# *Odd impact in daily life of children 4-6 years old*

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## Abstract

*Oppositional Defiant Behavioral (ODD) deals problems controlling emotions and behaviors. According to the Diagnostic Manual (DSM-V), the main characteristics of ODD are the persistence of irritated/angry moods, hostile and defiant behavior, and revenge against others. The prevalence of oppressive defiant disorder ranges from 1% to 11% (American Psychiatric Association, 2013), and uncooperative, opposing, and hostile behaviors toward parents, teachers, other authoritarian figures, and their peers. The article is compiled by collecting data from the literature about the specifics of this disorder. In this way, detailed information is provided about the history, diagnostic criteria, various causes that may affect the occurrence of this disorder, as well as information about various therapeutic interventions and how they affect this disorder. This paper was developed through a qualitative method, specifically with a case study, where a deliberate sample was selected, which meets the three pre-established criteria: to have been diagnosed with the oppressive defiant disorder; be around the age of 4-6 years; as well as pursue therapeutic interventions based on the behavioral approach. The paper raises two research questions regarding the impact of this disorder on the daily life of a 4-year-old and the impact that therapeutic intervention with a behavioral approach has on improving this daily life. The study was conducted through information obtained about the case through the method of triangulation of resources (parents, therapist, educator), as well as from direct activity environments.*

*High number psychosocial and biological risk factors have been identified to influence the occurrence of this disorder. Studies have also been conducted on the best ways to intervene and treat this disorder, where behavioral approaches were noted to be amongst the most used interventions.*

***Keywords**: Oppositional Defiant Disorder (ODD), children, opposing behavior.*

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## 1. Introduction

Antisocial behavior among young people has gradually increased in recent decades, despite improvements in identifying and treating them (Wilson, 2000). Diagnosis oppressive defiant) in the category Disorders that begin infancy, childhood, or adolescence. This diagnosis required the individual to meet 2 out of the five following behaviors: (a) minor rule violation; (B) outbursts of anger; (c) objections; (d) provocative behavior; and (e) stubbornness. It is classified as Destructive Behavioral Disorder. Hence, nine diagnostic criteria were set, and the individual had to meet 5 of them, since no distinction could be made between ODD and other normal children (Rey, 1993). In the transition from DSM-II-R criteria for ODD continued to be tightened. It specifies that behaviors are of development impairments to qualify for ODD. The DSM-V also sets severity symptoms, which vary based on the number of environments in which the behavior occurs. We can also talk about ODD based on the onset of symptoms. This way, we can divide them into:

Early onset (usually around of offensive behavior more than of the cases, was maintained even in adulthood, so that there was no reduction from the time the participants were taken into the study until their thirties. This lifelong characterized style-related (adolescent unstable primary caregiver) low disorder cases of meet above factors. Another indication is related to the father's behavior.

Usually another of adolescent's actions in which the disorder started at an early age. It has been observed that this level is reduced by half in their late twenties.

## 2. Methodology

The paper applies a case study-based qualitative method, where the case study model is descriptive-comparative, aiming to describe the phenomenon and the real-life context of the selected case in detail. It also provides a case comparison before and during the intervention with the behavioral therapy that the individual follows. The case study method was used to observe and obtain detailed information about the case studied.

*Instruments used in this study*: at the beginning, to obtain basic information disorder, including its history, beginnings, and changes that the diagnosis of this disorder had undergone; information on diagnostic criteria was obtained; risk factors that may affect this disorder; information was obtained about the various therapies and interventions that could be used, as well as some studies showing the importance of early therapeutic intervention.

*Data collection* was conducted through the observation triangulation method, which encompasses collecting data from different perspectives and points of view. Thus, data were obtained via parents' report, professionals (therapist, teacher), and through the direct observation of the daily premises of the case study.

