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Abstract

Oppositional Defiant Disorder (ODD) clinically affects children and adolescents through the display of unwanted disruptive, hostile, defiant, and oppositional behaviors. Development of these can be linked to parental psychopathology, family and marital dysfunction, poor parent-child interaction, atypical parenting, maternal age, substance abuse, poor supervision, and inconsistent or harsh discipline. The effects of ODD lead to impaired social functioning, depression, low self-esteem, academic failure, substance abuse, delinquency, and family discord. Compared to other treatments (e.g., medication, behavior modification, punishment, or removal from the home) the most effective course of treatment for ODD is the use of family therapy and parent training techniques. Examples of effective programs and interventions are described, and recommendations for future research are discussed.

**OPPOSITIONAL DEFIANT DISORDER:
USING FAMILY THERAPY AND PARENT TRAINING TECHNIQUES FOR
EFFECTIVE TREATMENT OUTCOMES**

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by

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Oppositional Defiant Disorder (ODD) clinically affects children and adolescents through the display of unwanted disruptive, hostile, defiant, and oppositional behaviors. Development of these can be linked to parental psychopathology, family and marital dysfunction, poor parent-child interaction, atypical parenting, maternal age, substance abuse, poor supervision, and inconsistent or harsh discipline. The effects of ODD lead to impaired social functioning, depression, low self-esteem, academic failure, substance abuse, delinquency, and family discord. Compared to other treatments (e.g., medication, behavior modification, punishment, or removal from the home) the most effective course of treatment for ODD is the use of family therapy and parent training techniques. Examples of effective programs and interventions are described, and recommendations for future research are discussed.

The development of behavior disorders in children and adolescents continues to be a growing concern for parents, teachers, and mental health professionals in American society (Kazdin, 1991). The concern is perpetuated by the supposition that immediate and effective treatment results are expected (Conoley et al., 2003). This desire for quick results can be exemplified by the extensive research which supports that behavior disorders such as Oppositional Defiant Disorder, Conduct Disorder, and Attention Deficit Hyperactivity Disorder can exist comorbidly (Eaves et al., 2000), and are treated similarly with medication to control the behaviors (Grizenko, Papineau, & Sayegh, 1993). This treatment modality presupposes the need to address a biological disorder leading to the behavior inadequacies or extremities that are impeding the family or classroom atmosphere (Eaves et al., 2000). However, research has overwhelmingly indicated that the most effective means of treating and changing unwanted behaviors in children and adolescents is through parent and family training and therapy (Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001; Webster-Stratton, Reid, & Hammond, 2004). The etiology of such behavior disorders are, “inadvertently developed and sustained in the home by maladaptive parent-child interactions” (Kazdin, 1991, p.789), and the result of, “counterproductive parenting strategies to deal with these problems” (Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004, p.1).

Awareness of the importance of treating the unwanted behaviors in a systemic view demands the focus of intervention to be a familial therapeutic response (Chronis et al., 2004; Huey, Henggeler, Brondino, & Pickrel, 2000). As Kazdin (1991) expressed, "...parent, family, and no doubt other contextual factors are part of the diagnostic picture because they may directly affect child treatment course and outcome" (p. 792). The ultimate goal of treatment should not only focus on the behavior of the child or adolescent (and the treatment of that behavior), but on the dynamics of the family system (Barkley et al., 2001; Frick et al., 1992; Schoenwald & Henggeler, 1999). To thoroughly re-establish desired behavior for the youth, assessment and evaluation (Bahl, Spaulding, & McNeil, 1999) along with multi-faceted (Grizenko et al., 1993) treatment involving many contextual factors of the child's life would theoretically result in effective treatment outcomes (Schoenwald & Henggeler, 1999).

The purpose of this paper is to evaluate the research that would indicate treatment of Oppositional Defiant Disorder (ODD) is most effective through family therapy interventions and parent training. The research will be reviewed and synthesized to determine which modalities support the most effective intervention and therapeutic module for changing behavior.

