Oppositional Defiant Disorder

H. Russell Searight, Ph.D.

What Is Oppositional Defiant Disorder?

Children with Oppositional Defiant Disorder are argumentative, negative, and frequently irritable ("touchy"). Preschoolers (3 to 4 years) and young adolescents (12 to 14 years) sometimes have periods of these behaviors, but they tend to be fairly brief. Refusal to interact with children when they are exhibiting these behaviors usually reduces these common tantrums.

Children with Oppositional Defiant Disorder, on the other hand, have a long-standing pattern (for at least 6 months) of losing their temper often, arguing frequently with adults, refusing to comply with adult requests, deliberately harassing or annoying others, failing to take responsibility for their mistakes or misbehavior, and being irritable, reactive, angry, spiteful, and vindictive (American Psychiatric Association, 1994).

These children frequently resist or argue about relatively minor issues. Parents often feel as if they are walking on eggshells with these children. A mother might say, "I quit asking Johnny to pick up his room or feed his dog; I just do these things myself. If I ask him to do it, he fights and argues with me until he wears me down, and the fight just isn't worth it." When confronted with their misbehavior or its consequences, these children frequently deny it or blame others. In addition, children with Oppositional Defiant Disorder instigate arguments and seem to harass and annoy adults and peers deliberately.

Oppositional defiant behavior might not be immediately evident at the beginning of a new academic year with a new teacher or in interaction with adults or peers whom the child has met recently. It is usually most pronounced in interactions with parents and, over the course of the school year, the pattern will become more apparent with teachers. These children tend not to recognize that their oppositionality or defiance, is a problem. They typically see their frequent arguing and irritability as a "logical" response to perceived provocation or unfair demands from others.

What Are the Causes of Oppositional Defiant Behavior?

The causes of Oppositional Defiant Disorder are not known precisely. Children who develop this disorder sometimes have difficult temperaments as toddlers. During the early years, it can be hard to soothe these children, and parents have problems keeping them on a regular schedule of sleeping and eating. In addition, they tend to have difficulty with transitions such as beginning preschool. Oppositional Defiant Disorder also appears to be more common in families in which the caretaker-child relationship has been disrupted, such as when children have been in multiple foster homes. In addition, parenting that is inconsistent or overly harsh or includes extended periods of neglect also has been associated with Oppositional Defiant Disorder. It is not known exactly how common Oppositional Defiant Disorder is in the general population. The literature reports rates between 2% and 16%.

How Does Oppositional Defiant Disorder Develop During Childhood?

This disorder typically begins in early childhood, and behavior problems usually are more pronounced at home until the teen years. By early adolescence, however, Oppositional Defiant Behavior becomes more evident at school.

It is important for parents and teachers to recognize that some oppositionality is common in preschool children and is a normal part of striving for greater independence (the "terrible twos"). There also can be a surge in "normal" oppositional behavior between the ages of 11 and 14 as children enter adolescence. Preteens and young adolescents are notorious for periods of irritability and obstinacy. However, those episodes are short-lived and decline with age.

Children with Oppositional Defiant Disorder generally do not engage in serious legal violations, nor do they typically become physically aggressive with others. They are likely to be verbally aggressive and perhaps even somewhat threatening with others, but this rarely takes the form of physical aggression.

What Can Parents Do to Change Oppositional Defiant Behavior?

Treating oppositional defiant behavior requires a high level of structure and consistency. The most useful responses from parents and teachers are rewards for compliance and punishment (most commonly time out or loss of privileges) for disrespectful or argumentative behavior or failure to follow rules. In the following example, an initial goal for Jimmy might be that he completes his morning routine and is ready for breakfast by 7 a.m. The morning routine

includes Jimmy's getting out of bed, brushing his teeth, washing his face, getting dressed, and making his bed. If he performs this routine successfully, he receives a star on a star chart. If he earns enough stars, he gets a reward at the end of the week, such as going to a movie, renting a favorite video, or being allowed extra TV time on the weekend.

Importantly, parents should recognize that when oppositional behavior has been in place for an extended period of time, they might need to modify the standards so that the child can experience some early successes with the behavioral program. For example, if the child hasn't been able to be ready on time every day for the past month without at least five reminders from the parent, an early goal might be that the child complete the morning routine with only two or three prompts. If, in the beginning, this occurs three or four days out of the week, the child would receive the reward. As the child meets the criteria for each successive week, parents can "raise the bar" so that the standard approaches the longer-term behavioral goal.

One of the unique issues for children with Oppositional Defiant Disorder is that parents and teachers often become caught in a vicious cycle of defiance, negativity, defensiveness, and arguing. In particular, if the adults are authority-oriented and believe that children need to respect them, they frequently will find themselves angry and arguing with these children.

It is important for adults to remember that any attention, positive or negative, is reinforcing to children with this disorder. These children have learned that the squeaky wheel gets the grease, and they will squeak long, loud, and hard. A common dilemma parents face is a child who has been sent to his or her room for a 15-minute time out. Five minutes after the time out has begun, the child will start calling out, "I'm hungry; I need to eat." This will escalate to, "I'm starving, I'm going to pass out." Parents should be careful not to respond. Another common situation occurs when, for example, the child is given a half-hour of time out in a room by him- or herself but comes out every 10 minutes asking if the time is up. In both situations, the parents or adults should respond with something like, "You have 30 minutes. I'll talk to you when you have served your time. If you come out before time is up or continue to call out, you will get 10 more minutes." The child often will try to provoke the parents with threats or complaints that seem to require an immediate response. It is important that parents not react to these and continue to state their expectation calmly and neutrally.

Another area where parents often get caught concerns whether or not the child has met the criteria for compliance. For example, the parent tells the child to tidy the room. The parent then inspects the room and finds that the child has hidden most of the toys under the bed. The parent points out that the child really hasn't cleaned the room. The child argues that, indeed, all the toys are out of sight, and the room *is* clean. The parent who continues to argue with the child, attempts to be logical, and tries to persuade the child that the room is not really clean, likely will become increasingly frustrated and diverted from the topic at hand. It is extremely important for parents to catch themselves before this process escalates. Parents should state the expectation and use the broken-record technique of simply repeating the same expectation over and over and not responding to the child's provocation.

References and Resources

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

H. Russell Searight, Ph.D., is the director of behavioral sciences for the Residency Program of Family Medicine of St. Louis. He is the author of several textbooks and an adjunct associate professor in the department of psychology and Community and Family Medicine at St. Louis University.