*Information obtained from the assessment* via VB-MAPP instrument: is an instrument that contains a description of how to use Skinner's language assessment and verbal behavior analysis, which contains specific scoring criteria for 170 milestones. This developmental instrument is divided into three levels for assessing the comprehended and spoken language, as well as the social skills of children (ages 0 to 4 years old) with various disorders (Sundberg, 2011). This instrument is based on the parent's and the therapist's observations about the child's abilities. Via this instrument, information was obtained regarding the skills that the child had prior to the start of the therapeutic intervention and the impact of ABA therapy on the development of the child's abilities.

The case study is established to be with only one individual/case to assert the research questions. As the sample is entirely intentional, some preliminary criteria have been set regarding its selection. Thus, it was decided that the case studied should meet the following criteria: be a child aged 4-6 years, be diagnosed with challenging adversarial disorder, and pursue therapeutic interventions with a behavioral approach. These established criteria were met by the sample, and this research consists in the observation of the case taken into the study in different environments (family environment, kindergarten, therapy, playground) and the case was enabled by a center for the treatment of children in Tirana, which due to confidentiality, its name and address cannot be revealed. The case under study is a four-and-a-half-year-old boy diagnosed with a challenging adversarial disorder. As a start, the child's parent was contacted, who, through a written request, gave his consent to observe the child in the settings.

Since the child spends most of the time in the family environment and the parents have the most accurate information about him, their reporting is significant. Through this reporting, one can understand how the individual in this study behaves; what family dynamics influence the behavior that he exhibits; what are the actions of family members that tolerate the management of these behaviors; observes how family members react to the child; as well as the impact that this disorder has on the interaction of family members with each other and the various concerns that they may have in their daily lives.

The child educator/therapist's reporting, same as parental reporting, is relevant in obtaining information about the child's behavior with ODD. Accordingly, from the data obtained from these two sources, we can observe how the child behaves in different environments where the parents are not present. This format provides information about how the child reacts to other authoritarian figures and the

activities and relationships that the child has with peers, and his interaction with children of different age groups.

## 3. Case study

D. is a four-and-a-half-year-old boy who lives in Tirana with his family consisting of parents and an older brother. He goes to a private garden. At age 3, an evaluation was conducted by a multidisciplinary team that included a developmental pediatrician, a speech therapist, a clinical psychologist, and a behavioral analyst who have determined the case diagnosis with the oppressive defiant disorder. From this moment, the child has attended ABA therapy, one hour a day for five days a week, for about one year and a half.

He spends a lot of time with grandparents on the mother's side, who are very interested in their nephew. Grandpa and mom are always present at the re-evaluation sessions held at the center every three months. For the most part, regarding the information about D., the grandfather responds more than his mother. It is reported that the child does not live with the grandparents, but they are very active in his life: they take him to the kindergarten in the morning then to the therapy class, and then keep him in their house until the mother arrives from work. It is reported by the head of the center that the father is not so much present in the child's daily activities and that he rarely picks him up from the therapy class. D. has an older brother. It is reported that the child plays a lot with his brother, but this game is more of a punch and violent game, where children pretend to play boxing, karate, etc. At the saying single words some double words in his interest, such as "I want water." The child could say a few words in English, since his grandparents let him watch more English language programs on television.

It is reported that the child is very rebellious; he says "No, I do not want" to everything, even if it is something pleasing to him. D. is a child who always wants his wishes fulfilled and insists on engaging in self-aggressive and "blackmailing" behavior. The mother states that he refuses to carry out the commands given to him, such as eating himself, getting dressed, cleaning, sleeping, etc. That is very difficult to manage. She says that very often she does almost everything for him: she dresses him, feeds him, swings him to sleep, meets all his requirements, etc. otherwise he would scream very loudly in the form of protest, strike himself, scratch his face, pulling out his hair, contracting his whole body so much so that it seems as if he is out of breath. Also, she states that it has been just a little time since the child has started to walk without a stroller. The child does not have any physical problems and can walk very well, but his conflicting behavior made it impossible for them to go anywhere, so they were forced to put him in a wheelchair to continue with

the activities during the day. The same thing happens with his grandparents, who often reprimand him, but do not stick to this decision and meet the demands and whims that the child has, anyway. Regarding autonomy and hygiene, the child has been up to the age of 4 in pampers, and it is very challenging to get him off them. It is reported that the child shows a lot of selectivity regarding the foods he eats; he prefers chocolates to fruits or meat or likes coffee and pizza. In terms of sleep, the child still sleeps with the parents, and the mother mentions that it is difficult to put him to sleep. They have to swing him for a long time, even let him watch TV programs for almost 1 hour before he falls asleep, for this reason, he wakes up late in the morning.