Characteristics of ODD

Diagnostic Criteria

Children and adolescents are often referred to treatment due to manifestation of disruptive, attention seeking, or hyperactive behaviors (Grizenko et al., 1993). Oppositional Defiant Disorder defined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000), is "a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months" (p. 100). It further describes this disorder as having a gradual onset, usually evident before 8 years of age and not later than adolescence, and more prevalent in boys than girls before puberty (DSM-IV-TR, 2000). DSM-IV-TR (2000) Diagnostic criteria for ODD include:

Often loses temper, often argues with adults, often actively defies or refuses to comply with adults' request or rules, often deliberately annoys people, often blames others for his or her mistakes or misbehavior, is often touchy or easily annoyed by others, is often angry and resentful, and is often spiteful or vindictive. (p. 102).

Comorbidity Features

The DSM-IV-TR (2000) identifies key diagnostic criteria for behavior disorders. Attention Deficit Hyperactive Disorder (ADHD), Conduct Disorder (CD), and Oppositional Defiant Disorder (ODD) are categorized under the

grouping of Attention-Deficit and Disruptive Behavior Disorders (DSM-IV-TR, 2000). Spitzer, Davies, and Barkley (1990) explained that although these three diagnoses have separate criteria, they often exist comorbidly. The outcomes for children and adolescents are often similar for this diagnosis including social impairment, depression, or academic failure (Grizenko et al., 1993).

Etiology of ODD

Parental Characteristics and Styles

Literature determined key risk factors of ODD to include family and parent functioning and interaction (Conoley et al., 2003; Frick et al., 1992; McKee, Harvey, Danforth, Ulaszek, & Friedman, 2004; Webster-Stratton et al., 2004), or more specifically parenting characteristics and style (Frick et al., 1992; Lindahl, 1998; McKee et al., 2004; Webster-Stratton et al., 2004). Correlations for development of ODD can be directly linked to parental psychopathology (e.g., depression and antisocial behavior), family and marital dysfunction, poor parent-child interaction, atypical parenting (Carlson, Tamm, & Hogan, 1999; Lahey, Miller, Gordon, & Riley, 1999), maternal age, and substance abuse (Frick et al., 1992; Lahey et al., 1999).

Parenting styles which have been found less effective overall have a more negative interaction and view of their children, lack consistency, are more demanding and less approving, more negative and critical, and have a coercive style of parent-child interaction (Lindahl, 1998). In addition, Frick et al. (1992),

Lahey et al. (1999), and Loeber and Stouthamer-Loeber (1986), found aspects of parenting which had the greatest impact on development of ODD were poor parental supervision, lack of parental involvement in the child's activities, inconsistent or harsh discipline (Dodge & Pettit, 2003), and ineffective parenting strategies (Lindahl, 1998). McKee et al., (2004) also stated maladaptive coping styles in parents correlate with over reactivity, coerciveness, and dysfunctional discipline of children

Family Structure and Function

As determined by Lahey et al. (1999) an important identifying risk factor is family structure and size. Children and adolescents who come from families with increased stability (controlled change and chaos) tend to have lower rates of disruptive behavior disorders (Lahey et al., 1999). Families with two parents in the home are able to provide more supervision, less change, and more stability (Lahey et al., 1999).

Families with higher rates of marital discord or overall family dysfunction are associated with the development of ODD (Frick et al., 1992; Lahey et al., 1999; Lindahl, 1998). Although as expressed by Lindahl (1998), "Family-level conflict has shown a stronger link with child conduct problems than marital conflict has, most likely because children are more frequently exposed to and involved in family, rather than marital conflict" (p.421). Calzada, Eyberg, Rich,

and Querido (2004) indicated that mothers tend to experience increased levels of stress due to disruptive behavior in children.

Overly rigid boundaries in a family system can lead to disengagement and lack of cohesiveness within the family, and result in the overall deteriorated functioning of the family (Lindahl, 1998). Overly loose boundaries, which lead to chaotic or inconsistent patterns of interaction in the family, are correlated with maladaptive child behavior (Lindahl, 1998). Thus, “disconnection and inconsistency within family relationships appear to be strongly associated with conduct problems in children” (Lindahl, 1998, p. 422).

