Oppositional Defiant Disorder through an Adlerian Lens

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Abstract

The rate of oppositional defiant disorder diagnosis is increasing in the U.S. across all samples in all studies, emphasizing the necessity for its understanding. In this paper, a literature review of the description, etiology, preventative measures, and treatment of oppositional defiant disorder is conducted. An emphasis on the perspective of Alfred Adler and his cohorts, past and present, is explored. All behavior is purposeful. Children with oppositional behaviors are not sick, only discouraged, and they have a purpose for their behavior. This paper explains their purpose and focuses on their health through the Adlerian concepts of encouragement and social interest.
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Introduction

Oppositional defiant disorder (ODD) is defined by the American Psychiatric Association (APA, 2000) in the *Diagnostic Statistical Manual for Mental Disorders*, referred to as the DSM-IV-TR, as “a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months…” (p. 100). This definition alone does not do this disorder justice because other disorders have similar symptoms. For example, conduct disorder (CD) and antisocial personality disorder may be directly related to ODD in that their symptoms, such as negativity, vary only by degree. This paper will discuss ODD and its relationship to other disorders. It will focus on the causes of, and responses to, ODD and will reveal options for testing, diagnosis, and treatment. It will explore aspects of ODD through various points of view emphasizing the perspective of Alfred Adler and his cohorts, past and present.

General Information

As the result of a comprehensive literature review done in 2007, it was estimated that behavioral disruptive disorders such as ODD affect from 2.6% to 15.8% of children in community samples, and in clinical samples, ODD was reported to have affected 28% to 65% of children (Boylan, Vaillancourt, Boyle, & Szatmari, 2007). The rates in the general population may vary by as much as 10% to 15% depending on the study; however, in all studies the rates are increasing, emphasizing the necessity for understanding of disorders such as ODD. Throughout the developmental process, children display oppositional behavioral traits. It can be quite normal for children to fight, argue, disobey and break familial rules as well as rules at school. In fact, a period quite well known for this behavior is referred to by loving parents as “the terrible twos.”
Kline and Silver (2004) explain that this is the time when a child attempts to gain more independence and autonomy from his parents. When the child rebels against his parents with verbal and non-verbal negativity, such as yelling “no” or throwing a temper tantrum, he is in a process of gauging just how far he can go. Through environmental feedback and a wealth of positive and negative responses to his behavior, the child will be able to understand what behavior is and is not socially acceptable (p. 268).

Children usually grow out of the “terrible twos” when they learn the acceptability of their behavior; however, there are those children that seem to never outgrow the need to behave oppositionally. When the children’s behavior tends to be continuously negative, such as getting into fights and arguments, and disobeying those in authority (parents and teachers), that behavior may be a telling sign of ODD. Entering school for the first time or entering adolescence can present challenges in children’s development. Oppositional behavior can be common at these times, as well. When the defiant behavior persists or becomes self-destructive, an ODD assessment may be necessary (Bernheim, Rescorla, & Rocissano, 1999).

The Adlerian perspective emphasizes that all behavior is purposeful. Rudolf Dreikurs’ “four mistaken goals of children” indicate that some of the purposes of negative behavior are: an attempt at gaining attention, a fight for power or control, an act of revenge, or a result of feeling inadequate or worthless (Dreikurs, 1990). It is important to understand that children will do what works for them to get what they mistakenly believe they need. For example, if children feel they need attention and do not receive it through the affirmations and encouragement they should receive from their parents or caregivers; they may attempt to gain that attention by misbehaving. It may be negative attention, but to them, negative attention is better than no attention at all. Children have needs, and they will behave in ways that respond to what they
believe is a lack of those needs. Often when children persistently behave inappropriately, or they react negatively to certain events or situations in an extreme way, a diagnosis of ODD may be made.

Since the line between normal child development and ODD can be difficult to draw, specific criteria must be used in order to diagnose the behavior as ODD. The third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), published in 1980, was the first manual to include the diagnosis of ODD as a childhood/adolescent disorder. Currently, the criteria for that diagnosis have been established in two different publications: the APA’s DSM-IV, and the World Health Organization’s (WHO) *International Classification of Diseases* (10th ed.) (ICD-10). Because the ICD-10 does not classify ODD as a separate disorder, rather it contends that ODD is simply a lesser form of conduct disorder (CD), this paper will focus on the criteria in the DSM-IV. The diagnostic criteria for ODD in the DSM-IV-TR (APA, 2000, p. 102) are as follows:

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

1. often loses temper
2. often argues with adults
3. often actively defies or refuses to comply with adult’s requests or rules
4. often deliberately annoys people
5. often blames others for his or her mistakes or misbehavior
6. is often touchy or easily annoyed by others
7. is often angry and resentful
8. is often spiteful or vindictive
Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

The ICD-10 contends that ODD is a milder level of CD. The diagnosis of ODD is defined by anger which involves more verbal and disobedient behavior. On the other hand, CD is diagnosed with behavior that becomes more physical, such as bullying, stealing, fire setting, initiating physical fights, forcing someone into sexual acts, and being physically cruel to people and animals. The contention appears to be that children with ODD will progress to a diagnosis of CD if not treated successfully. However, Lahey et al., (1992, 1994) reports that “approximately 75% of children who meet the criteria for a diagnosis of ODD do not progress to a diagnosis of CD…” and that “there is a significant number of children that develop CD during adolescence without indication of a prior diagnosis of ODD” (as cited in Essau, 2003, p. 15).

Gorman-Smith, Tolan, and Henry (2000) performed a meta-analysis of mother-son reports of the son’s involvement in delinquent and violent behavior to show patterns of delinquent behavior. The results were as follows: Four nonoverlapping groups emerged: 26% of the samples were classified as nonoffenders (those with some aggression and fighting, but no delinquent behaviors); 34% were classified as chronic minor offenders (those consistently involved in minor offenses only over each of the four waves); 12% were classified as escalators (those starting
delinquent involvement at a later wave, ages 13 to 15, and quickly, within a year, escalating to more seriousness and violent offending); and 28% were classified as serious chronic offenders (those involved in serious and violent offending at every age wave).

Aggressive behavior typical of ODD tends to be associated with other types of psychiatric problems such as ADHD and depression. According to McGough, Smalley, McCracken, Yang, Del’Homme, and Lynn (2005), a higher rate of ODD exists in cases of combined ADHD (attention deficit with hyperactivity), and children with ADHD showed earlier onset of ODD than those without ADHD. Also, in an examination of the National Comorbidity Survey Replication, it was concluded that lifetime ODD is associated with secondary mood, anxiety, impulse control, and substance abuse disorders. In this study of 3,199 adults, the lifetime prevalence of ODD was estimated at 10.2%, and of those, 92.4% met the criteria for an additional mental disorder in the DSM-IV-TR. It was determined that 68.2% met the criteria for impulse control disorders which included disorders such as ADHD, CD, and intermittent explosive disorder (IED), 62.3% met criteria for anxiety disorders, 45.8% met criteria for mood disorders, and 47.2% met criteria for substance use disorders (Nock, Kazdin, Hiripi, & Kessler, 2007). So it is apparent that other disorders are frequently associated with ODD.

Of those mentioned previously, the impulse control disorders have a higher prevalence for co-occurring disorders. Since ODD is an impulse disorder as well, it may be difficult to determine if the child’s behavior is indicative of ODD or ADHD, or a combination of both. In a study of types of noncompliance in boys with ADHD, with and without oppositional behavior, and boys with neither ADHD or oppositional behavior, the results indicated that the boys with ADHD and oppositional behavior were more covert or sneaky, overt or confrontational, and emotionally labile. They were also less skilled verbally and less emotionally regulated. There
was little significant difference between the ADHD boys without oppositional behavior and the boys without ADHD or oppositional behavior (Johnston, Murray, & Ng, 2007).

Different types of aggression exist in this group, as well. In fact, Kempes, Matthyss, de Vries, and van Engeland (2005), identify two understood types of aggression evident in today’s society: reactive and proactive aggression. Reactive aggression is in direct response to a real or perceived threat. Proactive aggression is carried out with the idea that there is a benefit or reward for the behavior. ODD would be considered proactive aggression because children are usually attempting to gain something from someone. Even though the behavior may seem reactive, the underlying purpose for the behavior is not. Benefits of proactive aggression may be the acquisition of attention, power, or revenge. As mentioned earlier, these mistaken goals of children can undoubtedly create oppositional behavior; however, many other risk factors can lead children down the road of defiant behavior, as well.

