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Research Article

Rules of Oppositional Defiant Disorder: A New Therapeutic Concept

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Abstract

Objective: Oppositional Defiant Disorder (ODD) commonly co-exists with ADHD and merits specific interventions. Our aim was to reframe ODD as a set of external rules that the child can reject. We surveyed parents for their views on 'Rules of ODD' as a therapeutic concept.

Method: Parents of 85 children with ADHD and ODD were invited to rank 7 Rules of ODD in order of relevance and give additional comments.

Results: Sixty-six (77%) considered the concept useful; 24 (31%) made additional comments or suggestions. The highest ranked rules were: 'Always argue or disagree' and 'Never admit to being wrong'. No parent suggested the concept was harmful.

Conclusions: Rules of ODD was considered useful by most parents. We hope that by redefining ODD as a series of external rules, the stigma of this diagnosis may be lessened, and the child empowered to make their own more rational decisions.

Keywords: Rules of ODD; Oppositional defiant disorder; Attention deficit hyperactivity Disorder; Stigma

Introduction

Oppositional Defiant Disorder (ODD) is a common comorbidity of ADHD, occurring in around 40% of affected individuals [1]. If ADHD is diagnosable in 11% of children and adolescents [2], it follows that the population prevalence of ADHD associated ODD would be around 4%, which is higher than the prevalence of depression (3%) [2]. The combination of ADHD and ODD tends to be associated with more severely impaired functioning compared to ADHD alone [3]. ODD, therefore, merits the development of specific, targeted interventions for use in cognitive behaviour therapy.

The Diagnostic and Statistical Manual of the American Psychiatric Association (Fifth Edition) defines ODD as 'A pattern of angry/irritable mood, argumentative/defiant behaviour, or vindictiveness lasting at least six months, as evidenced by at least four symptoms…' [from a list of eight] [4]. These symptoms should be expressed to a greater extent and be outside the range expected for the individual's developmental level, gender and culture, and impact negatively on functioning.

The characteristic behaviour of ODD generally elicits little empathy: parents and teachers may struggle to respond positively towards a habitually hostile child. The name oppositional defiant disorder, although it aptly describes the condition, is stigmatising due to its negative connotations. This may present a dilemma for clinicians: if a child already carries a diagnosis of ADHD, is it in the child's interests to collect another diagnosis that in effect may formalise the impression he/she is a 'bad kid'? Making a diagnosis of ADHD maybe viewed as positive if it is the gateway to effective treatment. Is there any way that a diagnosis of ODD could be positive for the child and his or her carers? Is it possible to reframe ODD in a way that separates the condition from the child's self-image?

One of the characteristics of children with ODD is the pattern of an angry/irritable mood. People who are feeling irritable may respond negatively, but parents may find their child to be far more co-operative when he or she is feeling calm and happy. This kind of observation indicates a link between mood and behaviour. It follows that a negative mood in ODD may be having a substantial impact on a person's decisions about how to behave. Decisions that are driven by emotion are not necessarily rational.

Clinicians who treat children with ODD see the same patterns of behaviour recurring in different individuals, almost as if these children were following a pre-defined set of rules. The primary aim of this study was to find out from parents of children with ODD whether they felt that re-defining ODD as a set of rules was a useful concept. The secondary aim was to identify rules that appeared to be most relevant to their experience as parents. The rules were intended to be broadly consistent with ODD behaviour as described in the DSM-5, but the process of re-framing as rules clearly demonstrated that the behaviour was not based on rational decision-making.

This research has the long-term goal of developing a therapeutic tool that will help parents and children to recognise when it is the ODD that is driving the behaviour. This may help the child to understand that they are capable of taking the decision-making away from the ODD and making their own, better, more rational decisions. This would affirm the child's identity as a rational being who does not have to follow the Rules of ODD, separating them from the ODD identity of being a bad kid.

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Methods

A set of seven rules was incorporated into a questionnaire which was presented to parents of children diagnosed with ADHD and ODD using the DSM-5 diagnostic criteria. These children were attending private and public clinics of 3 paediatricians in Western Sydney. The questionnaire was anonymous, but after the first 26 questionnaires had been collected, it was amended to include the age and gender of the child. The rules were based on the DSM-5 diagnostic criteria for ODD and the types of problems described in clinical practice by parents of children with ODD. The attitude they exemplified was of negativity, a conviction of being right and an entitlement to misuse others. The rules described behaviour covering the following attributes: being competitive/combative; showing negativity for its own sake; showing low priority for truth; and being unkind (Table 1). Parents were asked whether they thought that Rules of ODD was a useful concept and then to rank the given list of Rules of ODD in order of importance for their child, starting with 1 for the most important, leaving out any of the rules that did not fit with their experience. They were also invited to comment, add to or change any rules. This study had ethical approval from the Nepean Blue Mountains Human Research Ethics Committee (2018/ETH00710). Informed consent was inferred by the parent returning the completed questionnaire.