Effects of ODD

Social and Psychological

The impact that ODD can have in the development, function, and adjustment in the life of a child or adolescent can be detrimental if left untreated (Grizenko et al., 1993). For example, Webster-Stratton, et al. (2004) projected that for young children who display conduct problems, these patterns of behavior can become permanent by age eight. Thus, this would initiate the escalating concerns of such things as impaired social functioning, depression, low self-esteem (Grizenko et al., 1993), academic failure, school drop-out, substance abuse, delinquency, and violence (Snyder, 2001).

Coie and Dodge (1998) reported significant indication that children who demonstrate conduct problems often suffer from cognitive delay and social skill

deficits. Hogan (1999) found clear indication that when ODD has onset in early childhood, there are typically cognitive difficulties. ODD children have lower IQ, academic difficulties, delay in development of age-appropriate social skills, maladaptive information processing, and trouble with self-regulation (Hogan, 1999).

Furthermore, Grizenko et al. (1993) and Lindahl (1998) indicated that the dysfunctional parent-child interactions that have been found to increase the likelihood of a child developing disruptive behavior disorders are predictive of social and peer interactions. The risk that can occur for children who have been identified with behavioral disorders is the experience of rejection by peers or adults (Ledingham, 1999; Webster-Stratton et al., 2004). This continual cycle of problematic behavioral interaction with others leads to life long issues of coercive interactions, peer rejection, lowered relational satisfaction, and escalation in the development of severe conduct problems (Ledingham, 1999; Webster-Stratton et al., 2004).

Developmentally, in a significant amount of cases, ODD is a precursor to CD (DSM-IV-TR, 2000). Due to the nature of the behaviors, if ODD is left untreated it has the strong potential to lead to CD in adolescence (McKee et al., 2004; Quay, 1999).

Long-Term Effects

The development of behavioral disorders in childhood can lead to “compromised physical and social well being in the adult years” (Dishion & Andrews, 1995, p.538). Precursors to this adult dysfunction can be observed in adolescents with high risk behavior such as early tobacco use, drug and alcohol abuse (which inevitably can lead to academic failure), and sexual and antisocial behaviors (Dishion & Andrews, 1995).

ODD effects family functioning since the presence of the child’s disruptive behavior leads to increased dysfunctional interactions (Chronis et al., 2004). ODD behaviors result in “increased stress among parents of children with the disorder...over time, parents may develop maladaptive and counterproductive parenting strategies to deal with these problems” (Chronis et al., 2004, p. 1).

Common Treatments for ODD

Psychopharmacological Treatment

Oppositional Defiant Disorder affects anywhere from 2-16% of the population (DSM IV TR, 2000). While of that percentage, only 5-8% are diagnosed and treated (Barkley & Benton, 2000). When considering ODD in childhood, issues affecting attention and concentration occur in the form of evaluation for Attention Deficit Hyperactive Disorder (ADHD). According to Schachar and Ickowicz (1999), the prescription of medication for children with ADHD has increased dramatically in the last decade with use of stimulants such

as methylphenidate (Ritalin). As found by Barkley et al. (2001) there is indication that parent and family treatments alone are less effective when a child requires biological treatment, such a medication, to combat genetic etiology.

However, in the case of ODD, if there is no comorbidity, the use of medication has been much less effective (Eaves et al., 2000; Schachar & Ickowicz, 1999).

School Interventions

In the school setting, practices such as extinction, verbal reprimand, physical punishment, and overcorrection have been proven ineffective when managing behavior (Kavale, Forness, & Walker, 1999). However, Barkley et al. (2001) indicated that strict behavior management techniques can be most effective. These techniques can include such things as tangible reinforcements, token reinforcements, contingency contracting, modeling, social reinforcements, time-out procedures, anger management training, and social skills training (Kavale et al., 1999).

