies indicate that the approach has significant impact on oppositional behaviors and antisocial behaviors.

Parent-Child Interaction Therapy (PCIT) is another approach that has been shown to be effective with young children who are oppositional defiant. PCIT uses weekly, one-hour sessions that are designed to assist parents to better manage their child’s oppositional behaviors. The first component of PCIT focuses on developing a nurturing and supportive environment for the parent and child. The second phase addresses behavior management. One of the unique features of PCIT is in session, the parent actually wears a hearing device that allows them to hear the therapist providing direction from the other side of a one-way mirror. The therapist can coach the parent in the moment, without being seen by the child.

Multi-systemic therapy (MST) is another approach that uses a community-based, rather than an office-based approach for treating oppositional defiant disorders. In this approach, a therapist usually receives a caseload of six to eight families. The therapists meets with child and family in their home for several hours per week. The intervention typically lasts three to five months. The child is also seen at school, and community partners, such as teachers, probation officers and others involved in the child’s life also participate in the process. The therapist is on call for the family when needed for crisis intervention (Society of Child and Adolescent Psychology, 2012).

Cognitive behavioral therapy (CBT) is also used to help children and adolescents with oppositional defiant disorder. In collaboration with a therapist, the client sets goals. Therapy is usually short-term and works on presenting problems in the here and now, rather than delving into the causes of the problems. In this approach, the client is empowered to be the expert on
their own life and to utilize the assistance of the therapist to guide them through the process of changing behaviors.

Numerous approaches to treating oppositional defiant disorder go beyond the more current, evidenced-based approaches. Some of the interventions are more global in their approach, drawing upon theoretical approaches and an eclectic approach to treatment. The outcomes are often, though not always, anecdotal in nature.

**Strategic Family Therapy**

One of the earliest attempts to work with behaviors related to oppositional defiant disorder was through the therapy model known as Strategic Family Therapy. Madanes in her classic 1981 book, *Strategic Family Therapy*, describes children with extremely oppositional behaviors and ways in which therapists may intervene with them. She explains that the families experiencing these types of situations with out-of-control children are in an incongruous hierarchy. She explains that children depend upon his or her parents. Children do not earn a living, pay bills, or take care of themselves. The parents earn the living and provide food and shelter to the child. The parents should be in charge by the very nature of their role. However, in families with oppositional children, the opposite has occurred. The dependent child has become the de facto ruler of the family, with the parents doing the child’s bidding. Madanes describes this imbalanced hierarchy further as paradoxical, “it is paradoxical to be in charge while simultaneously dominated by those over whom one has control,” (p. 123-124). She observes that two dominant hierarchies cannot exist within one hierarchical framework. She goes on to note that while some children dominate “benevolently” in which they may dominate a family because they have an illness, for example, but oppositional behavior is not benevolent. Over time, these
patterns become chronic. The goal of strategic therapy in these cases is to restore power to the parents.

Her approach emphasizes changing the statements that parents and children make to one another. Parents should use language that emphasizes that they are in control. They are coached to not use language that makes them sound weak, indecisive, or incompetent. Likewise, children are discouraged from using messages that sound as if they are in charge, and they are encouraged to use messages that emphasize their appropriate place in the hierarchy. Madanes notes three issues with appropriate parental communication and hierarchies:

- The parent does not feel that they are powerful enough or strong enough to hold a hierarchal position in the family.
- One parent feels that the other parent is not able to hold a position of power.
- The therapist is not qualified to lead the family through the necessary changes.

Madanes believes that parents disqualify themselves in several ways: First of all, parents often give away their power by turning it over to experts. Madanes states that in order to take back their power, the parents should be encouraged to lose jargon such as the terms “oppositional defiant disorder,” or “emotional problems.” Instead, these behaviors need to be renamed as solvable problems that parents can handle themselves, not as psychiatric disorders that only experts can handle. For example, instead of using diagnostic labels on acting out behaviors, behaviors are reframed as misbehavior, laziness, or childish. These new labels sound like problems that parents, rather than experts, can solve. Parents must learn to establish clear rules and enforce consistent and serious consequences.
Madanes notes that many of the parents in these situations with oppositional children do not know how to communicate clearly. For example, she notes that many parents cannot answer the question, “What are your expectations of your son?” They will instead state that it is a hard question, or one that requires a lot of thought to answer, or say that “it depends.” Madanes states that the therapist should not accept this type of vagueness. Therapists should steer the parents towards clear, firm expectations, reminding them of the goals of therapy. Madanes believes that parents act in a way she terms “ignorant,” but they are not at all ignorant. They feign ignorance in order to pass responsibility for setting rules and consequences off to others.

