Oppositional Defiant Disorder

Emily J. Rowe

University of Northern British Columbia

EDUC 635: Educating Exceptional Students

Dr. Andrew Kitchenham

December 1st, 2022

# Oppositional Defiant Disorder (ODD)

Children with oppositional defiant disorder (ODD) are categorized as having a behavioural disorder that can present itself in many ways depending on severity. Children often struggle with authority, rules, and emotional regulation problems (Winzer, 2008). The classification of behavioural disorders is extensive, and ODD is no different. Winzer (2008) explained that children are diagnosed using the DSM-5 but can be classified further by severity, dimension, type, and age of onset. ODD is often comorbid with other disabilities such as anxiety, depression, conduct disorder and most commonly, attention-deficit hyperactivity disorder (ADHD) (Veenman et al., 2018). Children with ODD have a higher chance of developing further emotional-regulation disorders later in life, as well as more severe mental disabilities such as conduct disorder, which involves more serious behaviour including physical aggression (Evans et al., 2015). Here we will explore oppositional defiant disorder more in-depth highlighting the symptoms, prevalence, strategies to support these learners and lastly, a dive into research regarding ODD in the classroom.

# Characteristics of ODD

The DSM-5 is widely used across the world to diagnose mental disorders of all kinds. For the validity and reliability of the diagnosis, all children who are suspected to have oppositional defiant disorder should be seen by a mental health medical professional with the appropriate credentials to assess these types of disorders (BC Children’s Hospital, 2022). Self-diagnosing or parental diagnosis can lead to issues regarding over-diagnosis or misdiagnosis with the potential to create unhelpful support plans, use incorrect medication or overlook a different medical condition (Molineux & Henderson, 2022).

## Symptoms

Oppositional defiant disorder is defined as having an angry or irritable mood, as well as argumentative or defiant behaviour while demonstrating vindictive tendencies for a minimum of six months. One must demonstrate four of the 8 symptoms listed below and the interactions must be with someone who is not a sibling (DSM-5, 2014).

***Angry/Irritable Mood***

1. Loses temper.
2. Touchy or easily annoyed.
3. Angry and resentful.

***Argumentative/Defiant Behaviour***

1. Argues with authority or for children, with adults.
2. Defies or refuses to comply with requests or rules.
3. Deliberately annoys others.
4. Blames others for their mistakes or misbehaviour.

***Vindictiveness***

1. Within the last six months, they have been spiteful or vindictive at least twice.

 Depending on the age of the child influences the diagnosis. If a child is younger than five years old, then the behaviour(s) should occur several days a week. However, for a child that is older than five, the behaviour(s) should occur at least once per week. The behaviour also needs to be developmentally appropriate and reflect the situation. For example, if a child is defiant because they did not receive enough sleep the night before then this would not be considered a symptom of ODD as it is situational. The diagnosis should also consider the child’s “normal” lifestyle such as family life, ethnicity, culture, and gender.

 Further analysis should observe whether the behaviour(s) are affecting the child’s life in a negative way and in what contexts. To receive a diagnosis the behaviour(s) should influence their overall functioning at home, school or with their peers. As well, the behaviour(s) cannot be attributed to another disorder or disability and should not be related to substance use (DSM-5, 2014).

 Lastly, once diagnosed, a classification of severity is made based on where the behaviour(s) are impacting the child. A mild severity would be demonstrating symptoms in one setting, meaning at home, school, work or with peers. A moderate severity would be the demonstration of symptoms in at least two settings and a severe classification is the presentation of symptoms in three or more settings (DSM-5, 2014).

**Comorbidity**

 Oppositional defiant disorder can be comorbid with other mental disabilities. It is not uncommon for a child to also have conduct disorder, which is a more intense behavioural disorder that can involve physical aggression (Winzer, 2008). It is also possible for ODD to develop into conduct disorder if left untreated. Symptoms can increase or become worse making the child more deviant and prone to physical aggression. The most common mental disorder to partner with ODD is attention-deficit hyperactivity disorder (ADHD), which has shown comorbidity rates between 25% to 50% (von Gontard et al., 2015). It has also been found that ODD can be a precursor for depression and anxiety, as well as substance abuse (Calub et al., 2020; Ding et al., 2020).

