OPPOSITIONAL DEFIANT DISORDER

DSM-IV

313.81 Oppositional defiant disorder
312.9 Disruptive behavior disorder NOS

A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, in which the child loses temper, argues with adults, often actively defies or refuses adult requests or rules, blames others, deliberately does annoying things, and swears or uses obscene language. This behavior creates significant impairment in academic/social functioning but does not meet the criteria for conduct disorder. (Disruptive behavior disorder NOS reflects clinical features that constitute the subthreshold for both oppositional defiant and conduct disorders.)

ETIOLOGICAL THEORIES

Psychodynamics

The oppositional youth is fixed in the separation-individuation stage of development. The youth insists on autonomy by negative adaptive maneuvers in which he or she continually provokes adults or peers. As the youth develops internal controls, he or she will eventually grow out of these behaviors.

Genetic/Biological

Similar to the predisposition for conduct disorder, heredity contributes to individual temperament, frustration, tolerance, and the tendency to seek risks or disobey authority. The disorder may be gender-linked, as the incidence is higher in boys than in girls.

Family Dynamics

Familial and cultural norms may prohibit the degree of individual differentiation among the family members. Attempts to maintain conformity are met by negativism, disobedience, and quarrelsome defiance. Parenting skills are ineffective and/or inconsistent with reactive and emotionally charged interchanges between parent and child. Some parents interpret average or increased levels of developmental oppositionalism as hostility and as the child's deliberate effort to be in control. If power and control are issues for parents, or if they exercise authority for their own needs, a power struggle can be established between the parents and the child that sets the stage for the development of oppositional defiant disorder.

A relationship between life events and the development of anxiety disorders has been identified. This theory suggests that disruptive behavior is learned as a means for a child to gain adult attention. Anxiety generated by a dysfunctional family system, marital problems, etc., could also contribute to symptoms of this disorder. Parents become frustrated with the child's poor response to limit-setting. Parenting intervention become oversensitive or the reverse, with no external structure provided.

CLIENT ASSESSMENT DATA BASE

Activity/Rest

Difficulty playing or engaging in leisure activities quietly

Ego Integrity

Feelings of rejection, powerlessness, fear of abandonment
Blames others for what happens to self; easily annoyed by others
Passive-dependent or demanding attitude of entitlement
Family may report emotional lability

Food/Fluids

Dawdling at mealtime
Oppositional battles over food choices and at mealtimes

Hygiene

Rebellious display of defiance in personal appearance, adherence to hygiene, and personal habits

Neurosensory

May be depressed, angry, or react with ambivalence or hostility
Dawdling, passive resistance to time schedules, missing school bus, etc.

Social Interactions

Displays impaired social and academic functioning
Shows provocative display of defiance of adult authority figures
Deliberately engages in annoying behaviors; ignores verbal instructions/requests
Often bullies or bosses others (peers, siblings)
Aggressively interrupts play activity of others; breaking toys, making up own rules for games, etc.
May/may not participate in social activities
Interpersonal relationships impaired (e.g., loses temper, argues, refuses to comply with requests or rules, is spiteful or vindictive, projects blame for own mistakes or misbehavior, interrupts or intrudes on others)

Teaching/Learning

Onset usually before age 8, and not later than early adolescence
Family history of alcohol abuse

DIAGNOSTIC STUDIES

(Studies are done to rule out other conditions that may contribute to presenting problems.)
Thyroid Studies: May reveal hyperthyroid/hypothyroid conditions contributing to problems
Neurological Testing (e.g., EEG, CT Scan): Determines presence of organic brain disorders
Psychological Testing (as indicated): Rules out anxiety disorders; identifies gifted, borderline-retarded, or learning-disabled child; and assesses social responsiveness and language development.

Note presence of physical symptoms that might indicate the existence of physical illness (e.g., rashes, upper respiratory illness, or other allergic symptoms, CNS infection [cerebritis] requiring appropriate diagnostic studies).

NURSING PRIORITIES

1. Promote client's ability to engage in satisfying relationships with family members, peer group.
2. Facilitate parents' development of effective means of coping with and interventions for their child's behavioral symptoms.
3. Participate in the development of a comprehensive, ongoing treatment approach using family and community resources.

DISCHARGE GOALS

1. Demonstrates appropriate response to limits, rules, and consequences.
2. Parents have gained (or regained) the ability to cope with internal feelings and to intervene effectively in their child's behavioral problems.
3. Therapeutic plan developed, with family and client participating in treatment program.
4. Plan is in place to meet needs after discharge.