The rules were scored in the following ways: the mean and standard deviation of the rank order; the number of times each rule was scored 1; and by the modal score for each rule. The number of times each rule was omitted as not relevant was also recorded.

Results

Eighty-five parents returned the questionnaires. Of those giving demographic details, 41 were parents of boys (71%) and 17 (29%) parents of girls. The children's mean age was 10.3 (SD 3.3) years (range 5-17 years) with no significant age difference between boys and girls.

Sixty-six parents (77%) felt the concept was useful; 10 (12%) felt it was not useful, and 9 (11%) left the answer blank. Three made comments indicative of strong support: 'I think the list of rules would help to remove emotion from the situation. It may also help the self-esteem of the child '; 'This would be especially helpful for other people who work with my son such as teachers, coaches, etc';'After 17 years I am only now really understanding ODD. These rules would have been a great help'. One pointed out that: 'Even more useful than Rules would be strategies for dealing with these behaviours'. One parent stated, 'When my child is having an ODD episode, it doesn't seem to follow any particular set of rules'. One parent was not sure how the concept would be used. No parent stated that they thought it would be counter-productive or harmful.

Most parents gave a score to every rule; one parent did not appear to understand the purpose of the rules. The rules and scores are listed in (Table 2).

Twenty-four parents (31%) made 36 additional suggestions. The main omission identified was aggression, violence and causing distress: 'There needs to be something about aggressive responses'; 'Extremely violent at times'; 'Takes the opportunity disrupt family any way he can'; 'Really enjoys intense interactions, e.g. rage, distress'; 'Will deliberately engage in behaviour to start conflict'.

Nine parents gave further suggestions for rules relating to competitive/combative behaviour, such as 'Always have the last word'; 'Always has to go first'; 'Playing mind games to get their way'; 'Getting even is imperative'. One parent added detail to the given rules: 'Opinion is more valid and will continually speak over the top of people'; 'Always try to win – and if winning seems unlikely, refuses to participate at all'.

Three parents highlighted negativity/non-co-operation: 'Having a negative outlook all the time. Focussing on the negative elements'; 'Extreme non-cooperation even when co-operation means getting something they want'; 'That it can present quietly by the child finding a task that makes them busy or appear helpful when upset by a request'.

One parent added, 'Disrespectful' and another gave an example of disrespect: 'Cleaning is for slaves'.

Rule 4 (Look for opportunities to get the better of someone) was one of the less highly ranked rules, but one parent gave an example of their child following this rule: 'Corrects generalisations, e.g. It's 10 pm – response – No, it's 9.47 pm'.

One parent highlighted dishonesty: 'Can never tell the truth, constantly lies. Always wants to cheat at anything'.

Two parents' comments appeared more related to the co-existing ADHD: 'Not listening when being spoken to; forgetful'; 'Doesn't feel real - in a dream'.

Discussion

The majority of this sample of parents of children with ADHD and ODD supported the therapeutic concept Rules of ODD. The two rules with the highest scores exemplified negativity, being combative and disregarding the truth. Although not all parents felt that every rule applied to their child's behaviour, even the least favoured rule was rated applicable by 84% of parents. No parent expressed any concern that the rules might be detrimental to their child. Aggression/violence and disrespect were notable omissions, although the former might be more consistent with a progression to conduct disorder.

A strength of this study is its origin in a clinical setting. It was based on clinicians' observations of recurring patterns of behaviour among multiple children with ODD. The substantial support expressed by this surveyed sample of parents, who experience living with ODD on a daily basis, adds clinical validity. However, the sample of parents who returned the questionnaire may not be representative and

Table 1: Rules of ODD and their attributes.

Rule	Attribute
1. Never admit to being wrong	Competitiveness Low priority for truth
2. Always argue or disagree	Negativity for its own sake
3. The answer to any request is 'No'	Negativity for its own sake
4. Look for opportunities to get the better of someone	Competitiveness Unkindness
5. Always try to win	Competitiveness
6. Winning is more important than reason or fairness	Competitiveness Low priority for truth Unkindness
7. Try to appear innocent by blaming someone else	Low priority for truth Unkindness

Table 2: Ranking of the Rules of ODD.