Madanes notes that therapists will have to guide some parents more directly than others. In setting expectations, the therapist can suggest simple, general expectations. She says that asking the parents directly about what time a child is to wake up in the morning is an example of a clear expectation that would pretty easily elicit feedback from the parents. Or asking if it is okay for them to engage in some outrageous behavior, such as breaking furniture, will at least start a conversation towards what is obviously not allowable and lead the way into those less outrageous behaviors and expectations.

Many parents will also state vague expectations, such as wanting their child to be a good or decent person. The job of the therapist is to elicit what parents mean by these vague statements. The therapist must also guard against doing the job for the parents and formulating the rules and consequences. The parents must be placed back into the position of expert. In addition, if the therapist continues to act as the power in the hierarchy, the child will continue to see the parents as weak and not in control, and in need of assistance from others to do their jobs as parents.

The second way parents give up power, according to Madanes, is to give the power to the child. Parents will often state things like they want what is best for their child, or they want their child
to be happy. Madanes emphasizes the parents need to understand that they know what is best and it is their job to set rules and expectations for the child, in order for the child to feel secure and function well. Oftentimes, getting the parents to form an alliance is difficult. The child will try to undermine the alliance by calling attention to himself. Madanes states it is the job of the therapist to intervene with the youth and not allow this to happen.

Madanes notes that one of the greatest dangers in these situations is the threat to kick the child out of the house. Parents may not see it, but in actuality putting the child out of the home gives the child the ultimate power. By expelling the child, the parents completely relinquish their authority over the child. Although parents rarely carry out such threats, Madanes finds that these threats undermine the therapy process and should not be allowed. She also notes that in some cases, the parents disagree over these expulsions, and one parent will threaten divorce if the other parent does not put the child out. Now the youth has the power to not only control the parents, but to split them apart. Madanes points out that these situations are some of the most dangerous in therapy with oppositional children and must stop in order for the parents to regain control over their family.

One of the more serious bids for power by a child is attempted or threatened suicide. Madanes notes that careful consideration must be undertaken in order to prevent a serious suicide attempt or an actual suicide. In some cases, the child may have to be hospitalized. In some cases, if the child does not really need to be hospitalized, the parents must undertake a twenty-four hour suicide watch. Madanes finds that these scenarios of twenty-four hours a day togetherness try the patience of most parents who are then exhausted enough to begin to undergo real changes.

Madanes also notes that the extended family can also cause problems in these cases, in that the extended family can be pulled in by the youth as allies who see things from the child’s
perspective and align with the child against his or her parents. In these scenarios, the extended family undermines the parents. Madanes finds this toxic to the hierarchical alliance and states it must stop in order for the parents to regain control.

The third scenario of parents giving up power is when one parent undermines the other. Madanes states that it is up to the therapist to emphasize that the past situation is gone and that therapy is a chance to start fresh with a new set of agreements and go forward. It is important for the therapist to deemphasize the mistakes of the past, when a parent was deemed incompetent or inadequate.

Madanes describes interventions that are somewhat radical at first glance, but do appear to work. She cites an example where the parents of a seventeen-year-old girl who was struggling with addiction came for therapy. The mother questioned the therapist’s credentials and training. The father was cooperative. The mother was concerned about how the daughter’s feelings might be hurt with all the new rules and consequences. The mother said the father did not understand their daughter, and that he was inadequate as a father. However, instead of attacking the mother, the therapist ignored the mother when she started to object to a rule the father had just agreed to, and stated how supportive the mother was of the idea. The mother did not object, but instead agreed that she was supportive of her husband and his idea for a rule.

Madanes also cautions therapists against being pulled into a parent’s complaints about the other. These complaints can take the form of suggesting the “incompetent” parent is having affairs, has engaged in criminal activities, or has a drug problem. Madanes states that if a therapist gives in to curiosity about these allegations, the therapist will lose sight of the problem with the child and start to align with the “competent” parent against the “incompetent” parent. Madanes suggests
that the therapist either completely ignore these allegations, or note again that the past is over, and the therapy is a chance to start fresh with a parental alliance to help their child.

The third way to give up parental power in the family hierarchy and avoid change is to question the competency of the therapist. Therapists may find themselves under scrutiny for their training, credentials, age, gender, etc. Parents will also point out what other experts have tried and how this directly conflicts with the suggestions given by the therapist. Madanes states that the therapist should emphasize to the parents that experts often disagree, but they should be encouraged to work with the therapist and give the new perspective a chance. Sometimes, getting the parents to agree to just stick with the therapist for a few months will help to get the parents to comply.

