

Influence of the Social Environment on the Onset of Oppositional Defiant Disorder: A Case Study of a Grade 2 Learner

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ABSTRACT This study investigated the role of the social environment in the onset of Oppositional Defiant Disorder (ODD). A case study was conducted. Semi-structured interviews were conducted with three informants (maternal grandmother, aunt, class teacher) in conjunction with the perusal of educational progress reports. The child presented with symptoms that fit the criteria for ODD. Her oppositional defiance is attributable to environmental factors. Inconsistent parenting was a factor as Tino grew up with a presumably more tolerant maternal grandmother before moving to stay with her strict aunt and teacher where she started to behave in an inappropriate manner. The study recommends further study with a big sample to obtain generalisable findings.

INTRODUCTION

Oppositional defiant disorder refers to a recurrent pattern of developmentally inappropriate, negativistic, hostile and defiant behaviour toward authority figures that lasts at least six months (Bower 2015; Kramer 2013; American Psychological Association (APA) 2000). In that duration, at least four of the following are present:

- ♦ Often loses temper
- ♦ Often deliberately annoys people
- ♦ Often touchy or easily annoyed by others
- ♦ Often argues with adults
- ♦ Often actively defies or refuses to comply with adults' requests or rules
- ♦ Often angry and resentful
- ♦ Is often spiteful or vindictive
- ♦ Often blames others for own mistakes or behaviour

The disturbance in behaviour causes clinically significant impairment in social, academic, or occupational functioning (Bower 2015; Chandler 2012). It often appears in the pre-school years. However, children who develop a stable pattern of ODD at pre-school are likely to go on to have it during their elementary school years (Hamilton and Armando 2008). They also posit that children with ODD have substantially strained relationships with their parents or caregivers, teachers and peers.

Social Epidemiology

According to Berkman and Kawachi (2000) and Kerr (2015), social epidemiology refers to a

branch of epidemiology that studies the social distribution and social determinants of states of health. It is different from the classic epidemiology in its explicit emphasis on investigating social factors through the judicious use of theories, concepts, and methods instead of merely assuming their effects as background variables in biomedical research (Hutten 2015; Krieger 2000). Social epidemiology helps to explain causal factors of a specified phenomenon. The notion of causation, in turn, raises not only complex philosophical issues but also issues of accountability and agency. Therefore, the central question becomes: who and what is responsible for ODD.

Risks Factors

ODD is moderated by both the environment and genetics. According to Kramer (2013) and Chandler (2012), the risk factors are biological, psychological and social in nature. The genetic factors that predispose a child to ODD include depressed mother (Bower 2015; Halverson 2007) and parents with some type of conduct disorder or depressed maternal family members (APA 2000; Kramer (2013). This makes oppositional behaviour a strongly inherited trait. Smoking during pregnancy and fetal alcohol syndrome are significant risk factors for ODD. Psychological risk factors include living in an abusive home, not having two biologic parents, multiple separations, and poor attachment to your parents are known risk factors. The social risk factors include poverty, lack of community, uninvolved parents, exposure to violence, child abuse, sub-

stance abuse and inconsistent parenting. Authoritarian parenting is associated with oppositional and defiant behaviour in children (Hutten 2015; O'Connor 2012). Such parents tend to be the "do as I say, not as I do" type. They demand obedience, issue harsh punishments and do not negotiate.

Temperament, social information processing bias and parent-child processes are the other risk factors (Bubier and Drabick 2009; Hutten 2015). A study by Burke, Pardini and Loeber (2008) reported a reciprocal relationship between ODD symptoms and less parental assertive disciplining behaviours. ODD predicts less assertive parenting practices, poorer reciprocal communication and decreased involvement between parent and child.

Prevalence and Comorbidity

Prevalence: ODD is the most common psychiatric problem in children (Bower 2015; Chandler 2012; Zadorsky 2013). It affects over 5% of children in the United States of America. The disorder is more common in younger in boys than girls, but as they grow older, the rate evens up.