**Risk Factors**

**Genetic factors.** According to a meta-analysis of genetic and environmental influences on ODD, CD, and ADHD, along with their own study, data suggested that there was a correlation of overlap (comorbidity) between the genetic influences within these disorders, but when broken down to a single genetic factor it was determined that “all disorders have a certain degree of unique genetic influences” (Dick, Viken, Kaprio, Pulkkinen, & Rose, 2004). Contrary to that, another study of three externalizing behaviors in child and adolescent twins reflect a difference in genetic liability between ADHD and ODD or CD, and that ODD and CD reflect the same genetic liability (Eaves, Rutter, Silberg, Shillady, Maes, & Pickles, 2000). There are no studies to date that can positively verify a specific genetic link or a gene that causes
susceptibility to ODD. However, other individual factors that may be innate could influence aggressive behavior.

One great topic of discussion that took place in the 1960s and 1970s with regards to a genetic influence on aggressive behavior was the effects of the XYY genotype. It was suggested that those who had the extra Y chromosome, low intelligence, and tall stature were more vulnerable to giving in to aggressive behavior. Indeed, a significant difference exists between the percentage of male prisoners who had the XYY genotype and those in the general population; however, many law abiding men carried the XYY genotype as well (Jarvik, Klodin, & Matsuyama, 1973). Having an additional Y chromosome, it is suggested, would make one display more masculine traits since the Y chromosome is representative of males, and physical aggression tends to be more of a male characteristic. Although the XYY genotype appears as positive evidence to those determined to find a genetic link to aggression, the fact is that at this time there needs to be more research done on the topic. Are there a higher percentage of men with the XYY genotype in prison than the percentage of those without the XYY genotype because of the XYY genotype, or is it because of the lower intelligence that is often associated with having it? Do those with the genotype get caught more easily, or are they more aggressive or violent? Many studies support the idea of aggressive behavior caused by the XYY genotype and some studies refute the idea. This discussion has tapered off in recent years, and the focus has switched to other factors involving physical influences for aggression. Further research needs to be conducted to determine the effects of the XYY genotype or another genetic connection to aggressive behavior.

**Neuropsychological factors.** Some of the behavioral symptoms of ODD, such as the inability to regulate attention and emotions, and the inability to inhibit impulses may be signs of
an anomaly within the frontal lobes of the brain (Kline, & Silver, 2004). The idea that the brain and behavior are somehow connected is not a new one, as evidenced by past attempts to alter behavior through lobotomies and drilling holes in the skull. However, according to Essau (2003), there are many cases where injury to the frontal lobe has caused a dramatic increase in aggressive, antisocial, and violent behavior. Many studies involving violent offenders and murderers exist showing abnormalities in the frontal lobes of the brains of offenders that differ from those in the control group.

In violent or aggressive individuals, some frontal lobe dysfunction has been detected on a variety of neuropsychological tests that include, but are not limited to, the *Halstead-Ratian Psychological Test Battery* (Yeudall & Fromm-Auch, 1979); the *Wisconsin Card Sort Test* (Krakowski et al., 1997); and the *Continuous Performance Test* (Kruesi, Schmidt, Donnelly, Hibbs, & Hamburger, 1989) (as cited in Essau, 2003). Also according to Essau (2003), these tests and others were used in a study performed by Séguin et al. (1995). Thirteen neuropsychological and cognitive measures were tested on a sample of adolescents to determine differences between aggressive and nonaggressive individuals. Of these, two factors stood out to be significantly different: verbal learning and executive functioning. Verbal learning deficit can be related to a lack of communication and social problem solving skills, both of which contribute to aggressive behavior. Executive functioning refers to the ability to execute plans, develop strategies, use the information stored in memory, pay attention, and change behaviors when necessary. A deficit in this area can lead to aggressive behavior, as well.

**Individual factors.** Unexpectedly, boys and girls have an equal prevalence of ODD throughout childhood. They show a slight increase in rates at around age ten or eleven, a greater increase at around age sixteen, and then a sharp decline after that. However, more boys meet
criteria for a diagnosis of CD before adolescence than girls (Essau, 2003). Kann and Hanna (2000), assert that girls and boys display their disruptive behavior differently. Boys display external behavior and are more overt in nature. Girls display more internal behavior which can result in other symptoms such as withdrawal and physical complaints. It is suggested that because of the covert nature of girls’ aggressive behavioral problems, they may not be noticed as easily as boys’ aggressive behavior. Therefore, many cases concerning girls may go unattended. Loeber, Burke, and Pardini (2009), reiterate that these gender differences combined with observer bias and gender-based expectations may affect the assessment of certain disruptive behaviors such as ODD.

In a 2004 study, boys in a control group were compared to boys with ODD and it was determined that boys with ODD continued negativistic behaviors long after punishment for those behaviors. Noticeably, boys without ODD discontinued their negative behavior immediately. ODD boys exhibited greater response perseveration than boys without ODD. Response perseveration is operationally defined as the tendency to continue a response regardless of the punishment. Also, there may be some physiological correlation to responses to reward or punishment. This study showed a positive correlation with skin conductance level and punishment sensitivity. Skin conductance level is a measurement of the amount of moisture in the skin that may be increased through sweating and a heightened sense of arousal that accompanies emotions such as fear or anger (Matthys, van Goozen, Snoek, & van England, 2004).

Many people believe, along Freudian thought, that children are born with a clean slate and that everything evolves from that point on. The parents of children who have always been difficult or callous and unemotional would find it easy to come to the realization that some
personality traits may be innate. Caspi, Elder, and Herbener (1990) suggest that children with a difficult temperament would be more difficult to understand, discipline, and relate to personally in a relationship. This situation can be very frustrating for the parents, and the result may be a parental tendency to deal with children out of anger. This style could increase children’s susceptibility to ODD.

Intelligence level is another individual factor that can influence child behavior. Lower intelligence is associated with conduct problems in youth. As suggested by Frick (1998), a few possible reasons exist for this: a child may not have the capability to respond properly to perceived threats because his known options may be more limited, the inability to understand verbal instructions may result in the child’s impaired ability to self-regulate, and anticipate consequences for his behavior, the child’s ability to understand social norms and moral expectations may be slightly impaired, and the child’s social experiences with his parents and other adults may be limited (as cited in Essau, 2003).

We are all born with feminine and masculine characteristics or traits. Some traits are more noticeable than others. Boys who feel that they are lacking in masculine traits and have confusion about their sexual role may act aggressively or defiantly in an effort to prove their manliness (Adler, 1964).

**Parent and family factors.** When children are in the process of developing their relationships with their caregivers, usually their parents, they can easily and unknowingly be led down the path of misbehavior that could affect not only their childhood but their adulthood as well. In a study of partner abusive men, their early childhood experiences were examined, and the results showed that a very close relationship between growing up in a violent home with defects in the parent-child relationship (attachment) and intimate partner violence existed. The
abusers received less love from both parents, more punishment from their mothers, and less attention from their fathers. Relationship aggression was a significant factor that resulted in ODD in childhood and abusive behavior in adulthood (Rosenbaum, & Leisring, 2003). Kline and Silver (2004) declared, “Aggressive parents are likely to model maladaptive behavior” and children will take that example and use it to form their means of settling confrontations or disagreements.

Bettner and Lew (2000) state that parents who hit send the message to their children that it is all right to hit those you love. This also leads to discouragement and the fear that they must not make a mistake. Children may become too afraid to try something new if they feel that they might fail. This avoidance can completely hurt the children’s self-esteem, increase inferior feelings, and get in the way of the development of their movement toward competence.

The parent-child relationship is the most important aspect of a child’s development. Parenting factors such as abuse, neglect, pampering, spoiling, teaching, patience and love can have a great influence on child development. However, the parent-to-parent relationship can affect the child greatly as well. Johnson and Lobitz (1974) reported clear evidence that parents with marital problems, such as separation or divorce, will have a child with higher rates of negative, disruptive behavior. Greater marital satisfaction will result in less disruptive behavior in the child. In a more recent study, Wymbs, Pelman, Molina, and Gnagy (2008) concluded that a positive correlation exists between the amount of interparental discord and the level of the child’s ODD and CD, with and without ADHD. They did not determine what the causal effect was; however, it is easy to see both how the child’s aggressive behavior could have an effect on the relationship between his parents and how the parent’s relationship could influence the child’s aggressive behavior. The DSM-IV-TR (2000) reports that ODD is common in families where
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childcare is disruptive, inconsistent, or neglectful, and it would also be common if at least one of the parents had a history of some externalizing disorder.

Loeber and Stouthamer-Loeber describe three family variables in relationships between aggressive children and their parents. The variables are as follows: poor parental involvement within the children’s activities, poor supervision and monitoring, and strict and inconsistent discipline (as cited in Northey Jr., Wells, Silverman, & Bailey, 2003). Parents often inadvertently model aggressive behavior, as well. As children inevitably witness positive and negative behaviors in their parents, they learn how to react in certain situations and become aware of the acceptance of behaviors in society. Unfortunately, many children believe that if their parents behave a certain way, even if it is aggressive or defiant behavior, it must be acceptable for them to behave that way, as well.