Other ways in which families try to disqualify the therapist include speaking loudly over the therapist and not listening when the therapist speaks. Family members may even walk out of the room or refuse to work with the therapist’s suggestions at all. Madanes states that the therapist must remain calm, firm, and continue to emphasize the goals of therapy to keep the family focused. Madanes notes, “The therapist should repeat his requests time and time again until he succeeds. A great many of the therapist’s tactics within this approach involves repetitiousness and tenacity” (p. 143).

Madanes does mention single parents in these therapeutic techniques. She states that if there is a supportive family member, such as a boyfriend or girlfriend, or a grandparent, the parent and therapist should utilize them. However, when the family is truly a single parent family, the therapist will have to take a more active and supportive role in the hierarchy.
Madanes notes that the goal is straightforward: parents set up the rules and expectations and the child obeys or faces concrete consequences. However, this path is often a twisting one, fraught with difficulties that a therapist must face in order to help families with an oppositional child.

As is the case with classic theories of family therapy, Madanes notes that the child’s acting out may actually be serving a purpose for the family system. A child may be acting out in an unconscious effort to bring his parents together over his behaviors. Oftentimes, in solving the real problem, such as in these cases, a troubled marriage, will lead to cessation of the acting out behaviors in the child.

**Solution-Focused Therapy**

Solution-focused therapy emphasizes changing the way traditional therapy has looked at emotional or behavioral problems. Instead of working on understanding the background of a problem, or the emotional purpose it has served, the therapist looks at the here and now and helps find solutions to the problem itself. Selekman (1993), in his classic article on working with oppositional adolescents, emphasizes seven theoretical assumptions in working with these cases.

1) Resistance is not a useful concept. Selekman, quoting the work of de Shazer (1984), notes that resistance assumes families do not want to change and that the therapist stands somehow outside of the system he or she is seeking to change. Selekman notes that the therapist must work to decode this “resistance” and understand that it is, in actuality, a form of cooperation, albeit one that the therapist has to figure out in order to join with the family and help them arrive at a solution. One of the key components of solution-focused therapy is to avoid “doing more of the same,” (p. 139). If a mother is pessimistic about her child’s
ability to do better, instead of just asking, why, he suggests instead to ask why things aren’t worse. This may seem counter-intuitive, but it begins to urge the parent to seek out what is actually going right and build upon these things. The so-called miracle question also elicits these type of responses. Therapists can ask the parent or child what things would look like if a miracle occurred. The client’s reply can hold some clues to what the family needs to work on and provide opportunities to form solutions.

2) Change is inevitable. Selckman notes that if the therapist expects change, it influences how the therapist deals with the client. If a therapist can emphasize to a family that change will happen and can happen, it also inspires them to work actively to bring about change, rather than having them dwell on the negatives and the pessimism that most problematic families may be feeling. The therapist emphasizes what is working, not what is negative. There is also an emphasis on solutions that could work, which again inspire hope about the possibility of change.

3) Only a small change is necessary. Therapists can feel overwhelmed, just like families do. If the therapist and parents attack everything at once, it can be overwhelming. Instead, therapists should break the problem down into achievable goals. For example, rather than solving an adolescent’s rule breaking, failing in school, and poor hygiene issues all at once, therapists can identify a simple goal for change. The therapist can ask the parent, “what will a small sign of progress look like in the next week?” This can give rise to a solution to a small issue that, if solved, can be built upon for greater successes of bigger issues. If change
occurs, even in a small area, it will give hope to the family that bigger changes can also happen.

4) Clients have the strengths and resources to change. The family may feel hopeless and overwhelmed, but all families do have the ability to make changes. However, if the therapist focuses on the problems, the families will not feel capable of making changes. Creative solutions can help. Selekman describes utilizing a difficult teenage client in the therapeutic process by asking her, “If I were to work with a teenager just like you, what advice would you give me as a counselor to help her out?” (p. 140). He notes that this increases cooperation most of the time.

5) Problems are unsuccessful attempts to resolve difficulties. Family members become stuck in their unhealthy interactions and view each other in rigid ways over time. When a parent over functions for an irresponsible child, the child will behave more irresponsibly. Doing “more of the same” maintains the problem, though initially it was seen as a solution in the heat of the moment.