Comorbidity: ODD often goes along with other disorders such as Attention Deficit and Hyperactivity Disorder. As such, some children will develop some form of affective disorder or mood disorder like depression or anxiety.

Treatment

There are several ways of treating ODD. A comprehensive therapy that addresses all factors that are present is required. Behaviour modification is an effective tool for extinguishing undesirable behaviour (Bharjoo 2008; Zadorsky 2013). In the same vein, Attwood (2012) suggests the use of Affective Education for treating a child who has difficulties with emotional expression. The child learns to verbally express feelings rather than rely on physical outbursts. Anger Management Therapy is a valuable resource useful tool for helping a child who has trouble controlling anger. The techniques include goal setting, problem solving, relaxation, identifying triggers and recognition of consequences. Family therapy is useful for helping people negatively impacted by the defiant behaviour (Adams 2012; Zadorsky 2013). It may be a vital

tool to mending disrupted family relationships. The affected family can also learn to love and support the behaviour disordered child. Parent Management Training that entails equipping parents and caregivers with cognitive behaviour therapy techniques is beneficial (Wagner 2008; Zadorsky 2013).

Case Study

Tino is 8 years of age. She is a grade two pupil at public school situated in the affluent suburb of a city in Zimbabwe. Her parents never married. She grew up at her maternal grandparents' rural homestead under the care of her mother. Her mother got married and left Tino to stay with her grandmother. A few years later, Tino's grandmother in consultation with her mother and father took her to her aunt (her father's sister) who resided in the city.

She enrolled for grade one at a good public school. Tino used public transport to commute from home to school every day. She was given money for transport every day. Later, her aunt received reports that she was not paying the transport fee. She sometimes used her bus to buy sweets at school. The class teacher reported that Tino was once a nice child but had surprisingly become difficult. She shouted obscenities in class and was aggressive. Her academic performance dropped. Tino at times took off her shoes and walked barefooted. She was disrespectful to the class teacher. All forms of punishment meted out by the teacher did not change her for the better. At home, Tino became troublesome. She was not honest. Tino aggressed her aunt's children. Her influence was bad and she became disruptive in the home. She sometimes through tantrums, shouted back at adults and became very difficult.

Tino was later taken back to the rural community to re-join her maternal grandmother. She consequently transferred to the nearby rural school. Her grandmother reported that Tino was a nice, obedient and respectful girl. Her school report corroborated that Tino was a bright, well behaved, smart and hardworking pupil. She was the top pupil in her class.

Aim of the Study

The aim of this study was to investigate the association between the social environment and ODD. The research questions were:

- 1). Do the symptoms that Tino presented with fit the criteria for ODD?
- 2). What caused the ODD symptoms?

METHODOLOGY

Research Design

A case study was conducted. A case study is an empirical inquiry that investigates a phenomenon within its real-life context (Flyvbjerg 2006, 2011). It is used when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used (Dehmer 2015; Yin 1984). It emphasises detailed contextual analysis of a limited number of events or conditions and their relationships (Soy 1997; Willis 2014). The design was used in the present study to help us to understand oppositional defiant disorder which is a complex phenomenon to extend experience and add strength to what is already known through previous research.

Participants

Three participants who took part in the study were purposefully sampled. The three were the aunt and maternal grandmother to the eight-year old elementary school girl who presented with symptoms of oppositional defiant disorder. They were viewed as information rich participants as they dealt directly with the child in their different capacities. Their ages ranged from 41 to 58 years. Their mean age was 48.3 years. All the three participants were females of Black African ethnicity. The aunt and class teacher stayed in the city. The aunt stayed with the child for two years of her elementary education. The maternal grandmother stayed with Tino from infancy to pre-school age in the rural community.

Data Collection

Consent to participate in the study was sought from each of the informants. Prior to obtaining consent, the purpose of the research and the procedure were explained. Participation in the study was voluntary. Confidentiality and anonymity were maintained throughout the study. The informants were informed of their right to withdraw from the study should they so wished. The author made appointments for in-

terviews with the informants. The aunt and grandmother were interviewed at the aunt's homestead while the class teacher was interviewed in town on a weekend.