**Diagnosis**

 The diagnosis of ODD can be tricky as it is observable data and there is no singular “test” that can determine if one has ODD. However, there are some techniques that can track behaviour to make the diagnostic procedure easier and more reliable (Riley et al., 2016). First, a child behaviour checklist can not only be helpful for teachers, but parents as well to determine the frequency and severity of a particular behaviour the child is experiencing. A mental health professional can use this information to make an informed decision about a child’s diagnosis. As well, the Connors 3 assessment screens for symptoms of ADHD, ODD and conduct disorder by examining different symptoms within the DSM-5. The Swanson, Nolan and Pelham Teacher and Parent Rating Scale can be used for many mental disorders but has questions specifically related to ODD for assessment. Lastly, the Vanderbilt ADHD Diagnostic Parent Rating Scale can provide valuable insight into not only ADHD, but symptoms of ODD and conduct disorder as well.

**Prevalence**

 The prevalence of oppositional defiant disorder varies significantly across the literature. The variance accounts for a difference of about 13%, making ODD one of the most common developmental disorders worldwide, varying from 2.6% to 15.6% of the population (Ding et al., 2020). British Columbia’s Pediatric Society (2019) stated the global prevalence is 3.6%. Typically, you can see signs of ODD before a child is eight years of age. If diagnosed before they turn eight, they may experience a slower rate of recovery and often need interventions as soon as the behaviours are identified (Calub et al., 2020). However, the prevalence of a child having ODD in a younger grade is low compared to the middle and upper grades (Winzer, 2008)

At an early age, more boys exhibit ODD compared to their female counterparts showing a 2:1 ratio (von Gontard et al., 2015). However, as time progresses, and children reach adolescents this number evens out (BC Children’s Hospital, 2022). It is thought that defiant and disruptive behaviour is displayed at a higher rate in boys, particularly at a young age which could be a contributing factor to why boys are diagnosed twice as much as girls when they are children (Veenman et al., 2018). As well, oppositional defiant disorder is more common among children of working-class families compared to middle or high-class.

 The rate of prevalence and incidence for ODD has changed in every version of the DSM and it is difficult to assess concrete numbers over the years due to misdiagnosis or children being undiagnosed. However, regarding the classroom, teachers are reporting an increase in defiant behaviour, as well as poor self-regulation skills more than ever suggesting that behavioural disorders are increasing today. What is known, is the rate of oppositional defiant disorder, along with other behavioural disorders is disturbingly high (Winzer, 2008).

**Causation**

***Genetics***

 Oppositional defiant disorder can arise due to many different genetic and environmental factors. Twin studies suggest that there is a link between brain chemistry, depression and irritability that influences one’s behaviour as a child, creating possible causation for ODD. There is also a correlation between a family’s mental health history and ODD symptoms in their children, especially maternal depression, and psychiatric disorders (Krieger, 2013).

***Environmental Factors***

 Parental response to a child’s behaviour is correlated with the onset of ODD symptoms. A child that has had inconsistent disciplining and has experienced abuse or harsh punishment is more likely to develop negative behaviours that are associated with ODD. Children who experience poverty or live in violent situations are also at an increased risk for developing ODD as well as children with a lack of social support and experience peer rejection (Riley et al., 2016).

**Strategies For Support**

Winzer (2008) mentions seven models of treatment for behavioural disorders: Biophysical, psychodynamic, psycho-educational, behavioural, ecological, psychosocial, and holistic. Each model has their benefits, however; choosing the right one is dependent on the child and the intervention that works for them. Before the use of any intervention, behavioural tracking should be completed to ensure the correct interventions are in place. Typically, this can be completed by teachers, special education teacher or parents at home. It is important to use this information to design an intervention plan based on the function of the child’s behaviour to help the child properly.