6) You do not need to know a great deal about the problem in order to solve it. Selekman notes that every problem has times when it does not occur. It is important to build upon the strengths that are taking place in these non-problematic situations. The therapist should always assume that there are non-problematic situations and elicit responses about them. This type of language assumes changes are occurring and that the family already possesses the strengths needed to solve the problem.
7) Multiple perspectives. There are numerous ways to look at any problem. Working on helping the family reframe problems can help them break the patterns that maintain the problem.

Selekman also describes solution-focused interventions when working with oppositional adolescents.

1) Purposeful systemic interviewing. The “miracle” question is one of the mainstays of this approach. Based on the work of de Shazer (1981) therapists ask this question to elicit the possibility of change and determine what it would look like. The therapist says to the family, “Suppose the four of you go home tonight and while you are asleep, a miracle happens and your problem is solved. How you will be able to tell a miracle must have happened the next morning?” (p. 142). These questions help set goals and provide focus during the therapy process.

2) Formula first-session task. This task is used for those clients who present with vague complaints. The directive is given at the end of the first session: “Between now and the next time we meet, I would like you to observe, so that you can describe to me the next time, what happens in your family that you want to continue to have happen (de Shazer, 1985, p. 137).

3) Observation tasks. With parents who are overinvolved, and particularly those who are over reactive, therapists ask them to observe signs of progress in the adolescent’s behavior. This observation often works to distance parents from their child’s behaviors, and this distancing can actually help bring about change. It also helps parents to see times when things are going well, which again reinforces to them that change can occur and is occurring.
4) Do something different task. Therapists ask parents to stop doing “more of the same.”

Therapists ask the parents to come up with novel, creative, even crazy responses to their child’s behaviors. Instead of nagging a child to get ready for school, for example, a parent may instead start dancing.

Selekman encourages therapists to approach their cases with “passion, spontaneity, and a playful use of humorous elements of the client’s story. Therapist creativity can only flow smoothly when we let go of our preoccupations with adhering religiously to our therapy model rules and our need to be technically precise,” (p. 144).

Selekman also encourages the therapist to externalize the problem. It is essential for the therapist to take the problem or behavior away from the idea that the identified client, in this case the adolescent, is the problem. Instead, the problem is seen as an external oppressor. He encourages the use of certain questions to externalize problem. For example, the therapist may ask, “How long has the depression been pushing all of you around?” The therapist may ask the adolescent, “When the depression is trying to get the best of you, what kind of things do your parents do to help you stand up to it?” (p. 145).

Selekman notes a case example of a client named Randy, who had just been released from juvenile detention. Selekman demonstrates some of his techniques here, with Mary (Randy’s mother), Randy, and the therapist taking part with Selekman’s observations in brackets:

“Therapist: Since Randy got of juvie, what have you noticed that is better?”

Mary: Everything has been great! He’s been going to school and following my rules. He’s not smoking that marijuana stuff. It’s like he’s another person.
Therapist: Wow! How did you get him to do all of those great things? [Here I am cheerleading to make those exceptions newsworthy. “How” questions are good for having family members compliment themselves on their resourcefulness].

Mary: Well, I told him when I picked him up at the juvenile center that I’m not going to put up with his nonsense anymore, and from now on he’s going to live by my rules or go to live with his alcoholic father.

Therapist: Have you been eating your spinach lately? Let me see your biceps. [I get up and feel her right bicep. Randy and Mary laugh. This is an example of my improvisational therapeutic style. I had this image of Popeye the Sailor Man flash into my mind while Mary was telling me about how she has gotten tougher as a parent. My humorous comments and actions serve to empower the mother as a parent].

Therapist: Randy, how were you able to do all of those great things after getting out of the juvie?

Randy: Well…I guess I really didn’t like that place and I had lots of time to think about things in there.

Therapist: What kind of things did you think about or tell yourself that made you decide “I’m going to turn things around when I get out of this place?” [Here I am utilizing a “unique account” question to have Randy ascribe meaning to what paved the way for him to embark on a new direction in life after getting out of juvie].

Randy: I thought about how I don’t belong in here. It’s crazy in there man…all of the fights and shit, gangbangers…Man, I’m just glad to be out of that place.
Therapist: What kind of things did you tell yourself in the juvie that made you decide “I’m going to be a different person when I get out”? [I decided to paraphrase my earlier “unique account” question, hoping that Randy would be more specific about the shift in his thinking regarding the new person he wanted to become after getting out of the center.]

Randy: I told myself, “I can do better than ending up in places like this”; “I have to stop smoking reefer”; “I need to stop cutting school”; “I gotta listen to my mom.” Things like that, man.