Alternative Programs

One of the most severe treatment interventions for clients with ODD, is the option of residential or day treatment programs (Grinzenko et al., 1993). As described by Chamberlain (1999) these programs consist of “community-based family-style group homes, cottages in larger institutional settings, large group living situations with shift staff...or therapeutic foster care” (p. 495). Similarly, but less restrictive are day treatment programs (Chamberlain, 1999). These

usually are based on the same principles as residential treatment, including the use of cognitive behavioral interventions and the process of developing positive peer cultures, but have the benefits of “community location and preservation of links to the family and peer group” (Grinzenko et al. 1993, p. 128). Grinzenko et al. (1993) also determined that the need for targeting a child’s social system holistically has added benefits compared to parent or behavioral modification only.

Using Family Therapy to Treat ODD

Treating the Family as a System

In contrast to the more common modalities to treat ODD, Kazdin (1991) determined that psychotherapy for children and adolescents is an effective form of treatment, and has advanced significantly over the last few years. The marked increased effectiveness of including the family in working with children and adolescents with ODD is clearly supported (Barkley et al., 2001; Conoley et al., 2003; Webster-Stratton et al., 2004). Family therapy has consistently shown effectiveness in dealing with family conflicts, especially among children and adolescents with ODD (Dishion & Andrews, 1995; Kazdin, 1991). While treating the affected client individually may have some effect, the long term benefits will be limited if the client continues to return to a family system that has not changed (Chamberlain, 1999).

Family systems theory explains that a family will work to maintain a state of homeostasis (Goldenberg & Goldenberg, 2000). This means families will attempt to deal with a disruption within the family system by using whatever mechanism they can to maintain a sense of balance (Goldenberg & Goldenberg, 2000). If we consider this example, it is clear that if the ODD client is the identified patient, there is an apparent possibility that the disruption is in part attributed to the family system (Lindahl, 1998). As McMahon and Forehand (2003) stated, “the child’s noncompliant, inappropriate behavior is shaped and maintained through maladaptive patterns of family interaction, which reinforce coercive behaviors” (p. 28). In addition, “Failure to include parents in youngsters’ treatment may be the single largest barrier to generalizing of treatment effects...” (Chamberlain, 1999, p. 502).

Using family therapy with ODD children and adolescents help to understand the patterns and rules by which a family organizes itself, and determine how the family copes with change (Goldenberg & Goldenberg, 2000). The basic tenant with most family therapies for ODD is that a change in the family system will result in a change in the disruptive individual (Schoenwald & Henggeler, 1999). Intervention programs focus on training and education of the parents to facilitate transforming the source that encourages the child to display unwanted behavior (McMahon & Forehand, 2003).

Treatment Procedures

Examples of effective family therapy intervention for ODD include parent training programs (McMahon & Forehand, 2003; Nixon, Sweeney, Erickson, & Touyz, 2003). Programs such as Helping the Non-Compliant Child parent training program (McMahon & Forehand, 2003), and Parent-Child Interaction Therapy (Bahl et al., 1999; Harwood & Eyberg, 2004; Nixon et al., 2003) facilitate parent training through management of the noncompliant behaviors in a structured yet flexible way while focusing on building stronger relationships between parent and child.

Commonalities of parent training programs consist of preparing and instructing parents to produce increased functional skills through refocusing attention from the disruptive behavior, to prosocial behavior (McMahon & Forehand, 2003). Using positive reinforcement procedures and active problem solving rather than physical punishment, empowers parents to actively redirect the unwanted behavior and focus on the child affirmatively (Bahl et al., 1999; McMahon & Forehand, 2003). Through these structured interventions, parents are taught to ignore specific behaviors, and focus their attention on the behavior the parent's desire through labeled praise (Bahl et al., 1999; McMahon & Forehand, 2003; Nixon et al., 2003). Barkley et al. (2001) concluded that training parents in the use of positive reinforcement, token economies, response cost,

time-out, and other contingency management techniques (Behavior Management Training) is an effective option in treating ODD.

