Abstract

Oppositional defiance disorder (ODD) represents a large percentage of referrals of children and young adults to mental health practitioners. The comorbidity of ODD with other mental disorders and behavioral problem creates a dilemma in studying ODD in isolation from conduct disorder and attention deficit-hyperactivity disorder. Owing to the fact that these disorders are often studies in connection with each other, there is less information about ODD’s progression, if the disorder does not spiral into conduct disorder. Moreover, ODD evolves from dysfunctional family dynamics and environmental adversity that are detrimental to the child’s development and not from a hormonal or chemical imbalance in a person. These facts present a question as how individuals diagnosed with ODD fair into adulthood as their environment plays a fundamental aspect in the disorder. The purpose of this literature review is to investigate what has been written about ODD into adulthood. To understand the long term affects, a clear understanding of the onset, duration and reasons for the disorder is needed. A second key component to understanding the affects of ODD into the persons adulthood is a look at the effectiveness of family oriented treatment, like parental training. Finally a look at the statistics of individuals with ODD in adulthood reveals a significant connection with ODD in childhood and adolescents with the development of other mental disorders in adulthood, particularly anxiety, depression and substance use disorders.
Literature Review on Oppositional Defiance Disorder

The behavior disorders are the leading cause for referral for youth to mental health services. Along with conduct disorder (CD) and attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD) represents a large percentage of childhood disorders (Nock, Kazdin, Hiripi & Kessler, 2007, p. 703). With ODD’s high rate of comorbidity with other disorders, it is often studied in conjunction with CD and/or ADHD. Together there is a plethora of research on these disorders (McKinney & Renk, 2007) but less information on ODD isolated as an independent disorder.

There is consensus that ODD is a disorder developed when family dysfunction coincides with difficult child characteristics early in life (Harvey, Metcalfe, Herbert, & Fanton, 2011). The purpose of this literature review is to understand what the diagnosis of an individual with ODD at childhood means for the patient in adulthood. To fully grasp the affects on adulthood, one must look at what ODD looks like at its onset and what immediate affects it has on the individual and the family. Secondly, one must look at possible treatments for individual and family units when ODD is present. What steps can be taken by families to lessen the affects of ODD on family relationships, on self-confidence and academic success and in turn the long term affects of these difficulties? Finally, an evaluation of statistics about individuals with ODD as children who move into adulthood and what problems can linger is needed.

Comorbidity

All these issues cannot be fully dissected without identifying the comorbidity of this disorder with other behavior disorders, namely CD, ADHD, anxiety and depression.
This intersection of disorders makes looking at isolated ODD more difficult and consequently has blurred the lines of ODD. In the famous Great Smokey Mountain Study of 2002 between the relationship of oppositional defiance disorder and conduct disorder, nearly 80% of ODD cases received a diagnosis of CD in subsequent assessments (Rowe, Maughan, Pickles, Costello, & Angold, 2002). The high rates of progression from ODD to CD suggest ODD is a key developmental precursor to CD. There also high rates of comorbidity with children with ADHD and ODD (Harvey et al., 2011). ADHD elicits negative family interaction; therefore, ADHD may lead to the development of ODD in children who are growing up within a poor family function. It has been determined that over a lifetime, an individual diagnosed with ODD has a 92.4% to meet criteria for another mental disorder. (Nock et al., 2007) The question remains if the connection between the disorders is derived from genetics and/or temperament of the individuals or because from the fact that the development of ODD so affects relationships, academics, and self-confidence that effects of ODD can be part of the reason for development of other disorders, such as depression and substance abuse in adulthood.