NURSING DIAGNOSIS	COPING, INDIVIDUAL, ineffective
May Be Related to:	Situational or maturational crisis Mild neurological deficits/retardation Retarded ego development; low self-esteem Family system with dysfunctional coping methods, negative role models; abuse/neglect
Possibly Evidenced by:	Inability to meet age-appropriate role expectations Hostility toward others; defiant response to requests/rules Inability to delay gratification; manipulation of others in environment to fulfill own desires
Desired Outcomes/Evaluation Criteria— Client Will:	Demonstrate appropriate ways to assert self and establish self-worth. Identify adaptive coping skills that will achieve a healthy balance between independence and dependence. Delay gratification without manipulating others.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Allow flexibility in shifting from one activity to another, particularly transitioning at bedtime for younger children.	Recognizing the onset of anxiety and providing flexibility will decrease likelihood of child taking an oppositional stance.
Reinforce all efforts of the child when displaying appropriate efforts to establish autonomy.	This decreases pattern of negative attention-seeking behavior.
Provide opportunities for imaginary play, including use of puppets, clay, sand.	The medium of play materials provides physical displacement of feelings and visualization of dynamics.
Set limits on disruptive behaviors (e.g., talking incessantly); suggest alternative competing behaviors such as playing quietly.	Child needs to know expectations and to learn competing acceptable behaviors (e.g., raising hand vs. shouting out, keeping hands to self vs. pushing others).
Encourage discussion of angry feelings and identity of true object of hostility.	Dealing with feelings honestly and directly helps discourage displacement of anger onto others.
Explore with client alternative ways for handling frustration.	Promotes learning how to interact in society with others in more productive ways.
Provide positive feedback for trying new coping strategies.	Supports efforts and encourages use of acceptable behaviors.
Evaluate with client the effectiveness of new behaviors. Discuss modifications for improvement.	Because client has limited problem-solving skills, assistance may be required to reassess and develop strategies.

Assist client to recognize signs of escalating anxiety. Explore ways client can intervene before behavior becomes disabling.	Helps client to recognize ineffective behaviors and develop new coping skills to effect positive change.

Collaborative

Administer medication as indicated, e.g.:	
imipramine (Tofranil), paroxetine (Paxil), sertraline (Zoloft);	Antidepressants may be used when depression is a factor in the disorder.
diazepam (Valium), chloridiazepoxide (Librium), alprazolam (Xanax).	Antianxiety medications provide relief from effects of anxiety, facilitating cooperation with therapy and enhancing sense of self-control.

NURSING DIAGNOSIS	**SOCIAL INTERACTION, impaired**
May Be Related to:	Retarded ego development; low self-esteem
	Family system with dysfunctional coping methods, negative role models; abuse/neglect
	Neurological impairment; mental retardation
Possibly Evidenced by:	Discomfort in social situations
	Difficulty playing/interacting with others; aggres-sive, loses temper, argues, bullies/bosses others
	Interrupts or intrudes on others; refuses to comply with requests or rules
Desired Outcomes/Evaluation Criteria—Client Will:	Identify feelings that lead to poor social interactions.
	Participate appropriately in interactive play with another child or group of children.
	Develop a mutual relationship with another child or adult.

ACTIONS/INTERVENTIONS	RATIONALE

Independent

Develop trust relationship with child, show acceptance of child separate from unacceptable behavior.	Acceptance and trust encourage feelings of self-worth.
Encourage client to verbalize feelings of inadequacy and need for acceptance from others. Discuss how these feelings affect relationships by provoking defensive behaviors such as blaming and manipulating others.	Recognition of problem is first step toward resolution.

Engage in play activities, board games, sports, team-building exercises.	Learning appropriate cooperative play activities provides outlet for healthy interactions, leadership skills.
Offer positive reinforcement for appropriate social interaction. Ignore ineffective methods of relating to others; teach competing behaviors.	Behavior modification can be an effective method of reducing disruptive behaviors in children by encouraging repetition of desirable behaviors. Attention to unacceptable behavior may actually reinforce it.
Identify situations that provoke defensiveness and role-play more appropriate responses.	Provides confidence to deal with difficult situations when they occur.
Provide opportunities for group interaction and encourage a positive and negative peer feedback system.	Appropriate social behavior is often learned from age-mates.

Collaborative

Encourage participation in psychoeducation groups on assertiveness training, problem-solving, social skills.	This is a helpful arena in which to practice new social skills, receive feedback with the support for efforts to improve.
Arrange staffings with other professionals (e.g., social workers, teachers). Include parents and child when possible.	Cooperation and coordination among those working with these children will enhance the treatment program. Including the child and parents provides them an opportunity to understand the total problem and proposed treatment program.