Family centered options for treatment of ODD include using brief, strength based programs such as Solution-Focused Family Therapy (Conoley et al., 2003; Milne, Edwards, & Murchie, 2001,). Barkley et al. (2001) also described the benefits of using family based problem solving, positive communication skill building, and behavior contracting through Problem-Solving Communication Training and Minuchin's Structural Family Therapy. In addition, Chronis et al. (2004) encouraged the use of family groups, rather than individual family sessions. According to Chronis et al. (2004), "group-based interventions are more cost-effective, efficient, and may be less stigmatizing for some families..." (p. 18).

Combating Challenges

One barrier to performing interventions with families is concern of drop-out and community availability (Nixon et al., 2003). Nixon et al. (2003) determined that one way to combat drop-out was to use an abbreviated form of Parent-Child Interaction Therapy. To secure participation and follow through, Schoenwald and Henggeler (1999) found effectiveness of family therapy was boosted when delivered in the home.

Another challenge in using family therapy is the ability to generalize and promote lasting change for families (Chronis et al., 2004; Schoenwald &

Henggeler, 1999). Research indicated that use of videotaped modeling and coping techniques can enhance the ability to generalize the acquisition of designated skills (Chronis et al., 2004; Dishion & Andrews, 1995; Schoenwald & Henggeler, 1999). Furthermore, addressing parent issues separate from the child's behavior (e.g., parental psychopathology, marital problems, father involvement, single parenting) will help to maximize the long-term maintenance of the desired behaviors (Chronis et al., 2004).

Significance and Impact

Research supports the significance of using family therapy in treating ODD (Barkley et al., 2001; Chamberlain, 1999; Chronis et al., 2004; Conoley et al., 2003; Dishion & Andrews, 1995; Kazdin, 1991; McMahon & Forehand, 2003; Nixon et al., 2003; Schoenwald & Henggeler, 1999; Webster-Stratton et al., 2004). Dishion and Andrews (1995) determined that substantial evidence supports the idea that family functioning changes were made through the use of parent and family focused interventions. Webster-Stratton et al. (2004) stated there is a "crucial role that parenting effectiveness plays in determining children's social competence and reducing conduct problems" (p. 105). Huey et al. (2000) found that improved quality of family functioning, cohesion and parental monitoring of children decreased further delinquent behavior or delinquent peer groups as the child continued to develop. Of course, while family therapy may be more logistically challenging the long-term effects tend to be worth this

challenge, especially if the child's overall social system is considered (Webster-Stratton et al., 2004).

Conclusion

The use of family therapy to treat the complicated and disruptive disorder of Oppositional Defiant Disorder is an effective therapeutic model (Barkley et al., 2001; Chronis et al., 2004; Conoley et al., 2003; Dishion & Andrews, 1995; Kazdin, 1991; Lindahl, 1998; Webster-Stratton et al., 2004). If this disorder is left untreated, the risk includes further development of Conduct Disorder, which demonstrates increased severity of disruptive or even criminal behavior (McKee et al., 2004; Quay, 1999). Other effects of ODD include limited opportunity for social and academic development (Coie & Dodge, 1998; Hogan, 1999). Risk factors that can lead to the development of ODD include overall parenting styles, parental psychopathology, family functioning, marital discord, or developmental and biological causes (Conoley et al., 2003; Dodge & Pettit, 2003; Frick et al., 1992; Lindahl, 1998; Pliszka, 1999). ODD can be treated and prevented with the use of clinical family therapy and parent training (Barkley et al., 2001; Kazdin, 1991; Webster-Stratton et al., 2004). There are several programs available for professionals to utilize in order to enhance the desired change in the identified ODD child or adolescent, as well as the family system (Barkley et al., 2001; Chronis et al., 2004; Conoley et al., 2003; McMahon & Forehand, 2003; Nixon et al., 2003).

Prevention of ODD is an area which should be further researched for the future. The research by Tremblay, LeMarquand, and Vitaro (1999) outlined important aspects in prevention methods such as social and cognitive skills training, academic skill intervention, parental training (including expecting parents), family intervention, teacher support, peer group intervention, and community support. Attending to potential ODD children and adolescents with risk factors can aid in the earlier intervention and prevention of further escalated behaviors and family dysfunction (Lindahl, 1998; Tremblay et al., 1999).

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