



Oppositional defiant disorder

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ABSTRACT: *Oppositional defiant disorder (ODD) has been on an incline among Kenyan children; as evidenced by a prevalence rate of 12.1% against the global average of 2%-16%. The Kenyan families are affected by ODD in diverse ways; including the disease burden when there is comorbidity, difficulties in dealing with the ODD child's behaviors, progression of ODD to conduct disorder, and ultimately to antisocial personality disorder. Diagnosis and treatment of ODD in Kenya is a challenge due to the cultural beliefs about existence of mental disorders. According to DSM 5 ODD is distinct from the more severe conduct disorder. Most Kenyan families may assume that the child will outgrow the misbehaviors. However, ODD symptoms, unlike the typical childhood misbehaviors are more severe and frequent, and persist instead of diminishing with age. ODD is diagnosed by the age of 8 years although it could be present in preschoolers and adolescents. In Kenya however, due to inadequate facilities and shortage of trained personnel ODD is often missed out. This research concludes that there is great need for collaborative care conducted by psychologists to work with this population. They would work with Kenyan parents, schools and society in general to offer psychoeducation and provide psychotherapy.*

Keywords:- Comorbidity, Diagnosis, Oppositional defiant disorder, symptoms, Psychotherapy

I. INTRODUCTION

It is the general expectation that children will develop prosocial tendencies. In this case, they are expected to obey their parents, teachers and other adults, and also be able to relate well with their peers. However, in some cases as have been found here in Kenya the prosocial behavior is lacking in some children. Such individuals may develop Oppositional Defiant Disorder (ODD). ODD is distinct from the more severe Conduct Disorder. It is distinguished from typical childhood misbehavior in that the problem behaviors do not diminish with age (Parritz and Troy, 2014 p.168 [1]). DSM 5 has classified ODD symptoms into three; namely, angry/ irritable mood, argumentative, and vindictiveness (American Psychiatric Association, 2013, p. 462[2]). In Kenya these symptoms are evident in children who frequently and persistently throw tantrums, argue with any authority figure and do things to deliberately hurt others. Families and teachers in Kenya are faced with the enormous task of handling such children yet they lack the capacity to do so. More often than not, Kenyan families are ignorant of the existence of mental disorders such as ODD. In Kenya, children with ODD present as being touchy, resentful, and frequently lose their temper. Such children defy authority; be it parents at home, or teachers and prefects at school. They are also spiteful and often blame others for their mistakes. Such children bully others and are therefore, shunned by their peers. In Kenya, such children are likely to be labeled naughty and will be the most punished in school and at home. A good number of Kenyan families may not seek treatment of a naughty child; which leaves the child's health to deteriorate. There is a possibility of some seeking traditional explanations and methods of treatment of a defiant child. Few seek psychiatric intervention only if there is comorbidity of ODD with others disorders, such as conduct disorder, attention deficit hyperactivity disorder (ADHD), depression, anxiety and autism spectrum disorder. In this case, psychiatrists treat ODD using antipsychotic medication.

Research has established that ODD is higher in boys than in girls(Parritz and Troy, 2014 p.169[1]). The global prevalence rate in the population is 2%-16% while in clinical samples it is higher at 28%-65%(Parritz and Troy, 2014 p.169[1]). In Kenya, the prevalence rate of ODD is 12.1%, (Kamau, Kuria, Mathai, Atwoli & Kangethe, 2012 [3]). What poses the greatest challenges in Kenya is the lack of proper diagnosis for ODD, the ignorance in the general population of the disorder, lack of proper intervention, and the inability of the parents to afford screening and treatment for the children. The current state in the country is that

ODD is crammed together with other mental disorders and is treated utilizing antipsychotic medication. If only the country had enough psychologists who were competent enough to diagnose and treat ODD, referrals would be made to them. This would offer great relief to stakeholders who work with children. The purpose of this meta-analysis is to shed light on some research findings on trajectories of ODD in some countries, etiology, impact on the family and treatment of ODD. The paper will highlight the current state of ODD in Kenya, discuss the prevalence rate, the challenges with the treatment protocol utilized here and finally it will highlight the need for psychologists work with this population.

II. DEVELOPMENTAL PATHWAY OF OPPOSITIONAL DEFIANT DISORDER

The developmental course of ODD may take many forms. It may deteriorate into conflicts and hostility as the individual grows older. It may also progress into conduct disorder which in turn becomes antisocial personality disorder in adulthood. Boys portray externalizing or overt disorders, while girls display internalizing or covert disorders such as anxiety and depression. A research involving 18,415 children aged between 5 and 16 years of age in the United Kingdom revealed that the presence of ODD in adolescents was a strong predictor of psychopathology in adulthood. It was evident that the three dimensions of ODD had different outcomes in later life; irritability was associated with emotional disorders and non-aggressive behaviors, hurtfulness was associated with insensitivity and aggressiveness, while being headstrong was associated with attention deficit hyperactivity disorder. The three dimensions combined were associated with conduct disorder (Stringaris and Goodman, 2009, p. 216 [4]). In Kenya however, it is easier to treat those who present with externalizing disorders but ignore those who display internalizing disorders. It is notable that, adolescent depression is a common phenomenon in the country, particularly among girls.