It is reported that the child had a very difficult time establishing a relationship with other children. He started kindergarten at the age of 3.4 years old but found it very difficult to adapt to his peers and new commands and displayed extreme conflicting behaviors, becoming a problem for the whole group. Sometimes D. managed to establish a social relationship, but this was always in his interest and to achieve his goals, such as when he had to leave an unwanted environment, he said "bye" and kissed his hand as a sign of his departure. Currently, he has managed to adapt and play with his peers in the kindergarten, though strong conflicting and challenging behaviors occur, such as shouting by saying "no"; intense crying the moment he is presented with a task; tearing down of kindergarten materials; challenging table strokes, etc. The therapist states that some of the therapy sessions often take place with other children, i.e., in the form of group therapy. D. engages with children of his age but also with those younger than him. He is very eager to stay with them, and he is very funny when it comes to group therapy. The first group comprises of only one boy who is the same age as D. and is named S. This child is vocal and possesses a lot of information. The therapist uses as a kind of support, since D. likes a lot to work and play with him. It is reported that when the child engages in contradictory and challenging behaviors, the therapist 'blackmails' him by saying that if he does not stay calm, he will no longer play with S. after which D. tends to ease his problematic behaviors and continuous normally. During the therapy at the presence of S., D. is very vocal and manages to respond correctly to advanced programs which require the use of longer sentences; he interacts very efficiently with S., acting in turns, conducting the program via questions they ask each other, and sharing his toys with S.

In the second group with several children younger than D., he appears in the role of "the big brother". Thus, he gives them his toys, shows them through gestures how they function, and helps them if they have difficulties; if anyone cries, he tends to hug and tells him/her "do not worry".

From direct observation regarding the family relationship, it was noticed that the grandparents speak to him in a spoiled language; caress him if he lies on the

ground and cries; tell him not to cry so they could give him the cell phone, the chocolate, or any other thing of his preference. Most of the time, D. is picked up from kindergarten by his grandmother and accompanied to the therapy session. She states that on their way (which is not far away), he lies on the ground and says, *'I do not want', 'no', 'I don't like you'*, etc. She carries him inside the therapy environment, while he challenges his grandmother raising his hand ready to hit her, etc. It was once noticed that when his grandfather went to pick him up from the therapy center, the child strongly objected to getting in the wheelchair and, when the grandfather reprimanded and raised his voice, the child started to contract, so he had to hand him the cell phone to calm him down apologizing at the same time for yelling at him.

## 4. Data analysis

According to the DSM-V, the case under study meets the established criteria. For example, when we talk about angry/nervous humor, we can mention many cases in which the child had no reason to be nervous but still reacted that way. Another aspect has to do with argumentative/challenging behavior. It is true that the child does not have a very extended vocabulary, but the way he says 'no' in many different situations, even about those things that may satisfy him, tells us that this criterion is also met. The fact that D. very often loses patience and often appears angry even for no particular reason, or the fact that he is easily touched, as was, e.g., the case when the other child says that he is not behaving well, and D. starts crying that explains the existence of these characteristics.

In terms of defiant behavior, he often 'blackmails' adults with actions that could cause serious harm to the child. He does not mind that his head might hurt, or his face might get scratched, however he is determined to get what he wants and at the moment he wants it and, to that purpose, he is willing to inflict wounds upon himself. If he is asked to get dress, to eat, or sleep, i.e., routine daily activities, he encounters many difficulties in meeting these requirements given to him by adults. Therefore, as his mother says, most of the times everything is prepared for him before hand and not much importance is given to his practical autonomy. D. does not intentionally try to annoy other people but is easily annoyed by them. This happens if he is interrupted in the middle of an activity he enjoys or if, without his knowledge, he has followed the instructions of his therapist and achieved the result she wanted. That was often observed during the therapy sessions. Since the disorder is very challenging, the therapist has to constantly develop new methods to achieve the therapy goals. Several times, she has applied various methods which have seemingly met the child's requests, however, the exact opposite has happened

and, when he has become aware of it, he has reacted by bursting into tears or hitting the table.