Research Instrument

Tools for collecting data included documentation review and interviews (Kuhn et al. 2015; Yin 2003). The school psychologist's assessment and the school progress reports were reviewed. Semi-structured interviews were conducted with the aunt, grandmother and teacher. The questions that the three answered centred on what, how and why Tino was behaving in an unusual manner.

Data Analysis

Raw data were examined using many interpretations in order to establish linkages between the objective and outcomes of the study (Boyce et al. 2014; Soy 1997). Three analytical procedures which were carried out were summary, explication and structuring (Rytwo et al. 2015; Titscher et al. 2000). *Summary*: attempts to reduce the material in such a way as to preserve the essential content. For this the text is paraphrased, generalized or abstracted and reduced. *Explication*: involved explaining, clarifying and annotating the material. *Structuring*: the text was structured according to content, form and scaling. Data locations were marked, processed and extracted.

Diagnostic Report and Interviews with Aunt, Teacher and Maternal Grandmother

The psycho-diagnostic assessment conducted using the Diagnostic and Statistical Manual-IV-Revised by the school psychologist indicated that the girl had oppositional defiance disorder. The signs and symptoms that Tino presented with met the criteria for ODD (APA 2000; Kramer (2013). This was corroborated by the interviews that were conducted with the girl's aunt, teacher and maternal grandmother. Seven themes emerged from the interview responses. These were loss of temper, annoying other people, easily annoyed by others, argues with adults, refusal to comply with adults' directives, vindictive and blaming others for own mistakes. The themes are explained next.

Loss of Temper

Both the aunt and teacher reported that Tino was temperamental. This is supported by the following vignettes:

Tino often throws tantrums. In anger she shouts at the top of her voice and throws things around. (Aunt)

Yes, she is unpredictable. She easily gets angry and fights other children in class. (Teacher)

Annoying Other People

The aunt reported that Tino annoyed others at home. This is supported by the following statement:

She is troublesome and disruptive when playing with my children. One day she slapped my six months old baby with her hand. (Aunt)

Easily Annoyed By Others

The teacher said:

She does not play well with others. She easily gets angry and when that happens she becomes dangerous to other children.

Arguing with Adults

The aunt said:

I am really surprised. The first time she came to stay with us she looked reserved and nice. She just changed. I do not know what happened. Now she no longer respects or fears me. She sometimes shouts back at me and several times I beat her for that. I often struggle to convince her to do certain things. Tino always gives excuses. She does not even listen to anybody. My house maid has problems with her.

Refusal to Comply with Adults' Directives

The study revealed that Tino resisted complying with adult authority. This is supported by the following statements:

I often struggle to convince her to do certain things. Tino always gives excuses. She does not even listen to anybody. My house maid has problems with her. (Aunt)

She has a habit of walking barefooted at school. I ordered her not to do it but it seems that what I said fell on deaf ears. I have given up. (Teacher)

Vindictive

The teacher said:

If another child does something wrong to her, she retaliates. She is not a forgiving kind of child. She fights back.

Blaming Others for Own Mistakes

The aunt said:

If she breaks up my cups and plates at home, she never accepts responsibility. I also had a problem with her when she spent the bus fare on sweets. She would not pay her transport fee but she never accepted that she did that.

DISCUSSION

It emerged from the interviews and reports by both the psychologist and teacher showed that Tino is a girl who behaves in an inappropriate manner. The behavioural symptoms that she reportedly presented with qualify her for a diagnosis of ODD. Most of her behavioural symptoms fit the category of a child with oppositional defiance disorder. This is in line with the Diagnostic and Statistical Manual-IV-TR, which indicates that ODD is a disruptive behaviour disorder that is diagnosed initially at infancy, childhood and adolescence (APA 2000; Bower 2015; Chandler 2012; Hamilton and Armando 2008). Furthermore, Tino presented with at least four of the symptoms that fit the category and classification for ODD. Conversations mentioned in the participants' vignettes attest to the patterns of behaviour indicative of a child with ODD. Tino presented with the ODD symptoms for more than a year and this fulfils the criteria for length of symptoms of at least six months stipulated by the DSM-IV (APA 2000; Chandler 2012; Kramer (2013).