NURSING DIAGNOSIS	**SELF ESTEEM disturbance**
May Be Related to:	Retarded ego development
	Lack of positive feedback with repeated negative feedback
	Family system with dysfunctional coping methods; abuse/neglect; negative role models
	Mild neurological deficits
Possibly Evidenced by:	Lack of eye contact
	Lack of self-confidence
	Engagement in physically dangerous activity; refusal to engage in activities or involvement without consideration of consequences
	Derogatory remarks about self and/or bragging about self
	Distraction of others to cover up own deficits or failures (e.g., acting the clown)
	Projection of blame/responsibility for problems; rationalization of personal failures, grandiosity

Desired Outcomes/Evaluation Criteria— Client Will:	
	Verbalize increasingly positive self-regard.
	Demonstrate beginning awareness and control of own behavior.
	Participate in new activities without extreme fear of failure.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Convey acceptance and unconditional positive regard.	May help child increase own sense of self-worth.
Assist child to identify basic ego strengths/positive aspects of self; give immediate feedback for acceptable behavior.	Focusing on positive aspects of personality may help improve self-concept. Positive reinforcement enhances self-esteem and increases desired behavior.
Spend time with client in 1:1 and group activities.	Conveys to client that you believe he or she is worthy of time and attention.
Provide opportunities for success; plan activities based on ability level (including noncompetitive and team building), set agreed-upon time limits for task completion.	Repeated successes can help to improve self-worth.
Discuss fears, encourage involvement in new activities/tasks.	Confronting concerns and engaging in new tasks promotes personal growth and new skills.
Identify possible consequences of actions (e.g., refusal to follow rules, engaging in activities for high-risk behaviors without forethought).	Helps client begin to recognize own responsibility for consequences of behavior and provides opportunity to consider alternatives.
Help client set realistic, concrete goals and determine appropriate actions to meet these goals.	Provides a structure to develop sense of hope for the future and framework for reaching desired goals.
Collaborative	
Provide learning opportunities, structured learning environment (e.g., self-contained classroom, individually planned educational program).	Successful school performance is essential to preserve a child's positive self-image.

NURSING DIAGNOSIS	FAMILY COPING, ineffective: compromised/disabling
May Be Related to:	Excessive guilt, anger, or blaming among family members regarding child's behavior
	Parental inconsistencies; disagreements regarding discipline, limit-setting, and approaches

	Exhaustion of parental resources due to prolonged coping with disruptive child
Possibly Evidenced by:	Unrealistic parental expectations
	Rejection or overprotection of child
	Exaggerated expressions of anger, disappointment, or despair regarding child's behavior or ability to improve or change
Desired Outcomes/Evaluation Criteria—Family/Parent(s) Will:	Demonstrate more consistent, effective intervention methods in response to child's behavior**.**
Desired Outcomes/Evaluation Criteria—	Express and resolve negative attitudes toward
Family/Parent(s) Will (cont.):	child. Identify and use support systems appropriately.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Provide information and materials related to child's disorder and effective parenting techniques. (Refer to CP: Parenting.)	Appropriate knowledge and skills may increase parental effectiveness.
Encourage parents to verbalize feelings and explore alternative methods of dealing with child.	Supportive counseling can assist parents in developing coping strategies.
Provide feedback and reinforce effective parenting methods.	Positive reinforcement can increase self-esteem and encourage continued efforts.
Involve siblings in family discussions and planning for more effective family interactions.	Family problems affect all members, and treatment is more effective when everyone is involved in therapy.
Collaborative	
Refer to community resources as indicated including psychotherapy, parent support groups, parenting classes (Parent Effectiveness).	Developing a support system can increase parental confidence and effectiveness.

NURSING DIAGNOSIS	**KNOWLEDGE deficit [LEARNING NEED] regarding condition, prognosis, and treatment needs**
May Be Related to:	Lack of knowledge; misinformation/misinterpretation
	Mild neurological deficits; associated developmental learning disabilities; inability to concentrate; cognitive deficits
Possibly Evidenced by:	Verbalization of problem/misconceptions
	Poor school performance; repeated school suspensions
	Inappropriate or exaggerated behaviors

	Development of untoward consequences of behavior
Desired Outcomes/Evaluation Criteria—Client/Parent(s) Will:	Verbalize understanding of reasons for behavioral problems, treatment needs within developmental ability.
	Participate in learning and begin to ask questions and seek information independently.
Client Will:	Achieve cognitive goals consistent with level of temperament.

ACTIONS/INTERVENTIONS	RATIONALE
Independent	
Provide quiet environment, self-contained classrooms, small-group activities. Avoid overstimulating places, such as school bus, busy cafeteria, crowded hallways.	Reduction in environmental stimulation may decrease distractibility and diminish onset of temper tantrums. Small groups may prevent opportunity for power struggles/control, enhancing ability to stay on task and helping client learn appropriate interaction with others, avoiding sense of isolation.
Give instructional material in written and verbal form with step-by-step explanations.	Sequential learning skills will be enhanced.
Instruct child in problem-solving skills; practice situational examples.	Effective skills may increase performance levels.
Educate child and family about the use of medications and response anticipated.	Lessening of depression and/or anxiety may promote cooperation in therapy, resulting in more acceptable behavior.
Coordinate overall treatment plan with schools, collateral personnel, child, and family.	Cognitive effectiveness will most likely be advanced when treatment is not fragmented and significant interventions are not missed because of lack of interdisciplinary communication.