It is worth noting the moments of D. taking responsibility for his actions. In many cases he has conducted inappropriate behavior and apologized for it. But it has been noticed was that his apology has always been prompted by the therapist, the teacher, or some other authoritarian person. He apologizes simply to be able to complete the assigned task and will continue to perform the same actions even though he knows it is wrong and may hurt someone else. Even the empathy he might feel when the kindergarten teacher tells him that she is very upset with him does not last long, and he ends up behaving the same way he best knows how to.

It is noticed from the data provided by family members, teachers, therapists, or even the information collected via direct observation of the case, that his challenging and contradictory behaviors have a more frequent and intense manifestation in the family context. In this context, we have a marked lack of genuine and consistent discipline, and we are dealing with negligence in terms of care from one parent, mainly the father. There is also not a very good relationship between his two parents, where the father judges and blames his wife for the various problems of the child. In addition to that, the fact that the child spends most of his time with his grandparents should be considered, which makes his consistent and sustainable parenting even more difficult. The grandparents treat D. same as like treating a 2-year-old, with plenty of pampering and spoiling acts but little education and authority. There is also a lack of consistency in education regarding his grandparents. Thus, his grandmother is very loving and spoils him and has powerful reactions the moment he challenges her by even hurting herself. This is a crucial point since it maintains the problematic behavior that the child causes. Regarding his grandfather, he initially appears strict and very authoritarian, raising his voice or often even losing patience with him. However, he does not stick to the end of this behavior, but often "lets the child win" by apologizing for his conduct or buying things and fulfilling every wish of his in a manner of apology. Regarding the relationship of the child with the father, it is noticed that it is not qualitative. Like other family members, the father initially appears with high demands for the child, but as soon as he realizes that the child is not listening, he leaves or shifts his focus elsewhere. The child has understood this style or way of parenting very clearly and manages to manipulate his family members to get what he wants. This is noticed in the way he often falls when he is in their presence, as they all gather around him, and he is always in the center of their attention.

In terms of social context and interaction with other children, nothing disturbing is noticed. He likes to stay and play with the kids, talk to them about things he or they are interested in. It is true that initially, the child had great difficulty adapting to the kindergarten environment or accepting his peers, but that was because he

was always in the presence of his grandparents and did not have relationships or a qualitative interaction with the other children. However, that has changed since he joined the kindergarten, where he appears more social and interactive with other children.

From the data collected, it was noted that there is a noticeable difference in terms of its information repertoire. He has learned many words, is able to create a structured sentence to describe different situations, stories, or objects, and manages to justify the feelings of different individuals presented in the picture or even in the actual context in which he is located. The child understands accurately the requests made to him and can easily comprehend them. D. can tell in short sentences the activities he has done during the day, what he has played with, or what he has eaten in the kindergarten. The child manages to get your attention in the right way, by saying 'hey look' or by pointing to or about something that has impressed him. He can also show the similar or different characteristics among some objects and can realize advanced programs such as i.e., FFC (Features Function Class), which is organized in the form of riddles (i.e., I am thinking of something that is an animal and has a gray color, and the child manages to ask if the other person is thinking about the elephant and so on).

## 5. Discussion

Analysis and conclusions noticed challenging adverse disorder has a tremendous impact on the daily life of the individual and his functionality. Thus, we can say that the biggest problems that a child with ODD faces are following the rules and accepting the requests made by most adults and authoritarian figures. Children with this disorder refuse to compromise with the commands given to them by most adults, and, precisely for this reason, they manifest various behaviors that affect the well-being of the individual and the family.