School reports and interviews revealed contrasting views of Tino. Her aunt and school teacher at her first school in the city reported that Tino was a problem child. In contrast, her maternal grandmother and the new teacher in the rural community where she grew up indicated that Tino was a well behaved, respectful, smart and bright child. This finding suggests that the social environment made a modest contribution to the aetiology of ODD (Berkman and Kawachi 2000; Hutten 2015; Krieger 2000, Krieger 2001; Zadorsky 2013). The symptoms of ODD

that she presented with while staying with her aunt in the city are attributable to the different parenting styles. In the present study, Tino presented with symptoms of ODD that were associated with both family dysfunction and change of parenting styles. The psycho-social risk factors that include not staying with biological parents, multiple separations and poor attachment to her parents might have led to the development of ODD (APA 2000). In addition, uninvolved parents and inconsistent parenting could have been risk factors as well. In Tino's *shona* culture, the maternal grandmother pampers the son-in-law's children. Therefore, the transfer from a supposedly tolerant environment (in the rural community with her maternal grandmother) to an authoritarian parenting style (in the city with her aunt and teacher) might have been a significant factor in the onset of the symptoms of ODD. This is in line with O'Connor's (2012) argument that authoritarian parenting causes oppositional and defiant behaviour in children. Authoritarian parents or caregivers tend to be the "do as I say, not as I do" type. They demand obedience, issue harsh punishments and do not negotiate. Consequently, Tino might have had substantially strained relationships with her caregiver, teacher and peers in the city (Hamilton and Armando 2008). This is in line with Hutten's (2015) argument that defiant kids function much better in environments in which they are given the opportunity to self-motivate. The parent or guardian should make a conscious effort to ask the child he/she wants to do rather than tell him/her.

The study does not rule out the core-moderating effect of genetic factors. The parenting component of the environment is believed to have genetic determinants (Hazell 2010). The inherited characteristics of Tino could have had interacted with the environment factors to produce ODD symptoms. According to Halverson (2007), the genetic factors that predispose a child to ODD include depressed mother, parents with some type of conduct disorder or depressed maternal family members (APA 2000).

CONCLUSION

The symptoms that Tino presented with fit the criteria for ODD. Her oppositional defiance is attributable to environmental factors rather than heredity. Born out of wedlock and growing up in a non-intact family under the care of the

maternal grandmother in a rural community and later with the aunt's family in an urban area seemed to have influenced Tino's behaviour. Inconsistent parenting was a factor as Tino grew up with a presumably more tolerant maternal grandmother before moving to stay with her strict aunt and teacher where she started to behave in an inappropriate manner. In addition, the behaviour problems ceased when she went back to stay with her maternal grandmother. Tino did not stay with her parents who never married which is a predisposing factor.

RECOMMENDATIONS

While there are no easy solutions to resolve the difficulties encountered when a child has a diagnosis of ODD, Fraser (2008) suggests the following strategies to reduce stress:

Child with ODD: needs to develop effective communication, problem solving and anger management skills.

Parents or Care Givers: need to improve positive parenting skills and enhance skills in communication, problem solving and conflict resolution.

Family: needs counselling and support to deal with the stresses in relationships and home environment.

Teacher: should provide social skills sessions to improve peer relationships.

LIMITATIONS OF THE STUDY AND FUTURE STUDY

The study was not without limitations. Factors that co-morbid with ODD in Tino were not established. The study relied on narrations of the caregivers that may not be reliable. To establish reliability and generality in a case study is subject to scepticism. The case study is viewed as an exploratory tool that biases the findings through the intense exposure to study of the case. This calls for further investigation with a big sample of children with ODD.

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