Methods

I began my search into ODD by going to our public library were I found a couple books that had a basic overview of ODD. After reading the chapter of ODD in E. Roberts’ book, Should you medicate your child’s mind: A child psychiatrist makes sense of whether to give kids psychiatric medication (2013), I had a better understanding of what defines ODD and that the disorder derived from family dysfunction. Therefore, this was not a disorder where medication would be beneficial. These insights led me wonder how ODD was linked to family dysfunction and the ramifications into adulthood. I proceeded to the Wake Forest Library website where I
conducted a search first for “oppositional disorder” but then added words to link it to what I was reading, such as “family dysfunction”, “maternal depression”, and “adulthood. I also looked through Google Scholar for similar searches and finally, did the same search in ERIC through the Wake Forest link to this search engine. In order to keep the information current, I eliminated articles dates prior to 2000. To ensure that the articles I found were of reputable sources, I remained focused on the journals that were peer edited. I also noticed a few authors that repeated under this subject and tried to find more articles by these authors who appeared to be leaders in this area of study, namely J.D. Burke, a professor of psychology at the University of Connecticut. My final step to further shift through the plethora of articles, I focused as much as I could on articles that talked only about ODD and did not include CD and ADHD in the title, because of the amount of studies that intertwined these disorders together. I wanted to identify articles that pertained to ODD as a separate disorder because most of the articles pertained to how it related to CD, ADHD, anxiety and depression.

Results

Definition

Although ODD has been classified as its own disorder since 1980, still there are many questions if ODD should stand as its own disorder and not as the less developed version of CD (Nock et al., 2007). Oppositional defiant disorder was first introduced as its own distinct child/adolescent onset disorder in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, 1985) and is currently defined by DSM-IV (1994) as a recurrent pattern of defiant, disobedient, and hostile behavior beginning in childhood or adolescence and lasting over a period of at least six months. An ODD diagnosis requires the individual to demonstrate clinically significant impairment in his or her functioning and must possess four of
the eight symptoms, which make up ODD. These are loosing one’s temper, arguing with adults, refusing to comply with adult’s requests, annoying others, blaming others for one’s own mistakes, being annoyed easily by others, being angry and being spiteful and vindictive (Burke, 2012).

However, although this list of symptoms is quite thorough, the problem remains that the diagnosis of ODD is a subjective diagnosis and a greater understanding is needed of the disorder as it stands alone, not in connections to disorders it is often associated with (McKinney & Renk, 2007). Some critics argue the ODD resembles normal “rebellious” behavior and the oppositional characteristics should be treated as a behavioral problem and not categorized as its own disorder (Rowe, Costello, Angold, Copeland, & Maughan, 2010). Others feel ODD is only a milder form of the more disruptive CD because the symptoms are both less severe and because the median age of ODD is younger (12.2 years) than CD (13.0 years) making it possible that ODD is a precursor to CD (Rowe et al., 2010). Due to these difference in opinion and the high rates of comorbidity with other disorders, there is more research needed in isolating ODD to study its’ effects on individual’s adulthood who have been diagnosed with ODD.

**Onset**

ODD is a true behavioral disorder not caused by a chemical imbalance but most commonly caused by ineffective, overindulgent, or nonexistent parenting style (Roberts, 2006). Families of ODD youth are characterized by significantly poorer cohesion and higher conflict in the home (Greene, Beiderman, Zerwas, & Monuteaux, 2002). Furthermore, parents of children with ODD have been identified as demonstrating less consistency, showing more negative expectation and poor ability of coping with stress. There is a high correlation between maternal depression and ODD because the depressed mother lacks the motivation and energy to follow
through with discipline and create an inconsistent home environment with significantly higher levels of negative-hostile interaction, both characteristics key ingredients to the onset of ODD. (McKee, Harvey, Danforth, Ulaszek, & Freidman, 2004) In a study identifying predictors for ADHD and ODD, a significant effect showed that mothers of children at risk for ODD have few suggestions on how to address poor behavior, again supporting that the parent lacks the skills needed to discipline children and raise well adapted adults (Cunningham & Boyle, 2002).