**Biophysical Model**

The biophysical model focuses on the points of genetics and the brain regarding the diagnosis, onset, and recovery of the child. Doctors will look for biological factors that are affecting the behaviour and often use medication to treat them (Winzer, 2008). Currently, the World Health Organization (2012) recommends that all medications to treat behaviour disorders be prescribed by a specialist and they note that the quality of evidence in treating ODD is low. It is suggested that medication not be used to treat oppositional defiant disorder unless comorbid with another disorder requiring medication, or the child is demonstrating severe physical aggression (Veenman et al., 2018).

**Psychodynamic Model**

Sigmund Freud no doubt had the largest impact on psychodynamics in the 1900s and his theories are still being used today. This model emphasizes the child's mental processes with a belief that their experiences impact their functioning. Using this model various counselling and therapy sessions can be performed to discuss the child’s thoughts and processes, and attempt to correct their negative behaviour (Winzer, 2008). BC Children’s Hospital (2022) recommends Cognitive Behavioural Therapy (CBT) to help the child cope with the world around them, manage their emotions, and identify their anger. They also state that this therapy can aid with problem-solving and peer conflict. Another form of therapy that can be helpful for parents and guardians is family therapy. This allows the child to be supported by their loved ones but also gives recommendations to families on how to deal with their symptoms in a positive way.

**Psycho-educational Model**

 Within a school, this model focuses on preventative classroom planning which involves creating trust between the staff and the child. The belief is that the behaviour rises from multiple causes. Some strategies that are beneficial with this model could include creating a relationship with the child to ensure they feel seen and heard, as well as ensuring their academic goals are aligned with their abilities. It could also involve therapy or crisis intervention as well as tolerating certain behaviours in the classroom and recognizing it may be out of their control (Winzer, 2008).

**Behavioural Model**

Behaviour is often adjustable with the help of classical and operant conditioning and when treating oppositional defiant disorder, these techniques are just as beneficial. The behaviour becomes the focus, and the underlying causes remain irrelevant. By using reinforcers or punishments the child learns what is acceptable behaviour and when they have crossed the line (Winzer, 2008). Utilizing positive reinforcement within the child’s life can shift their behaviour as they long for that connection and reward (Veenam et al., 2018). The end goal is to have positive behaviour that was rewarded replace the negative behaviour that was punished (Winzer, 2008).

**Ecological Model**

 The Ecological Model focuses on the interaction between the child and their environment. How they interact with their classroom influences their behaviour and therefore, changes based on positive or negative interactions. Something as small as a change in their schedule which may seem minor to someone who is neurotypical could impact someone with ODD in a negative way. Being proactive in ensuring the norm of the environment is stable and altering interactions between the child and the classroom to ensure they are positive, can impact the child’s reactions (Winzer, 2008).

**Psychosocial Model**

 Familial and extra-familial influences play a role in how a child interacts with others in social settings. Winzer (2008) explained that the psychosocial model is like the ecological model and often they can be put together. Where they differ, is the psychosocial model examines a child’s behaviour based on how they are brought up or how their interactions have impacted their development. A child that has experienced a harsh discipline or little parental involvement are predisposing factors that contribute to the child’s overall well-being. However, precipitating factors are a current situation that could be occurring that create emotional stress on the child; These could include divorce, separation, or a chronic illness. By creating a relationship with the child, this information could be made readily available and providing emotional support or counselling could create a positive impact on the child’s behaviour.

**Holistic Model**

 This model encompasses a multitude of factors that could be influencing the child’s behaviour. It does not solely focus on a single aspect of the child’s life but examines their relationships, environment, genetics and current situation to create an intervention plan for them. While this sounds like an immense amount of work to study each area of the student’s life, it can be beneficial for understanding the function of behaviour (Winzer, 2008).

# Discussion

**ODD in the Classroom**

Evans et al. (2015) suggested that oppositional defiant disorder can be broken down into two main dimensions, irritability, and defiant behaviour. This is certainly easy to break down in the classroom. Teachers have been found to be reliable raters for the symptoms of ODD and often report increased social impairments as well as anti-social behaviour that disrupts their learning process whereas parents report a higher rate of interruptions at the familial level (Evans et al., 2015). This is no surprise as the classroom is a more demanding environment when it comes to the socialization of peers, as well as a more academically challenging and demanding environment. Putting a child in a situation where they are challenged with more rules and routines can create a trigger for children with ODD.