Mary: Wow! It sounds like you were really doing some heavy soul-searching in there. I’ve noticed that he’s really trying this time.

Therapist: How else is he showing you that he’s really trying this time? [Here I am utilizing Mary’s language to further elicit exception material. I am also keeping the “change talk” going in our therapeutic conversation.]

Mary: Well, he’s been really helpful around the house. I haven’t seen him running with those “druggy” type kids he used to run around with. I haven’t found any strange radios or bicycles hidden in the basement, like I used to.

Therapist: That’s great! What are you doing differently around Randy now, as opposed to before he went to juvenile detention? [Besides cheerleading to further reinforce Randy’s changes and Mary’s awareness of them, I am attempting to make a distinction between mother’s old parenting style and what she is now doing differently that is working for her.]

Mary: Well, I am staying on top of him and not backing down anymore. I’ve told him that I’m proud of him on good days, but there are still days when he’s his old lazy self, where he…
Therapist: How did you come up with those great ideals? [Most therapists would be tempted to inquire about Randy’s bad days when he’s “his old lazy self.” However, I feel that it is more helpful to the family to keep the focus on what is working. I ask a “how” question to amplify the mother’s resourcefulness and to return us to our “change talk” conversation.]

Mary: Well, I think he responds better when I don’t let him slide with things. Before, he could get away with a lot of things. The praise idea comes from how I’ve thought for a long time that he’s got low self-esteem. His alcoholic father used to always put him down.

Therapist: What else will you have to continue to do around Randy to keep these great things happening? [My use of the “how” question effectively returns us to “change talk” and elicits evidence of Mary’s parental resourcefulness and wisdom.] (p. 147-149).

The session goes on at length, but the above section serves to illustrate some of the techniques in action.

Selekman also illustrates other techniques of solution-focused therapy in another book, Solution Focused Therapy with Children (1997). In working with oppositional children, Selekman recommends the use of positive consequences. Selekman notes that many parents use punitive consequences for negative behaviors that have no relation to the behaviors demonstrated by the child. For example, taking away a child’s electronic games or music players for refusing to do chores is not recommended. Instead, positive consequences for misbehavior should be used. An example of positive consequences would be to have a child who refuses to clean his room go and mow a neighbor’s lawn for free, or have to help his father with chores around the house on Saturday. These consequences teach responsibility and increase a child’s self-worth. Selekman cites the example of Jimmy, an oppositional child whose parents were highly frustrated and
angry with him. They had tried yelling at him, taking away toys, and making him stay in the house instead of playing with friends. When using the suggested positive consequences, his parents felt that there was finally improvement in his behaviors. When he talked back for example, he was required to do laundry. When he refused to clean his room, he had to clean the yard.

Selekman also highly recommends the use of the reflecting team. For many families who become stuck in old patterns and with whom a therapist is not feeling any progress, the idea of using a team of other therapists to observe and give input often helps. It can provide alternative explanations for a problem. It helps the family to see that their story is not absolute and final, but is fluid and changing.Selekman notes that a one-way mirror can be used, or video systems. Or if these systems are not available, another therapist can sit in the room. He makes the following suggestions for the reflecting process, paraphrased below:

1) Being reflections with qualifiers, such as “I wonder” or “Sometimes.”
2) Do not overwhelm the family with too many ideas at one time.
3) Do not pressure the team to come to a consensus.
4) Reflections should be concise; they should not go on and on.
5) Negative phrases or terms which pathologize the family should not be used.
6) Do not reframe situations as “positive” too much. This can be interpreted as sarcastic or as minimizing the problem.
7) Ask questions about what may be kept secret. The therapist can ask if anything has not been shared or said.
8) Reflections should not be either too much like the family’s own observations, or so radically different that the family feels no connection to the reflection as it relates to their own story.

The reflecting team has advantages for both the therapist and for the family. It offers new perspectives and pathways to progress. Selekman credits reflecting teams for helping him become unstuck with certain difficult cases.

Selekman also discusses the concept of “wu wei,” a Chinese philosophy term that means non-doing or inaction. He notes that at times, by working too hard in therapy with oppositional clients in particular, the therapist is perpetuating the patterns that parents have already engaged in and that did not worked. He was as a therapist, doing exactly what he told the parent not to, which was more of the same. He cites the example of a mother, Charlotte, who was married to an alcoholic with whom she had three children. Charlotte was concerned that her children needed to talk about their feelings, especially how they felt about having an alcoholic father. She pressured her children to talk about their feelings, and the more she did this, the more they clammed up and retreated. In therapy, initially Selekman followed her lead and was too preoccupied with setting goals and making progress. Using the principle of wu wei, he followed the children’s lead and asked them open-ended questions and allowed them to set the lead of the sessions. Over time, the children began to spontaneously discuss their feelings about their father without being pressured.