Identifying the factors associated with parenting and the ineffective and negative discipline styles help pinpoint where ODD stems from. Two types of negative parenting have been linked with current and future oppositional behaviors and attitudes, permissive parenting and authoritarian parenting (McKee et al., 2004). Permissive parenting refers to parental tendencies to make few demands, not enforce rules and to be inconsistent and bend for children’s tantrums and refusals to oblige. Authoritarian parenting refers to punitive and forceful discipline and overly harsh and hostile language toward the child (McKee et al., 2004). Furthermore, it has been identified that the coping style of parents to stressors such as marital and financial difficulties, behavioral problems with children or combative environments, also serve as indicators to the risk of their children developing oppositional behaviors. Parents and caregivers that responded to life’s stressed by avoidance-focused coping style or by emotion-focused coping style were more likely to create a negative environment in the home with less cohesion and more aggression. Avoidance-focused coping style to stress was seen in permissive parents who wished to avoid the stress or ignore it. Emotion-focus coping style was seen in authoritarian parents who where explosive and harsh in their discipline (McKee et al., 2004).

One theory suggests that relationship between parenting and child behavior is bidirectional (Harvey et al, 2011). The pathway toward ODD may be set as early as the age of
three, where a child is naturally rebellious and active. The parent’s response to this stage, either by overreacting and excessively harsh reprimands or by ignoring and avoiding discipline, causes the child’s behavior to worsen. The cycle of poor behavior and ineffective parenting continues into older stages of development and solidify the negative family processes. Harvey believes the pathway toward ODD is set long before the diagnosis of ODD or even the symptoms are displayed (2011).

On the other hand, many parents surveyed report their children’s symptoms have always been present (Nock et al., 2007) supporting the idea that temperament and genetics play a part in the disorder. In addition there is a correlation between parents who exhibited ODD symptoms in their youth raising children struggling with ODD. This further supports the idea that it is genetically passed through families, but at the same time, supports the lack of parenting skills are also copied from parents perpetuating the problem into the next generation. Jeffery Burke points out the development of ODD results from the “perfect storm” between a strong and defiant temperament placed in the environment of poor family structure and weak parenting skills (Burke, 2012).

**Treatment**

As mentioned at the beginning, ODD does not respond to medication because it is not a chemical imbalance but rather a behavioral problem (Roberts, 2006). The assumption is early parental training is the best form of solving the problem of ODD. However, there is a major glitch. Often the reason the individual has developed ODD is because the parent, most often the mother, are inconsistent and have an avoidant-focused coping style for dealing with problems and stress (McKee et al., 2004). This means that even with training, the parent isn’t in the position to follow through and implement the plan of action when faced with oppositional
behavior. Research shows depressed individuals are less likely to follow though with discipline and respond positively to behavior problems (McKee et al., 2004). It has been found that in general, the relationships and coping styles of the mothers did not hold into the post-treatment phase after receiving parental training classes (McKee et al., 2004). The book, *Your Defiant Teen* by R. Barkley and A. Robin (2008) outlines a plan to fix the relationship with the defiant teen. The authors list steps including scheduling a positive one-on-one activity, change communication style, and writing a behavior contract with your child in order to solicit better behavior. The book begins by asking the parents to identify and seek change for their personal issues as well. The authors ask if the parent might have ADHD as well, or if they could be dealing with depression. This emphasizes the importance for the caregiver to confront their own issues or helping their child will be ineffective. The book ends with a chapter about “Keeping it together”, where the authors address the need to stay with the program for the long haul, again identifying the regular pitfall for parents attempting to make permanent positive changes in their children’s oppositional behavior.

In the sum of all the literature covering ODD there were few effective results with parent training. The one exception was training fathers who used harsh words in their discipline style. They did see significant and permanent improvement in the father’s relationship with their children, especially girls, and thereby affecting positively the oppositional behavior of the child (McKee el at., 2006). This, however, points to the training of a parent who doesn’t have the skill or is unaware of their impact on their child, but doesn’t represent a change when a parent feels overwhelmed with depression or lack of confidence as a parent. In those cases, there was not any long-term positive impact on the child’s behavior.