The study found that the cause of this disorder is often related to a family in which the rules are unclear, where discipline is unstable, and there is no consistency between what the child is initially required to do and sticking firmly to it until the requirement is met with. In this way, we can also rely on the model proposed by Patterson (1982), according to which the parental behavior model may further deteriorate the negative behaviors the child exhibits. He described it as a "coercive family process." Patterson's such behavioral unstable regarding the way they enforce the rules or commands they give to the child. This is very evident and is supported by the case in study, where parents initially appear very coercive towards the child, urging him to conduct a particular activity, which, however, does not last long, and they give in to the challenging and contradictory behaviors that the child manifests.

What can be noticed from the results derive from this study, as well as other studies conducted in general, is that early diagnosis and the intervention through therapy are of great importance in terms of the progression of this disorder. Accurate diagnosis based on the information coming from different viewpoints is crucial for this disorder. As defined by the DSM-V (APA, 2013), behaviors performed in different surroundings where the child spends his day should be considered for diagnosing the challenging adversarial disorder. Even in this study, this issue must be considered, since it was observed that the child exhibited somewhat different behaviors from one environment to another. Hence, he displayed tough behaviors and reactions when in contact with authoritarian figures, mainly family members, but in the social environment where he was in touch with his peers or children of different age groups, he appeared loving and interested in establishing a relationship. and interaction with other children as well as enjoyed playing with them.

As mentioned in the literature, the therapeutic process has positive effects in improving the symptoms of this disorder. Relying on studies conducted in different countries, such as the study of Reid et al (2004) with 159 families or the study of Laezer (2015), we could say that the therapeutic process is of great importance when it comes to this disorder. Throughout the studies of the above-mentioned authors as well as in the current study, it is observed that through interventions based on the behavioral approach noticeable results may be achieved regarding the reduction of these behaviors and the daily activity of a child with the oppositional defiant disorder.

There is another point that needs to be discussed regarding the future of the child I of this study. He is currently 4.5 years old, and he will soon start first grade. Changing from kindergarten to first grade is very challenging for many children (Farmer & Bierman, 2002). These children who start first-grade are faced with higher expectations in terms of their behavior and the academic criteria. This is especially difficult for children who manifest difficulties regarding their social management abilities as well as sharing attention with other children in the class. Thus, as mentioned above, the child taken in the study will face many difficulties since he was accustomed to a completely different reality where every requirement of his was met and, as the data obtained during his direct observation state, his grandparents have very low expectations of the child which do not coincide with his biological age. Therefore, the beginning of the first grade will mark an increase of requirements relating to the comprehension of new information, social interactions which will not be supervised all the time by an adult, the attention of the authoritative figure (in the case of school, teachers) will not be focused only at D. but will be shared with all children in the class which will make it very difficult for the child to self-control his behaviors. This may lead to an increase

in maladaptive behaviors and can manage the child. Farmer & Bierman (2002) further developed their study by proposing that early interventions, promotion of social skills, and positive behavior should begin in the kindergarten and continue to be further reinforced during the transition period, at the highest academic levels, which is currently being developed with the child under study.

## 6. Conclusions

Based on the various findings that have been ascertained during the analysis of the data collected from the parent-professional-observation triangle and raising the research question about the impact of the oppositional defiant disorder, it can be concluded that this disorder has a significant impact on all surroundings taken into study, i.e., a person with ODD.

Thus, it is noticed how the disorder is affected by family dynamics and how this challenging contradictory disorder affects the daily life of all family members. It is precisely the family system that impresses you most, regarding the case in study, with the father is not so much present in the life of the child, however, the grandparents, on his mother's side, interfere a lot in the education and upbringing of the child. This brings about many problems, since the grandparents' approach in dealing with the child is wrong and not appropriate for his biological age, the child is almost five years old, whereas they treat him as if he is 2 years old. All grandparents spoil their grandchildren, and this is especially noticed in the Albanian culture. However, their type of approach about this disorder simply preserves the contradictory and defiant behaviors of the child and teaches him that via opposing and stubbornness, he can get everything he wants.