As previously mentioned, teachers and educational staff are reporting an increase in negative behaviours within their classrooms (Winzer, 2008), however; the lack of training for general-education teachers seems to be a key component missing to reduce the number of negative interactions between them and their students. Teachers who have less training in behavioural management experience higher rates of outbursts or temper tantrums, not only for children with ODD but with all children (Calub et al., 2020). Thus, making teacher training in behavioural interventions as well as social strategies critical for the functioning and well-being of not only students in their classroom, but also the adults working with them.

***Academic Functioning***

 There is no doubt that disruptive behaviour impairs learning for not only that child but for other children as well. Reports indicate that ODD affect a child’s social life and functioning in the classroom, as well as their academic journey to acquire new knowledge (Evans et al., 2015). When a student is not engaging in a lesson, refusing to listen or do their work they are missing out on integral concepts of learning. At a young age, problem-solving skills are essential to development, however, as previously stated ODD can immensely affect one’s judgement to problem-solve effectively. Teachers need to be trained in assessing problem-solving skills and providing the proper support to assist children who are struggling with this skill. Utilizing accommodations such as social stories, chunking assignments, and using graphic organizers or diagrams can ease the child into their work without creating distractions for others and promote their learning (Winzer, 2008).

***Positive Approaches***

 Being approachable, trustworthy, and promoting positive relationships in the classroom is essential to mitigating behaviour in the classroom. Students with ODD thrive on positive interactions, positive reinforcements, and simple social instructions to help them get through their day (Calub et al., 2016; Evans et al., 2015; Winzer, 2008). While it can be tough to stay positive and not overreact when a behaviour becomes frustrating or violent it is important to remain calm to deal with the behaviour appropriately. Remembering that children with ODD often react negatively to harsh consequences and inconsistency is imperative to not make the situation worse or break the trust you and the student have built (Riley et al., 2016).

***Language***

 We often do not realize the impact that our language has on situations and how others react to our requests and for children with ODD it is even much more apparent how closely we need to monitor the words we use. Our language should be kept short, using simple phrases, and explaining tasks as “first, then” so the child knows what is being asked of them. Giving one request at a time makes it easier for the child to comply with the rules and allows them to focus on a single task. If someone gives a child a multitude of things to do at once, while using complex language this could impact their reaction and create frustration much easier (Winzer, 2008).

***Accommodations***

Creating an accessible classroom can proactively mitigate behaviours in the classroom, not only for children with ODD but for all students. Some accommodations that can be used with the whole class are visual timers or introducing a “calming corner” to the whole class for when our emotions seem to be uncontrollable which creates a safe space for a student while containing the behaviour in a small area. As well, creating a whole class reward system can provide motivation for students to obtain a reward for making good choices. Lastly, being organized and consistent can provide a more structured environment for each child in the class that can be beneficial to their functioning at school (Calub et al., 2020; Winzer, 2008).

***Time***

 Teachers have so much to do, and it seems as though each year there are more tasks to be completed which at times, makes it difficult to focus on the needs of students, especially when not properly educated on special education or behavioural management strategies. Accommodations and modifications should be integrated into the regular classroom routine as if it is normal procedure. By doing so, it reduces the number of changes to students within the classroom throughout the year and is already taking an appropriate step towards inclusion for all. As well, proper collaboration needs to take place between the teacher, special education teacher and administrators to provide the proper safe and beneficial environment for a child with ODD.

**Summary**

Oppositional defiant disorder can present itself in many ways both at home and in the classroom. Receiving the proper diagnosis by a medical professional, tracking behaviour, and identifying the needs of the student are found to create the best outcome of success for the child. ODD is a mental disorder that can be treated with the appropriate resources and supports creating a more adjusted child as they age to social and academic situations. As teachers, the proper collaboration, education, and accommodations should be provided to best serve the students while focusing on a positive approach and creating a relationship with the child. No doubt, ODD is complex on a multitude of levels, and while time-consuming the end goal is to help the child become the best version of themselves.