**Adulthood**
Oppositional Defiance Disorder

Given the little amount of positive feedback on parent training programs to help resolve the ODD behavior in children, the question remains what do these children have in store for them in their adult future. The median age is 12.2 to have ODD and the duration of the disorder is approximately six years. By the age of 18, 70% of the individuals diagnosed with ODD will no longer have symptoms (Nock et al, 2007). It is interesting to note though, that although ODD is considered a childhood and adolescent disorder, 30% continue to report symptoms into adulthood. Further study is needed to understand how these symptoms are manifested in adulthood as compared to childhood and adolescence to help identify when symptoms are present in adults.

Individuals who have shown ODD behavior are 92.4% more probable to meet the criteria for other mental disorders at some point in their lives (Nock et al., 2007). 58% have self-reported anxiety disorders and almost half have a mood and/or substance use disorder. (Nock et al., 2007) The history of ODD is indicative of a vulnerability to a wide range of mental disorders not necessarily related to ODD. One explanation is the genetic make up of the individual is predisposed to these mental disorders, thereby connecting the occurrence of the disorders (Rowe et al., 2010). In contrast, engaging in oppositional defiant behavior may lead to long-term interpersonal problem, harm academic endeavors, and possibly create legal issues that carry into adulthood. The lack of support from cohesive family structure and strained relationships results in higher risk of depression, anxiety and substance abuse (Nock et al., 709).

Discussion

The vast majority of the journals and books covering the topic of ODD address the fact that there is a high rate of comorbidity of ODD with other behavioral disorders, resulting in confusion identifying the specifics of ODD. Prolific writers on the subject of ODD, such as R.
Greene, R. Rowe and J. Burke, agree research is needed about ODD, isolated from CD and ADHD (Greene et al, 2002, Rowe, 2002 & 2011, Burke, 2002). A second strength in the literature about ODD is the clear, precise explanation as to what environment aggravates ODD. There are studies on parenting style and the connections between maternal depression, low socio-economic levels, harsh discipline and/or parental avoiding discipline and the development of ODD. Research reports ODD is equally present in boys and girls but escalates into CD more often in boys than in girls (McKee et al., 2006). There is also a clear understanding and plenty of research about the statistics of mental disorders in adults who developed ODD in their youth. The heightened risks of developing other mental disorders adulthood is also well documented throughout the literature about ODD.

To the contrary, more research is needed to identify steps individuals can take to avoid the life-long threat of further mental disorders. At what point can the individual choose to make changes and what changes are suggested to protect against the heightened risk of other mental disorders. More information is needed to see what type of therapy is most effective to avoid the high rates of depression, anxiety and substance abuse. Or in other words, what steps and actions have successful adults who had been diagnosed with ODD taken to change the trajectory of their lives to avoid mood and anxiety disorders?

Secondly, further study is needed to determine if ODD is indeed a separate disorder as it is listed in DEM-. Because of the vagueness, there is still the need for agreement if it is its own separate disorder, a subset of CD, or just “rebellious” behavior in a stage of development. Most would agree it is its own disorder but greater concensus would help encourage research of ODD independent of CD and ADHD. This isolated research would better help understand ODD and perhaps offer a more effective ways to address it, other than parental training programs. Finally,
further research on the idea that the pathway to ODD is determined prior to the age of four or five would allow parents to understand the importance of preparing for responding positively to the rebellious threes. A greater understanding of the age of onset of ODD, whether the pathway was determined before symptoms were reported, would allow focus our therapy appropriately.

References


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This paper presents a few perspectives on oppositional defiant disorder (ODD), conduct disorder (CD), and early forms of psychopathy. The developmental changes and stability of each, and the interrelationship between the three conditions are reviewed, and correlates and predictors are highlighted. The paper also examines effective interventions for each of the three conditions and makes recommendations for future research. Discover the world's research.