Post traumatic stress disorder (PTSD) is common in children and adults alike after encountering a disastrous event such as a flood, tornado, earthquake, or hurricane. In a study on the mental health of children and their caregivers who experienced Hurricane Katrina, the authors found that 50% of children were diagnosed with PTSD, of which, 94% were attributed to Hurricane Katrina. Eighty-six percent of those were co-morbid with another disorder such as ADHD or ODD. The study revealed a positive correlation between the children’s reactions and their caregivers’, and an increasing correlation was present when the caregiver had been given a pre-Katrina diagnosis. It also determined that the longer the children are separated from their caregivers after a traumatic event, the quicker they recover from the PTSD and subsequent disorders (Scheeringa, & Zeanah, 2008). Parents and caregivers influence their children through modeling their behavior. Although traumatic events frighten children and adults alike, continued parental fears and concerns can have a detrimental and lasting effect on their children. Children
believe that if an event causes continued distress and concern for their parents, it must be warranted by them, as well. Also, some children may believe that the way the parent or caregiver is handling the situation is the way it should be handled. The modeling of the parents’ behavior can be interpreted by children as the “correct” way to deal with issues, which may create a lasting and possibly dysfunctional way of handling issues emotionally.

Another factor that contributes to aggressive behavior is a feeling of abandonment children experience, such as in cases of divorce or adoption. Children often feel unwanted, and in some cases, such as with continued placement in various foster homes, the child feels “victimized” over and over again. Lewis, Dozier, Ackerman, and Sepulveda-Lozakowski (2007) determined that children that are moved from home to home in a foster care system are less likely to develop inhibitory control and more likely to display oppositional behavior. Inhibitory control can be operationally defined as the ability of children to refrain from doing what they know is wrong or the ability to do what they do not want to do. Inhibitory control can be very useful in the prevention of oppositional behavior. However, children who have been moved from one foster family to another seem to have more difficulty controlling their behavior regardless of whether or not the behavior is “right” or “wrong.”

The Adlerian perspective of oppositional defiant children has very much to do with the parent-child relationship. Dreikurs and Soltz (1990), reveal what is known as the four mistaken goals. These are goals that compensate for the beliefs that children have developed through their interactions with their parents, caregivers, or other authority figures. The mistaken goals have created negative self-talk that suggests to the children that in order to get what they need (and what children need is to feel significant), they must behave in ways that can lead to aggressive
behavior. These four mistaken goals are as follows: a need for attention, a struggle for power, revenge, and withdrawal or avoidance.

Children’s need for attention is innate. All children desire attention because human beings are social beings and need the participation of others in their lives. Also, when children receive attention, they feel as if they are significant. They matter. Their need for attention may extend from their feelings of insignificant or feelings that they do not belong. According to Dreikurs and Soltz (1990), children’s need for “undue” attention is due to the mistaken belief that in order to be significant they must have attention. The children’s position in the family may be one factor that can create or destroy their feeling of significance. Children who are in an “only child” position in the family would not find it difficult under normal circumstances to receive attention from his or her parents. However, children who may come from a family with many siblings, and who lie somewhere between the first born and the baby of the family, may engage in competition for the parent’s attention with the other siblings. They may not experience attention from their parents or caregivers, or they may perceive that the attention that they do receive is less than the attention their siblings receive. Dreikurs and Soltz (1990) also suggest that the roles that each member of the family plays (especially the children) have an effect on the other members. For example, when children who behave well are labeled “the good child,” other children in the family may become “the bad child” so they can receive equal attention from the parents. Children may wish to be a “good children;” however, another sibling in the family may have that role. So to get an equal amount of attention, they become the “bad children,” even if the type of attention is different. Parents who encourage all their children and give attention equally may find less difficulty dealing with children who are struggling to feel as if they belong in their family.
Often, when children are seeking attention from parents, the parents’ response may be one of irritation or annoyance. They may give attention that lasts only temporarily because it extends out of their annoyance rather than their encouragement. In line with Dreikurs’ four mistaken goals, Lew and Bettner (2000) developed the “Crucial C’s.” They use the “C” word of “connect” to point out that children need to feel as if they belong or are connected. In order for them to prove that they are connected, they mistakenly believe that they must get their parents’ or caregivers’ attention.

Another desire of children that Lew and Bettner (2000) describe is to be “capable.” This is the second “Crucial C” the authors speak of. When children are not given the opportunity to become capable or to show that they are capable, they may mistakenly substitute capability for power. When children fight for power, Dreikurs’ second mistaken goal is realized. Children mistakenly believe that their capability lies in their ability to have and maintain power or control over others.

Often, when parents get caught up in a “power” struggle with children, they respond with fighting, yelling, or arguing to get them to do what they want. When parents feel angry and challenged by their children, their responses can intensify the defiant behavior, and as a result, the anger of the parent intensifies, as well. Oppositional behavior will increase in this type of scenario and parents can feel helpless in dealing with their children. It can be a vicious cycle. Dreikurs and Soltz (1990) contend that there is a connection between children’s desire for power and their need for attention. They state that the power struggle between children and their parents ensues after the parents attempt to forcibly put a stop to their children’s seeking of attention. It is apparent that Dreikurs and Soltz believe that when children’s needs for attention
are handled poorly by the parents, their behavior can escalate into a fight for control or power. This is what they can be “capable” of (misbehavior).

A child’s search for revenge is another mistaken goal of children that Dreikurs and Soltz indicate is a progression of behavior from the child’s fight for power or control. When the child’s and parents’ struggle for power becomes unfruitful (and it will), the child will realize that he cannot win the fight for control, and therefore, he cannot be significant as well. This is very hurtful to the child and the act of striking back to hurt the parents or caregivers becomes the only recourse in the child’s mind (Dreikurs, & Soltz, 1990).

The act of revenge is a behavior that children display when they feel that they do not “count.” This is the third “Crucial C.” Children need to know that they count, or they feel insignificant. When they do not feel as if they count, they will feel as if everyone is against them and feel hurt. In extreme cases, children will retaliate by trying to hurt those from which they desired the attention and feelings of significance. Parents will respond to these acts of revenge with hurt feelings of their own. Often wondering why children would or could do something so hurtful, the parents resort to punishments that reinforce the mistaken goals children create in their search for significance (Lew, & Bettner, 2000).

Although the fourth mistaken goal of a child does not seem to be pertinent to oppositional behavior, it is considered a progression from the vengeful behavior previously written about. The child’s mistaken goal is an attempt to protect him through withdrawal or avoidance. Dreikurs and Soltz (1990) contend that the behavior of avoidance is a demonstration by the child to prove his or her complete inadequacy. The attempts to gain significance have gone unrewarded, and the child, through total discouragement, has given up completely. The child’s self-esteem has been hurt, and feelings that there is nothing he can do right increase to the point
that the child will not even try. He believes that if he does not try, his failure will not be as noticeable.

The response of the parent is often that of despair about their child. They are unsure of what they can do to rectify the situation, and in their frustration, they give up on the child and give up on parenting him. The “Crucial C” that is helpful to know in this situation is “courage.” A child who does not have courage to go on in times of adversity will become discouraged and will give up or avoid anything that he imagines is too difficult for him (Lew, & Bettner, 2000).

**Psychosocial factors.** There are many social factors that have an influence on children today. Their interaction with peers, the neighborhood they live in, and the school they learn and play at, all play a role in the behavior of children. Bloomquist and Schnell noted that the way children interact with their peers can influence their continuing behavior. Children who show signs of aggression may be avoided by other non-aggressive children, leaving other aggressive children to account for the role of playmate. The aggressive children feed off of their similar behaviors, often encouraging one another in support of the misbehavior (as cited in Kline, & Silver, 2004).