# References

BC Children's Hospital. (n.d.). *Behavioural disorders*. Kelty Mental Health. <https://keltymentalhealth.ca/behavioural-disorders>

British Columbia Pediatric Society. (2019, November 18). *Factsheet: Care of Children and Youth with opposition defiant disorder ...* Retrieved November 22, 2022, from <https://www.bcpeds.ca/wp-content/uploads/2019/11/17_Factsheet_Youth_with_ODDCD.pdf>

Calub, C. A., Rapport, M. D., & Alexander, K. (2020). Reducing aggression using a multimodal cognitive behavioral treatment approach: A case study of a preschooler with oppositional defiant disorder. *Clinical Case Studies*, *20*(1), 39–55. <https://doi.org/10.1177/1534650120958069>

Ciccarelli, S. K., & White, J. N. (2014). *Psychology: Dsm 5*. Pearson.

Ding, W., Meza, J., Lin, X., He, T., Chen, H., Wang, Y., & Qin, S. (2019). Oppositional defiant disorder symptoms and children’s feelings of happiness and depression: Mediating roles of interpersonal relationships. *Child Indicators Research*, *13*(1), 215–235. <https://doi.org/10.1007/s12187-019-09685-9>

 Evans, S. C., Pederson, C. A., Fite, P. J., Blossom, J. B., & Cooley, J. L. (2015). Teacher-reported irritable and defiant dimensions of oppositional defiant disorder: Social, behavioral, and academic correlates. *School Mental Health*, *8*(2), 292–304. <https://doi.org/10.1007/s12310-015-9163-y>

Krieger, F. V., Polanczyk, G. V., Goodman, R., Rohde, L. A., Graeff-Martins, A. S., Salum, G., Gadelha, A., Pan, P., Stahl, D., & Stringaris, A. (2013). Dimensions of oppositionality in a Brazilian community sample: Testing the DSM-5 proposal and etiological links. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*(4). <https://doi.org/10.1016/j.jaac.2013.01.004>

Molineux, A., & Henderson, E. (2022, June 22). The Health Risks of Self-Diagnosing Mental Disorders [web log]. Retrieved from <https://www.news-medical.net/health/The-Health-Risks-of-Self-Diagnosing-Mental-Disorders.aspx#3>

Riley, M., Ahmed, S., & Locke, A. (2016). Common questions about oppositional defiant disorder. *American Family Physician, 93*(7), 586-591. <https://search-ebscohost-com.prxy.lib.unbc.ca/login.aspx?direct=true&AuthType=cookie,ip,url,uid,custuid,cpid,athens&custid=s5672293&db=mnh&AN=27035043&site=ehost-live&scope=site>

Winzer, M. (2009). *Children with exceptionalities in Canadian classrooms*. W. Ross MacDonald School Resource Services Library.

World Health Organization. (2012). *Pharmacological interventions for children with Disruptive Behaviour Disorders or Conduct Disorder or Oppositional Defiant Disorder*. World Health Organization. <https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme/evidence-centre/child-and-adolescent-mental-disorders/pharmacological-interventions-for-children-with-disruptive-behaviour-disorders-or-conduct-disorder-or-oppositional-defiant-disorder>

Veenman, B., Luman, M., & Oosterlaan, J. (2018). Efficacy of behavioral classroom programs in primary school. A meta-analysis focusing on randomized controlled trials. *PLOS ONE*, *13*(10). <https://doi.org/10.1371/journal.pone.0201779>

von Gontard, A., Niemczyk, J., Thomé-Granz, S., Nowack, J., Moritz, A.-M., & Equit, M. (2015). Incontinence and parent-reported oppositional defiant disorder symptoms in young children—a population-based study. *Pediatric Nephrology*, *30*(7), 1147–1155. <https://doi.org/10.1007/s00467-014-3040-z>