Rule	Number of times omitted	Mean (SD)	Number of times scored 1	Modal score	Rank by mean	Rank by first choice
1. Never admit to being wrong	4	2.8 (1.4)	16	4	2	2
2. Always argue or disagree	2	2.0 (1.1)	34	1	1	1
3. The answer to any request is 'No'	4	3.4 (1.7)	12	4	3	4
4. Look for opportunities to get the better of someone	10	4.2 (1.7)	7	5	5	5
5. Always try to win	9	4.3 (1.7)	6	5	6	6
6. Winning is more important than reason or fairness	14	5.2 (1.9)	3	5 and 6 equal	7	7
7. Try to appear innocent by blaming someone else	12	4.0 (2.1)	14	1 and 6 equal	4	3

could be subject to selection bias. The respondents gave the highest rankings to the first three rules. While this might be an artifact based on the order the rules were presented, it might also show consistency with the prioritisation of the investigator as the rules, once written, were not randomised.

Encouraging the child to be the boss of their behaviour and not let their condition dictate their decisions is an approach that is used successfully in Obsessive-Compulsive Disorder (OCD) [5]. In this situation OCD is framed as an entity separate from the child, who is then encouraged to 'fight the OCD'. This approach has been used in motivational interviewing and was shown to enhance the effect of cognitive behaviour therapy for improving the symptoms of OCD [6]. However, we are not aware of this being used as a therapeutic strategy in ODD. Behavioural intervention for ODD typically involves teaching the child problem-solving skills and parent training, reducing positive reinforcement for negative behaviour and giving positive reinforcement for compliance, with prompt and predictable consequences [7].

One of the reasons that ODD is a difficult condition to manage is because young people with ODD often have a conviction that they are entitled to behave as they choose and do not have to submit to any rules. This conviction is not rational and may have an analogy with irrational convictions in OCD: that by performing their compulsive behaviour the child believes that they are safer. However, a young person with ODD might find the idea that they are unconsciously following a pre-defined set of rules and being controlled by the ODD particularly confronting. The child is encouraged to look at the rules and reflect on their behaviour. Gaining insight that these rules could describe some of their behaviour is clearly critical. It would also immediately be clear that these are very bad rules to live by. The child is encouraged to reject the Rules of ODD and allow their rational mind to take control so that their decisions are truly their own. The attitude of not wanting to submit to any rules is therefore used to encourage the child to oppose and defy the ODD itself. The process of rejecting the Rules of ODD affirms the child's autonomy, rationality and self-worth.

While this study demonstrated support for the concept and broad agreement with most of the rules, there appeared to be no consistent pattern to the suggestions for additional rules from the parents. This may reflect differences in their experience. It may also be that the given rules and the parents' suggestions reflect overlapping types of behaviour but with different particulars. Competitiveness was ranked last by the parents and 'always argue and disagree' was first. However, in practice, those two often go together as children with ODD may argue because they want to compete to have the last word.

We view using the Rules of ODD as a flexible therapeutic tool, using the current seven rules as a starting point. Therefore the clinician would present the families with the rules and establish whether the child's behaviour appears show a pattern that could be seen as following a set of rules. At that stage the clinician might invite the family to add their own one or two rules. This would aim to make the therapy as relevant as possible and would also confirm their understanding of the concept. Some parents might then highlight disrespect or aggression, similarly to some of those completing the present survey.

Some physicians may be reluctant to diagnose ODD due to the stigma associated with the diagnostic labelling. However, as experienced physicians, we have found the behaviour itself to be the main cause of social rejection by peers and family members. Naming the condition allows the child's behaviour to be better understood and may promote the formal recognition of ODD as a significant disability of a similar order to autism spectrum disorder. We would hope that in the longer term, the willingness to recognise and name this condition will be a step towards the children and their families gaining better access to psychosocial intervention to support them in the development of more functional behaviour patterns.

Rules of ODD are a simple concept that is easily explained and understood, but makes the point that ODD is not a lifestyle choice but is a condition that takes away the child's autonomy. We hope that by defining ODD as a series of rules, this stigmatising diagnosis can be framed in a way that is empowering for the child and positive for his or her family. Further research is necessary, focusing on the outcomes of using the Rules of ODD in therapeutic settings. We would encourage others to pilot this concept and report on their experience.

Declaration of Conflicting Interests

Dr Poulton discloses personal fees and non-financial support from Shire/Takeda, outside the submitted work, and royalties from her book: ADHD Made Simple (Disruptive Publishing, 2020). The other authors declare no conflicts of interest.

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