The neighborhood in which children live can affect their behavior. Children whose family has a low socioeconomic status may find themselves in a neighborhood surrounded by delinquent and criminal behavior. Safety concerns may affect parenting, and unemployment issues may increase tension in the home. The behaviors that are learned by children, and modeled by their parents, are affected by their circumstances as well as the neighborhood social construct. In a collection of data, Tolan et al. found that aggression and delinquency rates for inner-city communities were 2.5 to 2.8 times greater than the national average (as cited in Essau, 2003).
Prevention

Prenatal prevention. Essau (2003) has performed a meta-analysis of six reports on the effects of maternal smoking on the fetus. The results suggest that the physiological effects of nicotine on the fetus have a direct affect on its health that increases the risk for ODD. In a longitudinal study on the effects of maternal smoking during pregnancy on children from conception until 22 years of age, the authors determined that the child’s covert behavior (in the case of this study covert behavior was defined as hitting others) was attributed to prenatal smoking, a lower socioeconomic status, and less parental education. This study was in agreement with others that suggest the combination of biological and social factors can have a great effect on oppositional behavior (Monuteaux, Blacker, Biederman, Fitzmaurice, & Buka, 2006). Fergusson, Woodward, and Horwood (1998) indicate that women who smoke are also more likely to be divorced or separated, have a history of alcohol abuse, take other substances harmful to the fetus, and have children who will be more likely to be sexually abused. Quitting smoking would definitely be healthy for the fetus; however, it alone may not be enough preventative medicine to avoid having a child with ODD. Other environmental factors, such as low socioeconomic status, academic failure, and families with high levels of unemployment can be an indicator of ODD, as well (Kline, & Silver, 2004).

Developmental stage prevention. One form of prevention is an intervention at the community level to offer support to new families with an in-home visiting service that will provide education and training of new parents. Also, some of the risks for ODD can be screened at that time. Children that are identified as being at risk for ODD can then be a target for preventative efforts (Essau, 2003). Edwards and Kern (1995) conducted a study that supported their hypothesis that teachers with increased social interest will influence behaviors conducive to
social interest in their students. Social interest can be operationally defined as having something in common with other people and being a part of them which creates a sense of belonging and a behavior of cooperation (Dreikurs, 1989). Getting children involved with others in the family, at school, and in the community can help prevent defiant behavior. Teachers and the community can aid in the prevention of aggressive behavior in children; however, the primary responsibility falls on the shoulders of the parents. Dobson (2004) insists, “It is vitally important to establish a balanced environment for them, wherein discipline and occasional punishment are matched by patience and respect and affection” (p.65). He emphasizes the importance of the parents’ participation in the development of their children. Dobson outlines six steps that parents can do to head off aggressive or antisocial behavior of young children. First, teach them respect for authority by establishing themselves as strong but loving leaders. Second, define boundaries before they are enforced. Third, distinguish between willful defiance and childish irresponsibility. Fourth, reassure and teach after the confrontation is over. Fifth, avoid impossible demands. Finally, let love be your guide (Dobson, 2004). Early child development begins with healthy attachment to a caregiver, usually the mother. For the first two years the child in a healthy relationship will attempt to follow the mother around and will always want to be with her. This will strengthen the bond between them that will grow into understanding and sharing experiences (Bowlby, 1973). This secure attachment can help prevent cases of ODD caused by neglect or abuse. According to the APA (2000), the DSM-IV-TR diagnosis for reactive attachment disorder (RAD) is very similar to ODD in that many of the aggressive features that accompany ODD may also accompany RAD. One distinction between the two is that a child with RAD has an inability to form lasting social relationships. For example, either
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the child cannot form close relationships, or the child will form relationships with anyone indiscriminately.

**Montreal Delinquency Prevention Program.** This program was developed for children in the early elementary school years that have exhibited aggressive-type behaviors but have not as yet met the criteria for ODD. This is a two-year program that is similar in concept to group therapy. The children who exhibit aggression attend sessions with those who do not exhibit aggression (referred to as prosocial peers) which are determined and chosen by the teacher. The first year, they meet for 45 minutes a week for nine sessions and learn social skills that include learning how to compliment one another, discovering appropriate ways to communicate with teachers and parents, and learn ways to meet and invite other children into a group. The second year they learn more problem-solving and self control skills within ten sessions. These skills are taught through modeling, verbal instruction, and role playing. The children are encouraged to practice their skills at school as well as at home. Several studies have found that this preventative program has been successful in the reduction of anti-social behavior (Reinecke, Dattilio, & Freeman, 2003).

**Adlerian perspective on prevention.** As mentioned earlier, the Adlerian perspective is that all behavior, even oppositional defiant behavior, is purposeful. There is a reason for the child’s behavior. Most often oppositional behavior is a result of some real or imagined neglect or abuse of the child by his parents or caregivers. Dreikurs and Soltz (1990) describe attention seeking as a cause of oppositional behavior and as one of a child’s mistaken goals. How do we help the child not make that mistake?

Lew and Bettner (2000), in their description of their “Crucial Cs” explain what factors are important for children to accomplish. However, children can not always accomplish these
factors on their own. They need the attention (there is that word again) and guidance of their parents or caregivers. There are things that parents can do to help their children feel significant so that they do not feel they need more attention; however, the parents need to be proactive and involved with their children right from the start of their development.

Parents can help their children “connect.” They want to feel as if they belong and often their cry for attention is evidence that they are struggling with that aspect in their relationships. Teaching children to be self-sufficient will help them feel secure in themselves and less likely to need attention. Parents should also be aware of their children’s need to feel capable. Planning activities together and giving them some say and responsibility will help in that regard, as well (Lew, & Bettner, 2000). Lew and Bettner (2000) also give guidelines about preparing children to live in a democracy. They believe that family meetings are the best way to teach children social responsibilities and democratic reasoning. Scheduling meetings and setting general rules about who gets to talk is important, and meetings should emphasize respecting and helping others. When parents are involved in their children’s lives, and they are proactive in their attempts to head off oppositional behaviors, the results can be happier, healthy children.

**Assessment / Testing / Diagnosis**

The DSM-IV-TR reveals the criteria for ODD; however, it does not mention methods for determining if a child has a specific symptom. Usually, a child is assessed or tested after some aggressive type behavior has been observed by a parent or teacher. Thus, observation is the first critical step toward assessment. Once the behavior has been brought to the attention of a therapist or counselor, information should be gathered from the child (self-report), parent (parent-report), and teacher (teacher report). Individual biases in all reports may influence the behavior reported. For example, teachers tend to report in a more general sense, parents report in
a way that is influenced by how they feel, and children underestimate their externalizing behaviors. For that reason, more sources of reports may be needed to increase the accuracy of a diagnosis (Kline, & Silver, 2004).

According to a 2007 study on the consistency of the Teacher’s Report Form (TRF) in 21 countries, the TRF has proven to be accurate and consistent in its approach to assessing aggressive behaviors that meet the DSM-IV-TR criteria for ADHD, ODD, and CD; however, it can still be affected by the teacher’s expectations. The accuracy can also be influenced by whether or not the teacher is reporting on a class or a particular individual student (Rescorla, Achenbach, Ginzburg, Ivanova, Dumenci, Almqvist, Bathiche, Bilenberg, Bird, Domuta, Erol, Fombonne, Fonesca, Frigerio, Kanbayashi, Lambert, Xianchen, Leung, Minaei, & Roussos, 2007). This information supports the opinion that reporters’ influence, bias, and other factors can affect assessment outcome.

After reviewing the reports, the counselor may want to utilize another assessment tool such as the behavioral checklist. Two of the most used checklists are the Behavior Assessment System for Children (BASC; Reynolds, & Kamphaus, 1992) and the Childhood Behavior Checklist (CBCL; Achenbach, 1991) (as cited in Essau, 2003). Also, according to Essau (2003), both measures involve a brief period of observation by the counselor, followed by the completion of the checklist by recording the behaviors. The checklists are compared to the national average for the age group of the child. Behavioral checklists are great assessment tools; however, additional assessment may be needed to gain a clearer picture of the child’s behavior. The interview process can help provide that.

The therapeutic interview can help establish rapport with the child that can lead to pertinent information about social, school, and family factors that contribute to his behavior.
Because much of a child’s behavior and/or treatment involve the parents or caregivers, it would be beneficial to use an observational assessment measure to help determine communication patterns between the child and his parents, as well. Frick and Loney assert that the *Dyadic Parent-Child Interaction Coding System* (DPICS; Eyeberg & Robinson, 1983; Forster, Eyeberg, & Burns, 1990) will accomplish that goal. It assesses parent-child interactions over three different five minute periods of play. The information can be used for aid in treatment, as well (as cited in Essau, 2003).

Sometimes having a direct conversation with a child does not give the results or the information needed to make an accurate assessment about the purpose of the child’s behavior. Yura and Galassi (1974) suggest that one way to help make an assessment is to observe the child’s play with other children. They point out that a child who is seeking attention may be very loud and may make attempts at getting the participation from others. A child who is fighting for power may become the leader of the group of children, or the leader of an imaginary army, football team, important club, or head cowboy. One who is vengeful may be destructive in the type of play he displays by breaking toys or hitting others. The child who has become withdrawn and displays signs of avoidance may not engage in any play at all or show little interest in participating with others. The child’s behavior during play with others is usually characteristic of his attitude in his family setting.