What we need to consider is the fact that after a year, the child is presumed to start the first grade. The new environment and different children will bring about a collision between the current reality provided to the child and the reality he will face at school, where other children will not likely tolerate and accept him if he constantly disrupts the lesson, destroys school materials, or interrupts the teacher.

We should also consider the relationship in the couple between the mother and father of the child. Since the father often blames the child's mother about the problems he displays, we can realize that it will also negatively impact the child's education by his mother. She must look after everything that is needed for the child so she can keep up with her daily life or that of the whole family. Therefore, it is understandable that it is difficult for his mother to be consistent in terms of parenting, as there is poor-quality communication between her and her husband, as well as a constant interference from her parents, since they seem to have a more significant influence and authority regarding the child. Since the mother is most of the time at work, she may feel powerless to maintain a strict and unwavering

behavior. She spends only a few hours with her child and considers it best if she met all his requests so the child will not miss her or his father during the day.

It should also be considered how the conflicting defiant disorder affects him. Based on the data analysis, it is noticed that the impact that this disorder has on the family's well-being is evident. According to the child's mother, the problems caused by this disorder in the family are noticeable. Therefore, it becomes very difficult for the parents to continue their daily activities, since the constant disagreeing and challenging behavior of the child make it almost impossible for them to be there on time and spend more time engaging in the child's routine activities, such as clothing, feeding, sleeping, etc. Since the child's behavior is very conflicting, all family members often need to get things done for him, which directly impacts his actions, as it is precisely his intention that others revolve around his routine and not the other way around. Therefore, everything carried out to facilitate the daily life of the family members, brings around a negative impact on the management of the contradictory and challenging behaviors that the child displays. The child has no reason to change his behaviors since everything is provided to him and he needs only manifest a defiant behavior to get exactly everything he wants. Understandably, these behaviors are maintained since family members find it challenging to manage the child's behaviors making their parenting not efficient, which is mainly favored and due to a not stringent and consistent behavior between family members and the child, as well as among family members themselves.

Based on our observation and the data obtained from the parents, we may state that the child's family members never stick to their demands addressed to the child. All the above cases infer that initially, D.'s parents or his grandparents seem very determined and even raise their voices or repeat their request to the child several times, but then they give in, letting the child do what he wants. This is harmful to the child's progress since he is preserving the same behaviors. It is worth noting that during the therapy sessions or while in the kindergarten environment and in interaction with these two authoritarian figures, the situation is quite different. Thus, the teacher and the therapist stand firmly by their decision, and if they ask the child to do something, he will comply even if he may have no desire to do so or objects. This proves that if the child is dealt with an unwavering authority and confident in what he says, the child manages to reduce the intensity of disobedience, control his behavior, and follow the commands or instructions given by these authoritative figures. This means that the child has the ability and capacity to restrain these behaviors and knows how and in which situations he can get what he wants through confronting and defying behaviors and in which situations he must fulfill the requests made by the adults. Therefore, we may conclude that the child's behaviors in the family environment remain unchanged because they are tolerated, and the parents do not follow the daily recommendations given by the therapist.

When it comes to the social environment and how oppositional defiant disorder affects a child's interaction with peers, it is noted that this impact is not negative. The child is inclined to socialize and interact appropriately with others. He is a loving child and approaches other children to play and learn with them. When D. is in contact with other children, he reduces his negative and challenging behaviors to the lowest level, joins the children in the game, share his toys with them, taking on different roles in different situations in which he finds himself. This is very positive, since the behavior that the child displays is somehow intentional, and he can choose where and when to manifest them, and by working in all the environments in which he finds himself, the intensity and frequency of the behaviors displayed may be significantly reduced. It can be said that interaction with other children has a very positive impact on the child. This interaction makes him display those personality qualities that he does not display in environments where various authoritarian figures are present, such as with his parents, family members, or educators. Thus, the child is inclined to establish functional relationships with peers, which is an excellent indicator of his progress when he starts school and changes his environment and daily life.

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