III. ETIOLOGY OF OPPOSITIONAL DEFIANT DISORDER

There are two models that explain the increase and persistence of ODD; they are the coercion model and the transactional model. The coercion model is also known as the Oregon model. This model mainly looks at the role of parents. It explains how some parental characteristics such as inconsistent discipline, irritable explosive discipline, inflexible rigid discipline, and low level of parental supervision and involvement lead to ODD in the children. This model deals more with social learning which leads children to be conditioned to always contend with their parents. Children develop externalising behaviors, such as aggression in an attempt to counter their parents' punitive measures. These behaviors may be generalized to other settings other than the home; the child will be viewed as difficult. The other model is known as the transactional model. This model posits that the incompatibility between the parent and the child is caused by many factors. This would in turn mean that the trajectories, interventions, and outcomes are varied. The transactional model therefore, examines many risk factors for ODD such as child characteristics, poor parenting, heredity, influence of peers, and the sociocultural factors (Parritz and Troy, 2014, p173 [1]). The different pathways of the disorder are likely to influence the treatment protocol. In Kenya, many factors are responsible for development of ODD in children. They include among others, poor parenting in which some parents are inconsistent in their discipline measures, genetic factors in which case ODD is passed from parent to child, sociocultural factors including harsh neighborhoods and unfriendly school settings. The government has crafted the child friendly schools in an attempt to make the learning environment more adapted to needs of the child.

IV. EFFECTS OF ODD ON THE FAMILY

It is evident that ODD takes a toll on the family. Having a family member with a psychopathology is quite difficult for the family. Research has found that the presence of ODD causes distress in the family. The child who has ODD is likely to have antisocial personality disorder as an adult. Such a person has no empathy and will deal ruthlessly with other family members. He or she is also likely to become a regular jailbird; this distresses the family further. As adults, individuals with personality disorders are psychopathological and will more often than not beget children who have psychopathology; therefore, propagating the vicious cycle of ODD (Erford, Paul, Oncken, Kress, & Erford, 2014 p.13 [5]). Another study involving 180 children aged between 6 and 17 years was done to find out the effects of atomoxetine treatment. The KINDL-R questionnaire was used to measure the quality of life. The dimensions of the quality of life measured were, physical and emotional well-being, self-esteem, friends, family and school. The FaBel questionnaire was used to measure the family burden of illness. The 9 week treatment revealed that with the atomoxetine medication there was improvement in the emotional well-being, self-esteem, friends and family. However, there were no significant effects on the family burden of illness (Wehmeier, Schacht, Dittmann, Helsberg, Schneider-Fresenius, Lehmann, Bullinger, & Ravens-Sieberer, 2011, p691-702 [6]). The families in Kenya, just like all other families elsewhere experience difficulties when one of their members has a psychopathology. Misunderstandings are rife in some families due to a mental illness in a child. Mothers are particularly blamed for the child's "misbehavior". Family conflicts occur where one spouse feels that the other is not doing enough to mould the child's behavior. A lot of time,

money, and energy are spent in an effort to take care of such children. The Kenyan family therefore, feels desperate when one of them has ODD; many of them do not understand what ODD is all about. Early intervention may not be sought and the child's condition may deteriorate with age.

V. TREATMENT FOR OPPOSITIONAL DEFIANT DISORDER

5.1 The commonly used treatment protocol

More often than not, a mode of treatment that addresses all aspects of the disorder is preferred. Some of treatment modalities include the Incredible Years Program, the Fast Track model, and the Early Risers program that have the child treatment component and the adult treatments in built in them. Some of the programs also have peer and school components (Parritz and Troy, 2014, p.181 [1]). In their study, (Dunsmore, Jordan, Booker & Ollendick, 2012, p444 [7]) found that parental emotional coaching coupled with child emotional regulation would act as protective factors for children with ODD. According to World Health Organization (WHO, 2010, p.17 [8]) acts of violence that progress through life having started as ODD could be reduced by cultivating warmth and nurturing relationships between children and their parents. In these warm relationships children would find the nurture they so much require so as not to be defiant. Programs that enhance life skills in children and adolescents are also recommended. Some programs also emphasize prevention of aggression and violent behavior. Such programs are preferred because they help equip the parent and the child with life-long skills. They also do not have side effects as would be the case with medications. A study carried out in Finland-Canada sought to establish the effectiveness of Internet- assisted parent training program in comparison with an education control condition. This training program was said to be effective in helping children with ODD reduce the problem behaviors (McGrath, Sourander, Lingley-Pottie, Ristkari, Cunningham, Huttunen, Filbert, Aromaa, Corkum, Hinkka-Yli-Salomäki, Kinnunen, Lampi, Penttinen, Sinokki, Unruh, Vuorio, & Watters, 2013, p1471-2458 [9]). Traditional Cognitive behavioral therapy (CBT) and marital and family systems therapy have successively been employed to treat children and adolescents suffering from ODD (Hughes-Scalise, Przeworski, Amy, 2014, p.52 [10]).