Almost always, the therapist meets with the parent or parents of the child first. The parents’ opinions and observations are reported and the therapist uses that information to help make an ODD assessment. However, the parents are giving more information to the therapist than they are aware of. Through information about how they feel when their child is behaving defiantly, the purpose of the child’s behavior can be determined. For example, when parents feel
irritated or annoyed, there is a high probability that the child’s purpose for his behavior is seeking attention. When the parents feel angry and challenged, a fight for power is the most likely choice as the child’s purpose. When parents feel hurt, and they want to punish the child or get back at him, there is a good chance that the child’s purpose is revenge. Finally, when parents feel hopeless, as if they want to give up, avoidance is the purpose of the child’s behavior (G. Folkers, personal communication, November, 2009).

According to Kottman and Stiles (1990), during storytelling sessions with the therapist, if the child’s mistaken goal is a need for attention it will show in the interaction with the therapist. The child will attempt to maintain the therapist’s attention while engaged in telling a story. If the therapist does not give complete attention to the child, the child’s behavior may become defiant. The therapist may respond with annoying feelings much like that of the parents. Children fighting for power at home may test the boundaries set by the therapist during therapy by behaving stubbornly, acting aggressively, or throwing temper tantrums. The therapist may discover that he has feelings of anger much like that of the parents. The therapist may feel hurt when he becomes the “victim” of the child’s vengeance. When the child lashes out verbally or breaks something of the therapist’s, the child’s goal is revenge. This can take place within the story being told or in reality. A child whose purpose is one of inadequacy or avoidance may not participate in therapy. The therapist may become frustrated and discouraged to the point of referral. The authors suggest that the storytelling sessions should be mutually narrated. Both the child and the therapist should jointly tell the story using aids such as puppets. The therapist can often tell the mistaken goal of the child through his or her own emotions in dealing with the child.
Although an assessment or diagnosis of ODD may be made, Lew and Bettner (2000) point out that the oppositional and defiant behavior is not the problem with the child, it is the child’s response to the problem. Thus, the therapeutic solution should be to address the problem, not just to change the behavior.

**Treatment Possibilities**

A variety of therapy plans for treatment of ODD are available. Because ODD can be diagnosed at anytime throughout the child’s development, counselors must make sure that the treatment plan they choose will fit the child’s age and circumstance. Note that in many of the treatment possibilities below (including family based therapy), parent training of some kind is either the treatment, or it is included with the treatment. Kelsberg and St. Anna (2006) contend that there have been no specific studies in the treatment for adolescents with ODD, but studies of treatment for adolescents with CD and younger children with ODD do exist. Successful treatment, which is recognized by a decrease in the amount of aggression or disruptive behavior, always includes parenting skills training. This is reflective of the importance of the parents’ involvement. Parent involvement can be influenced by many factors. Among them are the expectancies of the parents. Parents with higher stress levels, depression, an older age child, and a child with a higher level of dysfunction have a lower expectation about the success of therapy for their child. Lower parent expectancies are positively correlated with parental participation (Nock, Phil, & Kazdin, 2001). Treatments given may reflect the orientation of the therapist, and some may work better than others for any particular client. It is important to know that there are a variety of successful options for treatment.

Not only is parent involvement crucial in the treatment of ODD, but the participation and willingness of the child is important, as well. This fact can make treatment difficult because by
definition, children with ODD are “oppositional” and “defiant,” and they have issues with people in positions of authority. So, getting them to be cooperative in their treatment may be a challenge. There may be other challenges, as well. In one 2008 study, an examination of the heart rate of children with behavioral disruptive disorders revealed that children with a higher heart rate significantly lowered their disruptive behavior after therapy. Those who had lower heart rates did not tend to benefit from therapy. This study suggests that heart rate is a significant indicator for success in therapy (Stadler, Grasmann, Fegert, Holtmann, Poustka, & Schmeck, 2008). When factors that indicate a greater or lesser chance of success present themselves, it would be advantageous to have treatment options that increase the chance for success.

**Behavioral Parent Training.** Usually, the behavior of a child with ODD can be quite troublesome to the parents. Especially if they are ill prepared or not educated in the type of communication and discipline needed to eradicate the aggressive behavior. The focus of this treatment option is to give parents the skills to better handle their child with ODD. Based on operant conditioning, this training method teaches parents to use reward and punishment, and positive and negative reinforcement to help induce change in their child’s behavior. Parents should first come up with goals that they want accomplished with their child’s behavior and then break them down into smaller tasks because larger more complicated tasks may be an impossible change for the child. Reinforcement of all behavior should happen on a daily basis. Parents will learn how to appropriately reinforce their child’s positive behaviors by using activities he likes to do (such as watching television or playing video games), and to extinguish the negative behaviors by using activities he does not like to do (such as chores). They will also learn to communicate in ways that are positive, reflecting praise, not criticism. For example, when
praising the child, the parents should be careful to add eye contact or a smile, and they should describe what the child did to receive the praise. This makes it more personal for him. Also, the parent can learn to sit down with the child and discuss what is expected from him and work out some sort of reward system; for example, charts with happy faces, stars, or a token system. When the child gets a certain amount of happy faces, stars, or tokens, he receives a reward. The child would have a goal that may induce behavioral change. In the training sessions, the parents will learn to be consistent in their discipline techniques and enforce consequences for their child’s failure to behave properly. They will participate in role playing and practice ways of responding to their child rationally (Corcoran, 2003).

**Parent-Child Interactive Therapy.** This type of therapy is based on interactions of play between the parent and their preschool-age child who shows signs of aggressive behavior. It can be divided into two types of play: that which is child-directed, and that which is parent-directed. The child-directed style is meant to increase the personal relationship between the parent and child. The parent and child engage in play without the parent’s direction or criticism. This allows the parent to observe the child’s behavior, pay attention to his likes and dislikes, and answer the child’s questions without parental input (like correction) so that any negative behaviors that are inadvertently reinforced may be extinguished. The parent-directed style is meant to increase positive behaviors and decrease negative or aggressive behaviors. The parent will do this by using clear and direct commands. They will learn to praise the child when he obeys and use discipline when disobedience is reflected. This family approach teaches new behaviors to the child as well as various new skills to the parent (Reinecke et al., 2003).

**Problem Solving Skills Training and Parent Management Training.** This program, developed by Kazdin, was designed for children from seven to thirteen years of age and has been
found to be effective in cases of ODD. The children are presented with situations not unlike those that take place at home or school. They are given the opportunity to work on their problem solving skills. The counselor helps children learn new ways to handle their problems through discussion, modeling, role playing, and reinforcement. Then they practice the new skills and learn to apply them to real life situations. The parent training portion of this treatment consists of teaching parents how to encourage and support their children in the things that they are learning. Parents are taught how to identify problems in their children’s behavior and administer proper disciplinary actions through the same techniques that their children had trained with. Some of these techniques include: discussion, modeling, role playing, and reinforcing (Reinecke et al., 2003).

**Solution Focused Therapy.** The focus of this therapy is on the family. The counselor helps the family to focus on the solution, not the problem. The family should pay attention to what works, what is not the problem, or what the exception is. By recognizing exceptions, focusing around topics that include those exceptions, and generating new exceptions, positive actions (exceptions) will increase, and the negative behaviors will decrease. One way of generating new exceptions is to have the child think of the times that he is not misbehaving and then draw pictures of what that might look like. The parents can be encouraging by complimenting and praising their child’s efforts and reward the times that are exceptions to the misbehavior. Change in one area of functioning in one family member will affect change in all members. Positive changes in the child’s behavior can directly influence various changes in the parents and the rest of the family. This allows the family to look at the situation more positively. It provides for a readjusting of their attitude toward the child. That attitude is then reciprocated by the child. Positive change begets positive change.
Counselor led, the sessions include communications that set solution focused therapy apart from other family interventions. Attempting to find exceptions, the therapist asks various questions about the family’s relationships and coping strategies. Then the therapist will reframe the negative behavior in a positive light. When asking what goals the parents would like to envision, the therapist will rephrase complaints in a positive light, as well. For example, instead of the goal “not yelling,” the statement is reframed as “communicates in a respectful manner.” The *miracle question* is a concept that can give the family and the child hope by allowing them to envision the future free from the maladaptive behavior that brought them into therapy. These questions illicit their imaginations, for example, “What would it look like if you woke up in the morning and the problem you came in here with was gone?” This gives the therapist an idea of what the family’s goals are. The *scaling questions* are ones that help to determine where the client is with regards to his or her behavior, feelings, communications, or on a variety of different topics. They allow the therapist and client to set goals for improvement by increasing the rating or ranking. An example of this can be seen in the following dialogue. “With regards to this behavior, you rated yourself a four. How would you rate yourself today?” or “What can we do to get you to a five?” With the use of these special questioning techniques and positive outlooks this therapy option has been very successful (Corcoran, 2003).

