

Free oppositional defiant disorder research paper example

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Oppositional Defiant Disorder is currently listed as a diagnosis for children or adolescents, with set symptom lists and diagnostic models for clinicians. However, this disease has undergone a wide array of changes to symptomology, diagnostic criteria, etiology, treatment, and theory. From the emergence of the disease in 1968 as a subtopic, through a specific diagnostic code and classification of its own, the evolution of this once-ignored disease has been rapid yet undertaken with a great deal of conscientious effort by those who develop the manuals and standards the entire mental health community follows.

Oppositional Defiant Disorder (ODD) is a diagnosis of a mental health disease, which is used to refer to “ a persistent pattern of negativistic, hostile, defiant, and disobedient behaviors towards others” primarily seen in children and adolescents (Pardini, Frick, & Moffitt, 2010). The basic foundation for this disease was first noted when childhood and adolescent disorders that were primarily known for an association with delinquency arose in the second edition of the Diagnostic and Statistical Manual of Mental Disorders in 1968. In that edition of the manual, there were three diagnoses considered arising from extremely diverse factors in the child or adolescent’s environment: runaway reaction, group delinquent reaction, and unsocialized aggressive reaction (Pardini et al., 2010).

Runaways were merely those who “ fled” when there were threatening or dangerous situations at home, and who typically stole to maintain self-preservation. Group delinquent reaction types were those who usually committed acts that were not aggressive, usually as a result of not being watched or monitored in low-income neighborhoods. Whereas those who

were in the unsocialized aggressive type were considered “loners”, with patterns of lying, stealing, and showing disobedience in a more hostile manner (Pardini, et al., 2010).

Because these subtopics were more behavioral, the primary treatment was individual or family therapy, group therapy, or cognitive behavioral therapy. As part of a subgroup, ODD was extremely undiagnosed and almost never treated with medications.

In fact, when ODD was first diagnosed during the transition from DSM-II to DSM-III, there was no set process for diagnosis. Instead, “it was up to the clinician to decide whether an individual’s behavior was consistent with one of the subtypes” (Pardini et al., 2010). Notably, this led to widely varying diagnostic criteria and treatments. Fortunately, with the implementation of DSM-III, there was a shift in how all mental disorders were formulated, because there was now a set of specific criteria provided to help address unreliable and widely varying classifications in the DSM-II system.

Originally, the ODD diagnosis required that an individual show at least two out of five symptoms over a previous six-month period. These symptoms were listed as: temper tantrums, arguing, stubbornness, violations of rules (even minor ones), and provocative behavior (Pardini et al., 2010). Yet, in the professional psychological community, adding ODD as its own psychiatric order was highly criticized because practitioners believed it “pathologized normative childhood behaviors” and there was a disconcerting “lack of empirical evidence supporting the proposed symptom thresholds” (Pardini et al., 2010).

Finding that the criteria were still lacking a sound foundation, a team began

compiling what would be known as the DSM-IV from 1987 (publication of DSM-III-R) to 1991. At that point, the committee decided it was crucial to “use more rigorous empirical information to justify any changes to the existing diagnostic system” (Pardini et al., 2010). This led to various requests for data to clarify the current symptoms of ODD and a potential link to other diseases such as Conduct Disorder (CD). Despite some earlier successes with clinician as the final decision-maker - as opposed to a set list of criteria for all clinicians - many skeptics continued to push for a more standardized list of symptoms and frequency indicators, to bring a more predictable and reliable system to a disease that had been lacking both, to this point.

In 1999 and 2004, Whaley and Sigman conducted studies in a surprisingly successful attempt to distinguish between child and maternal anxiety, and more carefully display the difference between children with anxiety disorders and those with oppositional disorders (Craighead, Miklowitz, & Craighead, 2008, p. 131). In both studies, observers noted that anxious mothers showed more criticism and catastrophizing, while simultaneously disallowing autonomy and showing less warmth. However, mothers who were not anxious but had children with anxiety disorders tended to show less warmth and disallowed autonomy more frequently. The results of these studies showed that “parenting behaviors predict offspring anxiety and offspring anxiety molds parenting behaviors” (Craighead, et al., 2008). Fortunately these studies coincided with the ongoing work by committees and teams with the APA, in the quest for a workable list of diagnostic standards and specific symptoms.

Finally, a work group was formed in 2007 to prepare for the DSM-5 to directly

deal with the ongoing controversy of how to best diagnose disruptive behavior disorders, primarily in children and adolescents. This group worked tirelessly to address four questions to support possible revisions: (1) whether ODD and CD was appropriately gender-neutral, (2) precluding a diagnosis of ODD when CD is present, (3) a question relating only to CD, and (4) whether a dimensional approach to ODD and CD symptoms is appropriate (Pardini et al., 2010). Fortunately, DSM-5 was well underway, and the groups chosen to carefully research and revamp the diagnostics and symptoms for ODD had not given up.