a. Treatment of ODD in Kenya

Treatment of ODD in Kenya is quite wanting. As Adams asserts, there are very few child psychiatrists in the country. As at 2009 there were only 70 psychiatrists in Kenya, 46 in the public sector and 24 in the private sector (Adams, n.d p.1 [11]). The study by Adams found that at the Moi Referral Hospital in Eldoret, the only trained child psychiatrist was working with adults. Many of the patients; including adults were attended to by psychiatric nurses. If this was the state in the second largest referral hospital in the country; one can almost guess the condition in other health care facilities in Kenya. In this study it was apparent that children with behavioral problems, aggression and ODD were treated mainly using antipsychotic medication. Adams reported that a good number of treatment programs were not suited to the specific needs of the children, and may thus not be very effective. There was concern too that the psychologists working in some programs were not well equipped to handle some disorders like ODD. Very few psychologists in the country are able to diagnose ODD. The few psychologists that have skills and can use screening tools are found in the capital city, Nairobi. Screening is done in extreme circumstances because of the enormous costs involved. Even when screening is done, it is done using Conners 3 Rating Scale because there is no tool that is specially designed for ODD. The Conners 3 Rating Scale was designed for ADHD but is able to pick ODD among other mental disorders that are comorbid with ADHD. The results are handed over to the referring agent. The dilemma for the parent, the school and the society in general is what to do with the child that has been diagnosed with ODD. It is also important to note that even after diagnoses, stakeholders may choose to deal with more life threatening disorders, and hence ODD is ignored.

VI. NEED FOR PSYCHOLOGISTS TO WORK WITH THIS POPULATION

As evidenced above there is a great need for psychologists to work with this population in Kenya. First, this is because children and adolescents with ODD may pass in the eyes of a common person as being naughty and difficult to handle. These are the children who are often punished at home and in the school. They may also be ignored, and shunned by their prosocial peers. In the process they join up with others like them and form gangs of antisocial persons. The internalizing disorders, such as anxiety and depression found mostly in girls with ODD greatly affect their mental well - being. It would be paramount for psychologists in Kenya to work with them to alleviate these impacts of ODD. Children with ODD in Kenya would benefit from testing and the intervention programs that psychologist would employ. Secondly, parents of children with ODD may find it difficult to cope with their children's behaviors. Psychologists in Kenya would then come in handy to train parents on how to handle these children to help reduce the effects of the disorder. Once trained, parents would be able to employ the skills acquired, knowledge, and attitudes to better deal with their children. Group therapy sessions would bring together parents in Kenya who have children with ODD. The sharing of

experiences would offer emotional support so that families do not feel alone in their struggle with ODD. Thirdly, schools in the country may dismiss a child with ODD as being naughty. However, psychologists would work with the school system in Kenya to help them better understand the child. Some interventions at the school level would greatly assist the teachers and other learners in assisting and coping with a learner with ODD. Psychologists would provide psychoeducation to help shed light on what ODD is; this way the teachers, learners and the school staff might show empathy for children with ODD. Fourth, psychologists would also sensitize the society about the disorder. This awareness would help cultivate empathy and a better understanding of the children with this disorder. Since adolescents and adults with conduct disorder and antisocial personality disorder are likely to have started with ODD, this awareness and advocacy for treatment for children with ODD in Kenya would be invaluable.

VII. CONCLUSION

ODD is a disorder that could pass for a child who is naughty or high headed. Children with ODD are often the most physically punished because people do not view it as a mental illness. Due to the two different trajectories, one may not tell the pathway ODD will take; whether if ignored it will dissipate on its own, or it may deteriorate to conduct disorder and ultimately the more permanent antisocial personality disorder. In Africa, Kenya in particular, ODD is not much researched about. Few therapists in the country are able to deal with children with ODD. In fact, more often than not the more obvious disorders like ADHD, anxiety and autism spectrum disorders are better attended to than ODD. In countries that recognize ODD as a mental disorder, some interventions have been put in place including parental emotion training, all family therapies, psychotherapies, and pharmacology if there is comorbidity. In Kenya, very little seems to be happening in as far as intervention measures for children with ODD is concerned. Some therapists who assess children with ODD in clinical settings screen it using Conner; a tool that screens for other disorders, particularly ADHD. There is therefore, a great need for therapists to work with children who have ODD, their families, and schools. In Kenya, awareness campaigns and advocacy would enlighten the population on the existence of ODD as mental health issue.

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