**Play Group Psychotherapy.** This type of therapy is group oriented, and the children meet once a week for an hour. The play group consists of no more than six children of the same gender, age, and level of symptoms. It is standard practice that two therapists are included in the group. Play is one of the modes of interaction that takes place in play group psychotherapy (PGP). Play in groups allows for communication between peers and between the children and the therapists. Play can contribute to change step by step. By starting slowly with individual
games and toys, and gradually working up to larger group type activities, all the while encouraging growth and modification of behavior, aggressive behavior can be eliminated. Another mode of interaction is verbal intervention. Together with play, verbal intervention has proven to improve patterns of communication and social relationships, increase self-esteem, and diminish aggressive behavior. When the therapy starts, ground rules are laid out, and the children discuss their goals with the therapist individually. All children in the group must adhere to the rules so that each child can feel safe. This is where the verbal intervention comes in. The therapist guides the flow of interaction between the children, discussing with the group all the children’s behavior including what they did, and what they should have done. Each individual case will be discussed in the group. Over time, therapist-directed conversations and interactions with all the children in the group, while in the group, will increase the children’s ability to express emotions, get along well with peers, and behave properly in home and school situations. Parents meet in groups as well, so that they can learn and understand what their children’s goals are and what progress they are making. Also, the parents can use this group time to inform the therapists of events that have taken place that might have an effect on all the children in the group. Group meetings for the parents can be a good source of support as well (Kernberg, & Chazan, 1991).

**Dinosaur School with Parent Training.** This training program has a child component called “Dinosaur School” for children ages 4 to 7, and a parent training component. In the Dinosaur School, groups of children are taught through the modeling of life size puppets (much like that of children’s shows on television) and through watching videotapes. Topics that are modeled include coping with being teased, making new friends, being empathetic, resolving conflicts, and controlling anger. After watching the videotapes and the modeling puppets,
children practice behaviors and improve on their social skills. Rewarding techniques are practiced when children make positive motion toward acceptable behavior at school and at home. The parent training is done in groups with a therapist after watching videotapes giving examples of how to deal with ODD children. The tapes, which give examples and information on subjects such as play techniques, setting limits, communications, emotions, and ways to deal with aggressive behavior, are discussed by the group of parents. Follow-up group sessions are given, and parents can encourage and support one another. Separately, both components of this treatment have proven to be successful, but together the rate of success is even greater. Success of the child component suggests that treatment can still be accomplished in spite of non-participating parents (Reinecke et al., 2003).

**Anger Coping and Coping Power Program.** Often aggressive behaviors are accompanied by anger. The Anger Coping Program (ACP) was designed for children from fourth through sixth grades who have trouble with issues of anger. The program is divided into two components, both within a group format. The first component teaches children the “rules for conduct” and a point system that is utilized to reward children for compliant behavior. It also helps children to direct their efforts on identifying and working on specific goals for behavior modification. Goals that are more easily accomplished at first are important to keep children motivated for change. The second component teaches them to increase positive coping and problem solving skills. The anger management portion focuses on teaching positive behaviors such as calming and distraction techniques. Through the use of puppets and role modeling, they learn proper responses to teasing and gain a truer perspective on what other children may mean when they speak. The children practice using real life situations that they may encounter. The ACP may be followed by a more intense program called the Coping Power Program (CPP). This
program is a continuation of the ACP. It has training in several additional areas such as emotional awareness, social skills enhancement, relaxation, and peer pressure. Extra individual sessions as well as parent training may be included. Parent and child training are to be taken simultaneously. Parents learn to set boundaries and make clear rules for children. They also learn how to discipline appropriately, communicate properly, and manage stress. Success in anger management programs have proven to be positive, and like other treatments, the inclusion of parent training increases overall success (Reinecke et al, 2003).

**Psychopharmacology treatment.** Essau (2003) informs readers that it would be inappropriate to give a child medication for ODD without first attempting to modify the child’s behavior through any of the optional therapies available. Medication can cause the symptoms of ODD to lessen; however, it cannot take the place of learning new skills or improving self-monitoring techniques. The taking of medication can reduce a child’s self-esteem, especially if taken in public because of the stigma that goes with it. According to Kline and Silver (2004), as of 2004, there has been no empirical evidence to suggest that any medication is successful to treat aggression caused by ODD alone; however, due to the high comorbidity rate of ODD and ADHD, success with the deterring of aggressive behavior has been accomplished when the child is given psychostimulants such as Ritalin for ADHD. There have been other medications that have been successful in alleviating aggressive behaviors such as those affiliated with ADHD and ODD together. Along with stimulants, there are also antidepressants, tranquilizers, antipsychotics, and mood stabilizers that have some success with altering aggressive behaviors. In a review of pharmacotherapy of disruptive behavioral disorders (DBD), Ipser and Stein (2007) reported that lithium (a mood stabilizer) and risperidone (an anti-psychotic medication) particularly showed positive signs for treatment of DBDs. Not all medications are effective for
all symptoms, and side effects and safety concerns should be taken into consideration when
prescribing medication as well. Prescribing medication should be used only in extreme cases of
maladaptive or aggressive behavior (Essau, 2003). Ipser and Stein (2007) suggest that “a careful
risk-benefit analysis is needed for each patient.”

As previously mentioned, some medications work well with children who have been
diagnosed with ADHD and ODD combined. Turgay (2009) suggests that medication that helps
children take control of their ADHD symptoms may find improvements in their ODD symptoms
as well because it may be that children’s ODD symptoms are a result of their attempt to deal with
their ADHD symptoms. This could be a basis for the strategy of administering only one
medication at a time; however, he also points out that an equally viable strategy would be to
administer more than one medication providing that ODD is associated with multiple co-morbid
disorders. The administering of medication needs to be given on an individual basis.

**Adlerian therapy.** The Adlerian position takes a nonpathological approach. It does not
look at clients as being sick, only discouraged (Bernheim, Rescorla, & Rocissano, 1999). This
frame of thought is the foundation for the concept of encouragement. Adler (1964) emphasized
“in every step of the treatment, we must not deviate from the path of encouragement” (p. 342).
When interacting with the client (both the child and the parents), encouragement is necessary for
the instillation of hope. Children need to be encouraged so that their self-esteem and motivation
will increase. Since ODD is a product of the children’s inferior feelings, encouragement and
continued affirmations are a very important part of therapy starting from the initial session when
the therapeutic relationship is built. According to Kottman (2001), encouragement
acknowledges children’s strengths and efforts to make progress, and it helps to build their sense
of competence and willingness to try new behaviors without fear of making mistakes.
Parents also respond well to encouragement. They will be learning new skills and techniques for parenting a child with ODD, and they may find it overwhelming at times. The therapist should encourage them through their doubts and difficulties by letting them know that they can accomplish this task to a positive resolution. Adler’s response to what encouragement accomplishes is that “everybody can do everything” (Adler, 1964, p. 342). In Adlerian Therapy, this common sense approach is the basis for its success. Many other methods of therapy will include some encouragement techniques, as well. For example, Solution-Focused Brief Therapy utilizes encouragement similar to Adlerian Therapy in three distinct areas: the therapist-client relationship, during the facilitation process or reorientation stage, and through both their similar perspectives on maladjustment. Clients are not sick; they are discouraged and helped mostly through the process of encouragement (Watts, & Pietrzak, 2000; Oberst, & Stewart, 2003).

Keeping the therapist attitude of encouragement as a constant, Adlerian Therapy has four basic steps to its process. The first step in the process is to establish rapport with the client. The second step is to make an assessment. The third step is to create awareness or insight within the client. Finally, the fourth step is to reorient the clients thinking and/or behavior.

One way to accomplish the first step of establishing rapport with children is with the use of play techniques. Kottman (2001) points out that play therapy allows children to communicate in a way that comes natural to them such as storytelling, playing, drawing, painting, making puppet shows, and constructing things out of clay. She emphasizes that little change may occur initially, but children may become more willing to talk with the therapist. Play therapy interests children. It can help in making an assessment of their behavior as well, but more importantly, play gets their attention. Children love to play, and joining them in playing games or talking to them through the use of puppets or action figures, can facilitate a cooperative environment
between them and the therapist (Yura, & Galassi, 1974). Letting children create something out of clay, or building up their self-esteem by delivering encouragement to them as they draw or color pictures, will also help the therapeutic relationship. Encouragement towards the children’s efforts rather than the results of the attempted task will help them become more confident in their abilities for solving problems, and it will help them gain some of the significance that they believe is needed (Kottman, & Warlick, 1989; Oberst, & Stewart, 2003). Oberst and Stewart (2003) insist that encouragement should be given even when children fail at a task or have difficulty reaching a goal. They emphasize that encouragement does not criticize but focuses on the children’s strengths.