**Behavior Modification**

Watchel (2004) wrote one of the more comprehensive books in helping children with behavioral and emotional problems entitled, *Helping Troubled Children and their Families*. Watchel built upon the psychodynamic and systemic theories of such pioneers of family therapy as Jay Haley...
and Salvador Minuchin. She acknowledges, as did the Madanes book previously explored in the Strategic Family Therapy section, that children’s behaviors often reflect the status of the marital dyad, while also suggesting that more concrete forms of intervention were needed for many families. Watchel encouraged therapists to be more hands on and directive with parents, stating,

“Rather than experiencing me as ‘expert’ and themselves as ‘inadequate,’” parents’ sense of competence and empowerment actually increases when I work with them on concrete and specific ways they can influence their children in more positive directions. Children, too, are empowered by some direct behavioral work. A child, for instance, who is given some cognitive strategies for impulse control or who rehearses better social skills ultimately feels stronger and more in control of his own life,” (p. 200).

Watchel encourages the therapist to gather comprehensive information before working in therapy with them. She suggests:

- Detailed questioning. It is vital that the therapist gather information on the events leading up to negative behaviors and their aftermath. It highlights such issues as control, overprotectiveness, or harshness that may make the situation worse. In addition, it is often helpful to get input from others, such as teachers to get detailed descriptions of behaviors of the child.

- Getting the child’s perspective: Oftentimes, parents may punish a child, but not understand how the child views the punishment. Watchel gives the example of sending a child to her room for misbehaving. The parent felt as if they had punished the child. To the child, being sent to her room meant very little, and she saw the situation as her parents not doing anything in response to her misbehavior. So while parents may think
their punishments are effective, in reality, they are not, because the child interprets their actions differently.

- Family dramatization: This is another technique for assessment suggested by Watchel. The family may recreate scenarios in which a child was oppositional, for example. Using this technique, the therapist can gain a better perspective on the situation, especially as family members tend to get into the dramatization and give explanations and feedback.

- Direct observation is also vital. Watchel encourages the therapist to watch not just what is said, but body language and facial expressions. She noted in one example that the parents were worried about their daughter’s poor social skills. However, in the session, when the child communicated with her father with her back turned to him, the father said nothing about it and continued to act as if she were facing him. Watchel was prompted by this display of nonverbal communication to point out how reinforcing this was to the child’s poor social skills. The parents had not thought of it in that way before.

Watchel outlines the strategy for behavioral modification.

- Watchel encourages the use of selecting target behaviors. She encourages the parents to pick one or two in order to avoid becoming overwhelmed by the process. In extremely conflicted couples, she acknowledges that this can be difficult. At times when parents cannot agree on anything, she suggests that behavioral approaches not be used. Even with divorced parents, she suggests getting them to agree on some target behaviors. She notes that it is important to specify goals. Stating that a child needs to cooperate more is ineffective. The parents need to state what this means, such as doing homework, or completing chores without being asked three times to do so.
• Reinforcing positive behaviors is also vital. She notes that most parents do feel more comfortable with giving rewards than with giving out punishments. One key component to this reinforcement that parents often overlook is that while it is important to reward positive behaviors, such as not talking back, it is also very important that a parent not reinforce negative behaviors, such as giving excessive attention to a child for whining. Many parents also need to learn to reward shaping, small steps in the right direction. When these steps towards positive change are ignored, they cease to continue. Learning to recognize and reinforce these incremental steps is hard for some parents. Charts work well with children, and younger children in particular tend to respond to gold stars, stickers, and the like.

Parents are not without resistance at times. Some parents do not want to reward children for things they are supposed to do, expressing that it is bribery and that the children are blackmailing them. For some parents, verbal reinforcement and hugs may be all they feel comfortable with in terms of rewards for some naturally occurring or expected behaviors.

She also does not advise losing points. She believes that parents should deal with misbehaviors separately, and only the targeted behaviors should be dealt with through the reward system.