With the development of DSM-5, the primary goal was to “ provide an evidence base that should be considered when updating the criteria for ODD and CD”. (Pardini et al., 2010). This included a need to examine the strengths and weaknesses of previous and current studies, with a marked emphasis on any results that were contradictory, defining symptom thresholds as necessary and the best methods for handling any subclinical symptoms.

In the most recent edition of DSM (5), the current definition of ODD is a “ frequent and persistent pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness” (APA, 2013). However, there is a specific note regarding mood and the outward display of ODD, specifically warning clinicians “ It is not unusual for individuals with [ODD] to show the behavioral features of the disorder without problems of negative mood” (APA, 2013). This specific warning to clinicians is clearly an improvement over previous diagnostic models, which allowed the clinician to refute a diagnosis of ODD if there was no presence of a negative mood.

Doing away with personal (clinician) opinion and implementation of a set standard has led to a much more predictable and reliable method of diagnosis and treatment, bringing much needed relief to patients who suffer from ODD and their loved ones.

Following the implementation of DSM-5, the most current diagnostic criteria of ODD is listed as:

a pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling. (American Psychological Association [APA], 2013).

Under each specific symptom, the DSM-5 lists one or more characterizations and frequency indicators of each, including Angry/Irritable Mood “ Often loses temper” and “ Is often touchy or easily annoyed” (APA, 2013).

Following the list of symptoms and characterizations/frequency indicators, there is a note specifying that persistence and frequency of the listed behaviors “ should be used to distinguish a behavior that is within normal limits” from those that are not (APA, 2013). This specific instruction is clearly a result of the conscientious efforts of countless members of committees and teams, developed over decades of purposeful research into the efficacy or failure of previous symptom-diagnostic models.

There is also a section dedicated to associated features of ODD, including the acknowledgement that the disease is “ more prevalent in families in which child care is disrupted by a succession of different caregivers” or even in families where there are common parenting practices of neglect,

inconsistency, and harshness (APA, 2013). Two conditions listed as the most common to co-occur with ODD are: ADHD and CD, however, there are several other conditions that may exist simultaneously, and may require separate diagnosis and treatment. In the past, the lists of co-existing diseases was considered exhaustive, but the implementation of new standards have led to a more complete understanding of the proper use and function of clinicians' diagnostic models.

According to the DSM-5, the current theory regarding development and course of the disease include first symptoms appearing during preschool years, yet rarely later than adolescence and OCD usually appears before CD is developed. Further, children or adolescents with ODD are more at-risk for anxiety disorders or major depressive disorders. Not surprisingly, adolescents with ODD have numerous adjustment problems in adulthood, which include: impulse-control issues, some antisocial behaviors, depression, substance addiction and abuse, and anxiety. (APA, 2013). Yet, despite many differences in cultures and sociological backgrounds, ODD is “relatively consistent across countries that differ in race in ethnicity” (APA, 2013).

Currently, the treatment for ODD is primarily therapy-based, with a focus on individual and family therapy in milder cases. In some instances, there is a need for Parent-Child Interaction Therapy (or PCIT), wherein a therapist will assist a parent by coaching as the parent interacts with a child. There is also social skills training, to help children and adolescents interact more appropriately with peers at school and in social settings. Some clinicians opt for training with cognitive problem solving, which helps the child identify unacceptable behaviors and change them.

Some parents may opt for training with a mental health provider to teach parents how to effectively manage an ODD child's behavior, outbursts, and triggers. Yet, for children or adolescents who also have a co-existing condition (most especially ADHD) some psychotropic medications may be extremely effective. However, medication is almost never used with children or adolescents who do not have a co-existing condition, as medication for those who only have ODD is typically ineffective or even disruptive (APA, 2013).

In fact, many medications offer a host of side effects, contraindications, and even severe allergic reactions in children. Additionally, some of the most effective medications for ADHD, including mood stabilizers and anti-depressants, are not recommended for those under the age of 18, which makes the medications useless for those children and adolescents who may truly need such medications. With the rise in frequency and variety of food and drug allergies in children and adolescents, many clinicians find it more prudent to try non-medication therapies before considering medications, with the exception of the most severe cases (those children and adolescents with co-existing conditions).

As both a disease and a diagnosis, ODD has undergone a complete overhaul in the mental health and psychology communities. At times throughout the previous decades, ODD was only diagnosed by individual clinicians under widely varying standards. Fortunately, currently the disease is only diagnosed according to specific, required standards, and the results are not just promising but extremely successful. In fact, now that ODD is part of a special group of disruptive, impulse-control, and conduct disorders, clinicians

have a more predictable method to follow, allowing the utilization of much more stringent and carefully-monitored standards.

Despite the fact that ODD will likely undergo more changes in the future, these changes can be seen as nothing but advantageous to a patient with the disease - or a long-suffering family at wits' end regarding how to obtain safe, effective help for their loved one. In the years to come, the DSM-5 will, once again, be updated, changed, and revised. But this arduous process of change and revision is only undertaken with extreme care and professionalism, which practically guarantees there will be many more good things to come in the future.

References

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