After establishing rapport and making an assessment (discussed in the assessment section), the next step is creating within children, insight, awareness, and understanding of their defiant behavior and the purpose for it. There are various techniques and methods used for creating insight with children in Adlerian Therapy. The use of play therapy can be one avenue that provides an atmosphere for children to gain insight into their own behavior and the purpose of that behavior. The therapist helps the children examine their behaviors and mistaken goals and then reveals the implications or consequences of that behavior to them. They will also learn how their mistaken goals have inhibited a positive self-image and successful social interactions (Kottman, 2001).

Another way to promote insight in children is to interview them and use the collection of early recollections and role playing. Children can give an early recollection, the most vivid moment, and the feeling about it. When the story is interpreted and then rewritten, the use of role play with or without the aid of play therapy such as using puppets or drawing to retell the story is emphasized. Often, children become aware that their mistaken beliefs might not be the
correct interpretation, and with the help of the therapist, a reframing of their story and their beliefs can be accomplished (Strauch, 2007).

Collecting early recollections can also be done through the use of children’s drawings, which may be a better alternative because children often have difficulty expressing themselves verbally. Children drawing or painting pictures may give the therapist an opportunity to see the early recollection through their eyes. These drawings expose their thought process and lifestyle, and they allow the therapist to question the children about their story or early recollection. As in any early recollection, questions about what is remembered most and what feelings accompanied it would be asked. Of course, asking children to draw the answer, giving encouragement along the way, keeps them interested and involved in the process (Rotter, Horak, & Heidt, 1999).

The next step in Adlerian Therapy is to reorient the client’s mistaken beliefs or thinking and the client’s oppositional and defiant behavior. When children have gained insight into their mistaken goal or goals, there will be a determination of their goal. According to Lew and Bettner (2000), children are seeking significance through connecting with others. They also need to feel as if they are capable, to know that they count, and to possess courage. They need to be able to work hard toward accomplishing something. Adlerian Therapy addresses how to meet all those needs of children. A lot of these concepts can be first accomplished through the interactions with the therapist. Later, parents can be educated and learn what needs are crucial for children. They can learn how to deliver what is needed in a successful way through skills training and practice.

As discussed by Kottman (1999), reorienting is a time “to use encouragement to foster growth in the less developed Crucial Cs.” A child that struggles with the ability to “connect” can be encouraged to make social connections through particular encouraging statements from the
therapist when the child makes positive movement towards others. Some examples given by Kottman are as follows: “I noticed that you smiled when I threw you the ball just now.” and “You looked happy to see your mother when she came” (p. 294-295).

Kottman (1999) also suggests that when a child is struggling with his sense of being “capable,” encouraging statements regarding the child’s progress should be made no matter how small the effort or improvement appears. Examples of these types of statements include: “Wow, you thought you couldn’t do that, but you did.” and “You look really excited about the picture you painted.” When the child views himself negatively and feels as if he does not “count,” statements of encouragement such as the following can be made: “I am really glad you came to the play room today.” and “It sounds like your part in the play was really important.” Finally, when a child lacks “courage” to try new things or participate with others, encouraging statements that will build up the child’s self-esteem can be made. Examples of those types of statements are as follows: “I believe that you are strong enough to take the lid off the sandbox yourself.” and “You can decide what color to paint the turtle” (p. 294-296).

The reorientation stage is a process of changing the oppositional and defiant behavior by changing the self-concept of children. The encouraging statements listed previously and others like them help to make children feel as if they are connected, they count, they are capable, and they can be courageous to try things. These tools of encouragement can be implemented by the therapist and the parents alike.

Since the children have undergone a period of time for learning, understanding, awareness, and insight, they could be asked “What kind of person do you want to become?” Their answer will begin the process of change, and they could be put in the position of determining for themselves the direction of their therapy, their growth, and their behavior
Children cannot move forward on their own accord; they may be ready for change, but they need help.

Parents of oppositional children need to learn skills that will not only help reframe their children’s way of thinking about them, but will deal with the misbehavior when it does happen. Before parenting skills can be taught, parents must first be educated on the Adlerian perspective of punishment and discipline. Lew and Bettner (2000) declare that “Punishment always involves pain.” and that “…pain is not a way to teach” (p.57). According to Oberst and Stewart (2003), “Punishment provokes anger and hatred.” The child will feel humiliated when punished which makes it much harder to learn new behaviors (p.113). The Adlerian concepts of logical and natural consequences replace punishment and acts as a disciplinary action itself.

According to Adler (1964), everyone should “experience the consequences of their errors” as opposed to “paying for a mistake” (p.397). Certain repercussions must take place for any misbehavior or mistake. Those that happen naturally as a result of the child’s behavior are referred to as natural consequences. Those that happen out of a failure to adhere to a previously established set of rules, regulations, laws, or limitations are referred to as logical consequences (Oberst, & Stewart, 2003). Both natural and logical consequences will replace the need for the parent to be “the bad guy” and punish the child. An undesired natural consequence will make the child think twice before behaving in a like manner in the future. Logical consequences have already set the consequence for future oppositional or defiant behaviors, so it becomes the choice of the child whether to misbehave.

It is very important that the parents not only learn what natural and logical consequences are but that they learn how to deliver them without the consequence sounding like a punishment. For example, if an adolescent child is supposed to put dirty clothes in a clothes hamper and it is
not done, the natural consequence is that the clothes that were not put in the hamper do not get washed (until the next time laundry is done). However, this may seem like a punishment if the parent responds to the child’s disappointment at not having clean clothes with statements such as “It is your own fault. You should have…” or “Maybe next time you will do what you are supposed to.” It would be better if the parent acted as if it is no big deal and respond in a friendly attitude with “I washed all the clothes in the dirty clothes hamper. When the clothes are in the hamper I know that they are dirty.” These techniques work well with oppositional and defiant children; however, non-problematic children do not always follow the rules, and the technique of using natural and logical consequences will work for them, as well (Oberst, & Stewart, 2003; Dreikurs, & Soltz, 1964).

Dreikurs and Soltz (1964) contend that our children’s responsibilities and the consequences for their actions “belong to them” (p. 77). It is the experience of our children’s consequences that create for them a real learning situation. Parents need to be able to allow time for the natural consequences to take effect. For example, children who do not eat go hungry. They will have another opportunity to eat at the next meal time. It is their choice. Parents who understand these concepts may have the foresight to establish a consequence for children whose behavior is unacceptable. Giving the children responsibilities that take the burden off the parents will put the choice in the hands of the children. Dreikurs and Soltz (1964) give an example of giving children who do not want to get up in the morning an alarm clock thereby putting the responsibility of waking up and getting ready for school solely on them. Parents must act as if they are not concerned about the children being ready and should go on with their own business. If the children miss the bus, they can walk to school because children have a lot of energy. One good walk and they will make sure to get up as needed next time. It is important that parents do
not let on that they are frustrated. “Many of the things children do which annoy us are done for that very purpose” and “logical consequences work very nicely here” (p. 82).

Finally, the Adlerian concept that, according to Adler (1964), “is the barometer of the child’s normality” is social interest (p. 154). Through the words of an unnamed English author, Adler suggests that social interest is well defined as “To see with the eyes of another, to hear with the ears of another, to feel with the heart of another” (p.135). He contends that social interest is an innate process that needs to be nurtured and practiced. However, it can only be improved in the presence of others. We as humans are social beings and socially embedded. We need to be around others, to work with others, to cooperate with others, and be dependent upon others, as well. Adler comments that “A man is called good when he relates to other humans in a generally useful way, bad when he acts contrary to social interest” (p. 139).

Social interest influences certain behaviors and abilities in children, as does the lack of social interest. In a study to examine the relationship between social interest and coping resources in children, Edwards, Gfroerer, Flowers, and Whitaker (2004) report that many children have difficulty coping with stressful situations at home and at school while others are quite resilient in their handling of similar situations. They found that there is a positive correlation between the social interest of children and their ability to cope with stress. They suggest that by increasing children’s social interest, their ability to cope with demanding events in life can be improved. The authors contend that when children feel connected to others and have some social support, their feelings of stress will decrease.