Special Considerations: Preschool Children

Oppositional defiant disorder can have some issues when it is present in very young children. Rockhill, Collett, McClellan and Spelz (2006) note that some of what may be considered oppositional and defiant behaviors in very young children is also normative behavior for that population. Tantrums, stubbornness, and irritability are all normal developmental behaviors in
two and three year olds. However, the idea that oppositional defiant disorder is not relevant for this population is incorrect. Many children who are diagnosed with the disorder during the preschool years show persistent problems with oppositional defiant disorders into the elementary and middle school years. According to AACAP (2012), children who are diagnosed with oppositional defiant disorder while still in preschool have more issues in adolescence with the disorder than those who are diagnosed later in life. Furthermore, children who are diagnosed with oppositional defiant disorder in preschool are three times more likely to later develop conduct disorder, as compared to children who are diagnosed with oppositional defiant disorder in later childhood.

In general, just as with older children, comorbid disorders are common, and typically include ADD, depression, and anxiety.

Diagnosing oppositional defiant disorder in this population is somewhat more difficult than doing so with older children. The CBCL is often used during structured interviews and observations.

Treating oppositional defiant disorders in the preschool population is often accomplished through the use of PCIT and the Incredible Years programs that were detailed in previous sections. An emerging treatment for this population is collaborative problem solving, or CPS (Greene, Ablon and Goring, 2003). This model uses psychoeducation for parents, and there is a strong focus on the antecedents of behavior issues. Parents are also encouraged to develop three layers of expectations. The first group includes those that are non-negotiable. The second group includes expectations that have some flexibility, and the third group includes those that the parents are willing to let go of in the present time.
Rockhill et al., also discussed the various psychodynamic approaches in the early childhood approaches to therapy. In these therapies, such as object relations therapy and attachment theory, the child considered the patient, per se. Rather, the relationship between the parent and child is considered the “patient.” In these perspectives, the acting out behavior of the child relates to some disruption in the relationship between the parent and child. These interventions focus on restoring the health of the child’s relationship with the parents in order to bring about relief of the issues with behaviors.

Group interventions can also help when working with young children. Head Start, for example, has shown to reduce the risk of delinquent behaviors in later life. The program provides parent education, as well as educational interventions with children at risk of developing such behavioral issues as oppositional defiant disorder, due to their living in low socioeconomic environments. The home visitation component of the program has shown to reduce oppositional defiant disorder in preschoolers (AACAP, 2012).

**Middle School Children and Adolescents**

Research has demonstrated that for middle-school-aged children, the best approach to treating oppositional defiant disorder is to engage the child in school-based programs, individual therapy, and parent training. For older adolescents, more favorable outcomes were achieved with a combination of parent training and individual therapy for the adolescent (AACAP, 2012).

**Medication**

According to many sources, including John Hopkins Medicine, medication is not a course of treatment for oppositional defiant disorder. Common comorbid conditions with the disorder include depression, anxiety, and ADD, which may be treated with medication. However, in cases
of severe aggression associated with oppositional defiant disorder, risperidone and quetiapine are proven effective in controlling aggression. However, the side effects of both drugs can be severe in some people, and risperidone in particular can lead to dramatic weight gain. The researchers noted that the prescribing of these drugs, termed atypical antipsychotics, is on the rise. The researchers raised concerns about the long-term safety of overprescribing these medications that warrant further research. (Loy, Merry, Hetrick and Stasiak, 2012).

**What Does Not Work**

Many so-called therapy approaches to oppositional defiant disorder have proven ineffective, although they may show short-lived improvement. These types of approaches include tough love, or boot camps, and may actually lead to more problems in the long run, as they potentially reinforce oppositional defiant disorders (AACAP, 2012).

**Outcomes**

With the frustrations present with this disorder, it may seem at times that there is little hope of improvement. However, this is not the case. Studies have shown that 67 percent of children diagnosed with the disorder who received treatment were doing well at follow-up three years later. However, one-third of all those with oppositional defiant disorder go on to develop conduct disorder (AACAP, 2012).

There is no perfect approach for the treatment of oppositional defiant disorder. While some parents have found help for their children from strategic family therapy, others who received this intervention showed no signs of improvement. MST has proven very effective with some families, but with others, it does not result in improvements in a child’s oppositional defiant disorder. A family may try several therapists and different approaches before finding an
approach that helps with this disorder. However, seeking a quick fix is not a realistic approach to therapy for oppositional defiant disorder. Families receiving help must prepare for many months of therapy and a serious commitment to the process.

REFERENCES


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Oppositional Defiant Disorder Treatment and Best Practices – 2 hr.

Exam

1. The following items are not part of the diagnostic criteria for oppositional defiant disorder ______.
   a. Often argues.
   b. Often loses tempers.
   c. Is angry and resentful.
   d. Harms animals.