A reciprocal relationship between children’s social interest and their sense of belonging is also apparent. Children who experience a high sense of belonging are very socially interested and vise versa (Edwards, et al., 2004). This lines up with Lew and Bettner’s (2000) Crucial C of
the children’s need to feel connected. A way to increase the children’s need to belong or feel connected is to increase their social interest. Edwards and Mullis (2001) suggest that in a school environment, children who need to develop a sense of belonging should be in classrooms that are smaller and that maintain the same teacher throughout the day and year. This would give them a longer period of time to make connections with other students and with the teacher. The teachers should allow time in the curriculum for students to get to know each other. The authors also make a connection between belonging and the children’s feelings of being capable. They assert that when teachers encourage children’s strengths, the children feel more capable, and they are given a sense of connectedness. Finally, they indicate that children’s need for belonging can be enhanced by volunteering in community service or a local charity. The children’s contribution to the community in a cooperative manner is crucial to the increase of social interest.

Cooperation is important in the family, but it is often lost when children have gone down the path of oppositional and defiant behavior. Dreikurs and Soltz (1964) explain that when children lose their place in the family (which can happen as a result of a lengthy period of misbehavior), cooperation can be furthered by helping them regain their place. It would be necessary for the family, and more importantly, the parents, to encourage them so that they feel valuable. This could be done by increasing their feelings of significance within the family. Letting them help in areas of need and asking for and considering their opinions will create a sense of belonging. Parents need to learn ways to phrase statements made to their children so that they feel significant, and therefore, will be cooperative with the family. In many ways, the parents will need to work as hard as or harder than the children with the oppositional and defiant behavior. Dreikurs and Soltz (1964) suggest that parents be polite when they speak to their children. The tone of voice is as important as the message. Resistant children will find fault not
only in what is said but in how it is said. The authors emphasize that comparing children in the family or using words such as “good” or “bad” may increase the misbehavior. Remember that when children are encouraged, they should be encouraged on their effort, not the result.

Creating an Adlerian Treatment Plan

To devise a treatment plan for ODD, some information and guidelines have been taken from *The Child Psychotherapy Treatment Planner,* (3rd ed.), (Jongsma, Jr., Peterson, & McInnis, 2003). When creating a treatment plan, therapists should attempt to incorporate their own interests and orientation into it. For example, if a therapist enjoys working with play therapy, it should be incorporated into the treatment plan, provided it is a good fit for the client, as well. This paper will incorporate Adlerian Therapy into the following treatment plan since its focus is through an Adlerian perspective. Because both the child and the parents are not only involved with each other, but have their own skills, training, and education, long-term and short-term goals for both will be helpful in the treatment plan. The treatment plan in Adlerian Therapy is the third and fourth steps of the therapeutic process. It represents the creation of client insight and/or reorientation of the client’s self-talk, mistaken beliefs, or disruptive behaviors and desires.

**Develop a list of long-term goals for the child.** These are goals of the child’s behavior changes, attitude changes, and resolutions of anger and conflicts that involve the child, parents, family, and/or school. Be sure to gather input from all sources in order to make a more complete list. The list can be altered as other issues are revealed. This is a fluid process, and flexibility of treatment is essential as new information about the child and his purpose for the defiant behavior surfaces. A goal of decreased disruptive behavior should be emphasized. Also, there should be a plan for an increased ability to connect with others, an increase in the child’s self-esteem and his feelings of being capable, an increase in the child’s feelings of significance (he should feel as
if he “counts,”) and a development of or an increase in the child’s courage to try new things (Lew, & Bettner, 2000).

**Develop a list of long-term goals for the parents.** These goals may consist of final outcomes for learning new parenting skills that may be quite different than skills needed for parenting non-problematic children. Parents should create a long range disciplinary plan in the joint understanding of what is expected and tolerated; for example, education about natural and logical consequences. They will also need to be able to implement the concepts of Adlerian disciplinary action through natural and logical consequences. Parents can determine what their long-term goals for dealing with their child would look like. For example, patience is a learned process and difficult for those with high expectations. It could take time to develop that skill.

**Develop a plan of action with short-term objectives for the child.** This will break down the list of long-term goals into smaller objectives. These smaller objectives give the therapist an outline of the treatment plan as a whole.

Adlerian Therapy starts with establishing rapport with the child so that he or she will feel comfortable. This opens the door for the therapist to gain information both verbally and observationally. The therapist makes an assessment of the child’s situation, determines a possible purpose of the child’s behavior, and decides on objectives for the child. The Adlerian approach can be utilized through individual, parent/child, family, or group intervention methods. More than one objective may be worked on at the same time because many of the goals overlap each other. One symptom or one behavior may affect more than one event.

Lew and Bettner (2000) have described a plan for treatment of the Crucial Cs. Their first goal is to help the child feel connected. They do this by providing: opportunities for interaction, positive attention, recognition of the child’s strengths, acceptance, and a plan for family
meetings. Their second goal is to help the child feel capable. Three steps are used in accomplishing this: making each mistake a learning experience, building confidence, and holding family meetings. The third goal, which is to help the child feel as if he counts, can be accomplished through the child making contributions, through recognition of those contributions, and by holding family meetings. The fourth goal, which is to help the child develop courage, has more steps which include: having the courage to be imperfect, pointing to strengths, avoiding comparison, asking questions, avoiding debilitating help, avoiding criticism, and holding family meetings. This is a crucial step to developing social interest.

**Develop a plan of action with short-term objectives for the parents.** The parents need to be encouraged that positive outcomes can be accomplished with their child. Seeing short-term goals being met will create confidence that the long-term goals can be met, as well.

Parents will need to understand how to interact with their child so that they can make them feel connected, capable, counted, and courageous. They must learn the Adlerian way of delivering encouragement. They must learn how to communicate natural and logical consequences to their child without making the consequence sound and feel like a punishment. Parents must also establish the family meetings. They should reflect the importance of the family meeting by setting times without interruptions (Lew, & Bettner, 2000).

**Develop a plan for termination.** This can be done immediately. The goal is for speedy success. Generally, determine the point at which treatment can be terminated with only follow-up appointments to check on progress, and then complete termination. Determine what goals need to be met in therapy, and what goals could be met with parent training at home. Another point to consider is the feelings of the child about termination. Many factors can affect feelings about termination. Some feelings may be positive in nature, which often reflect the client’s
satisfaction with experiences in therapy and any positive outcomes or personal gains the client
has accomplished, as well. Often, when therapy is successful, termination can be an indicator of
client readiness for independence and use of any newly acquired skills (Roe, Dekel, Harel,
Fennig, & Fennig, 2006). Of course, continuous encouragement from the therapist helps in this
regard.

Some feelings about termination may be experienced as negative for some clients. The
therapist may not have established good rapport with the client, or the client may have felt as if
the therapist was not accepting or respecting of the client’s decision about termination. Often, a
client in this position feels lonely, abandoned, or rejected. Thoughts of unfinished business in
therapy may be a precursor to feelings of anger and frustration (Roe, et al., 2006).

Be prepared to refer the client to another therapist. Although early termination is not
desired, it may be necessary. Not all clients (or their parents) will be a good fit for therapy with
every therapist.

Internet Resources

When parents or families of children with ODD are concerned enough to not only seek
help but ask for any information that might be useful to them, it would benefit them greatly if the
counselor had such information. Internet sites can be tremendous resources that offer
information on topics such as diagnosis, treatments, research, and medications. It can also
provide suggestions and strategic plans that help guide parents to take proper steps for
intervention. See appendix A for internet sites that may be useful resources.

Conclusion

This paper defined oppositional defiant disorder (ODD) and reported the symptoms
needed to meet the criteria required for its diagnosis. Some of the major factors or causes of
ODD were discussed along with ways to prevent it. The most used tests and measures were presented, along with the importance of observations and the interview process. Many possible treatment options are available, and some successful ones have been listed as well as steps to develop a treatment plan. ODD can be prevented, and it can also be treated to its elimination.

Throughout this paper, within the sections on risk factors, prevention, and treatment measures, Adlerian concepts have been discussed with an emphasis on encouragement and social interest. If the symptoms of ODD can be recognized by a parent, teacher, or counselor, and an Adlerian treatment plan can be implemented, the child has a great chance of reorienting his thought process, changing his aggressive behavior, and living a happier life in cooperation with others.
Appendix A

Big’s Place (www.bigsplace.com/ODD.html)

Conduct Disorders.com (www.conductdisorders.com)

Kwik Link Internet Services (www.klis.com/chandler/pamphlet/oddcd/oddcd-pamphlet.htm)

Internet Mental Health (www.mentalhealth.com)

Not My Kid.org (www.notmykid.org/parentArticles/ODD/default.htm)

New York Online Access to Health (www.noah-health.org)

Kentucky.gov (www.state.ky.us/agencies/behavior/homepage.html)

Uplift-Wyoming (www.upliftwy.org/publications/dis/odd_pub.pdf)
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