2. There has always been controversy in behavioral health research over whether or not oppositional defiant disorder is the same as ______ (Quay, 2013).
   a. General anxiety disorder.
   b. Malingering.
   c. Bipolar disorder.
   d. Conduct disorder.

3. According to Shapiro, the following is a common comorbid disorder with oppositional defiant disorder ______.
   a. Bipolar disorder.
   b. ADHD.
   c. Antisocial personality disorder.
   d. Malingering.

4. According to Frick and Nigg, deliberately annoying others, and arguing with authority figures is part of ______.
   a. Defiance.
   b. ADHD.
   c. Angry, irritable mood.
   d. Vindictiveness.

5. Which of the following is a risk factor in the development of oppositional defiant disorder?
   a. Maternal smoking.
   b. Obesity.
   c. Mother is schizophrenic.
   d. Father in prison.
6. Uninvolved parents, abuse, chaotic environments, poverty, and lack of supervision are all examples of _____.
   a. Risk factors for oppositional defiant disorder.
   b. Economic repression.
   c. Causes of ADD.
   d. Risk factors for developing ODD.

7. AACAP (2012) notes several biological risk factors for the development of oppositional defiant disorder, including parents with a history of oppositional defiant disorder, conduct disorder, or ADD; and parents with a (an) _______________.
   a. Addiction.
   b. Tendency to move often.
   c. Mood disorder, such as depression or bipolar disorder.
   d. Lengthy criminal history.

8. The Incredible Years is _____.
   a. An approach to dealing with behaviors.
   b. A college course.
   c. A Webinar.
   d. Novel for adolescents.

9. PCIT is designed for treating _____.
   a. Adolescents.
   b. Substance abusers.
   c. Young children.
   d. Bipolar disorders.

10. Madanes notes that one of the greatest dangers in ODD is the threat to _____.
    a. Kick the child out of the house.
    b. Hospitalize the child.
    c. Take away privileges.
    d. Send the child to bed without dinner.
11. Questioning the therapist’s competence is one way that parents _____.
   a. Act out.
   c. Give away their power.
   d. Feel superior.

12. Solution-focused therapy emphasizes that the therapist looks at the __________ to help find solutions to the problem itself, instead of working on understanding the background of a problem.
   a. Past tantrum pattern.
   b. Here and now.
   c. Goals of the child.
   d. Family dynamic.

13. Change is ____ according to Seleman,
   a. Inevitable.
   b. Unsafe in early therapy.
   c. Always a good thing.
   d. Always desired by a family.

14. Problems are ______ attempts to resolve difficulties.
   a. Always.
   b. Unsuccessful.
   c. Half-hearted.
   d. Incomplete.

15. The idea that you don’t need to know a great deal about a problem to solve it is _____.
   a. Theoretical assumption.
   b. De Shazer’s quote.
   c. False.
   d. From strategic therapy.

16. Externalizing the problem is an idea from ________ therapy.
   a. Play.
   b. CBT.
   c. Solution-focused.
   d. Psychodynamic.
17. A reflecting team should _____.
   a. Bombard a family with ideas
   b. Present a very similar story as that of the client.
   c. Be lengthy
   d. Begin with phrases like “I wonder”

18. Wu wei means ___________.
   a. Inaction.
   b. Do more of the same.
   c. Work harder.
   d. Be kind.

19. Family dramatizations are used by _____.
   a. Watchel.
   b. Madanes.
   c. de Shazer.
   d. Selekman.

20. The following is an example given by Watchel regarding parents unintentionally reinforcing negative behaviors _____.
   a. Paying too much attention to whining.
   b. Zero praise.
   c. Overpraising.
   d. Collaboration.

21. Watchel believes that parents should deal with misbehaviors ________, and only the targeted behaviors should be dealt with through the reward system.
   a. All at once.
   b. After they have cooled down.
   c. Separately.
   d. By grounding the child to his room.
22. For middle schoolers, ________ is best used along with individual therapy and parent training.
   a. A school-based approach.
   b. Medication.
   c. A spanking.
   d. Group therapy.

23. Home visits with Head Start have been shown to reduce _____.
   a. Oppositional defiant disorder.
   b. Child abuse.
   c. Illiteracy.
   d. Bedwetting.

24. Risperidone and quetiapine have been shown to be effective in controlling ________.
   a. Bipolar disorder.
   b. Aggression.
   c. Oppositional defiant disorder.
   d. Anxiety.

25. About one-third of those with oppositional defiant disorder will develop ________.
   a. Conduct disorder.
   b. Bipolar disorder.
   c. ADD.
   d. Depression.