Child Planning: A Treatment Approach for Children with Oppositional Disorder

A Treatment Approach for Children with Oppositional Disorder.

Duration: 3 hours

Learning Objectives:

Obtain a basic understanding of how to identifying, causes, symptoms and learning different options to complete a treatment plan that includes:

a. Behavioral Definitions
b. Long Term Goals
c. Short Term Goals
d. Strategies to Achieve Goals
e. DSM V diagnosis Recommendations

***For a full list of 20 short term goals with dozens strategies listed next to each goal check the Child Treatment App for Windows or Apple PC and Android Devices, under our main menu Windows-Apple Apps. Download the Free Demo to Evaluate***

Course Syllabus:
Introduction

Symptoms

Probable Causes

Diagnosis Criteria

Steps to Develop a Treatment Plan that includes Behavioral Descriptors, Long Term Goals, Short Term Goals, Interventions/Strategies and DSM V CODE Paired with ICD_9 and 10-CM Codes for ODD

Sample Treatment Plan

Introduction:

Even the best-behaved children can be difficult, and challenging at times. Teens are often moody and argumentative. But if your child or teen has a persistent pattern of tantrums, arguing, and angry or disruptive behaviors toward you and other authority figures, he or she may have oppositional defiant disorder (ODD). As many as one in 10 children may have oppositional defiant disorder in a lifetime.

Treatment of oppositional defiant disorder involves therapy and possibly medications to treat related mental health conditions. As a parent, you don't have to go it alone in trying to manage a child with oppositional defiant disorder. Doctors, counselors and child development experts can help you learn specific strategies to address oppositional defiant disorder.

Symptoms of ODD:

It may be tough at times to recognize the difference between a strong-willed or emotional child and one with oppositional defiant disorder. Certainly there's a range between the normal independence-seeking behavior of children and oppositional defiant disorder. It's normal to exhibit oppositional behaviors at certain stages of a child's development.

To diagnose oppositional defiant Disorder ODD, symptoms must be persistent and have lasted at least six months. In additions, these symptoms are clearly disruptive to the family and home or school environment.
Probable Oppositional Defiant Disorder Oppositional Behaviors:

1. Blames others for own mistakes
2. Blames others for own misbehavior
3. Is resentful toward others
4. Is angry toward others
5. Vindictive on those that corrected behavior
6. Poor social functioning
7. Poor academic functioning
8. Argues with adults most of the time
9. Refuses to comply with reasonable requests
10. Refuses to comply with reasonable rules
11. Likes to annoy people
12. Gets easily annoyed by others
13. Behaves negatively
14. Hostile behavior
15. Defiant toward most adults
16. Views parents as an enemy
17. Views teachers as an enemy
18. Views authority figures as an enemy
19. Erupts in temper tantrums (screaming- throwing objects etc)
20. Defiance if confronted with a negative behavior

Causes:

There’s no clear cause underpinning oppositional defiant disorder. (2) Contributing causes may include:
The child's inherent temperament.

The family's response to the child's style.

A genetic component that when coupled with certain environmental conditions - such as lack of supervision, poor quality child care or family instability - increases the risk of ODD.

A biochemical or neurological factor.

The child’s perception that he or she isn't getting enough of the parent's time and attention.

A number of factors play a role in the development of oppositional defiant disorder. ODD is a complex problem involving a variety of influences, circumstances and genetic components. No single factor causes ODD. Possible risk factors include:

Having a parent with a mood or substance abuse disorder.

Being abused or neglected.

Harsh or inconsistent discipline.

Lack of supervision.

Poor relationship with one or both parents.

Family instability such as occurs with divorce, multiple moves, or changing schools or child care providers frequently.

Parents with a history of ADHD, oppositional defiant disorder or conduct problems.

Financial problems in the family.

Exposure to violence.

Substance abuse in the child or adolescent.

**DSM Criteria:**

To meet DSM-IV-TR criteria, certain factors must be taken into account. First, the defiance must interfere with the child’s ability to function in school, home, or the community. Second, the defiance cannot be the result of another disorder, such as the more serious Conduct disorder, depression, anxiety, or a sleep disorder such as DSPS. Third, the child's problem behaviors have been happening for at least six months. The diagnostic criteria for this disorder are as follows:
1. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level:

a. often loses temper.

b. often argues with adults.

c. often actively defies or refuses to comply with adult's requests or rules.

d. often deliberately annoys people.

e. often blames others for his or her mistakes or misbehavior.

f. is often touchy or easily annoyed by others.

g. is often angry and resentful.

h. is often spiteful or vindictive.

2. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

3. The behaviors do not occur exclusively during the course of a Psychotic or Mood disorder.

4. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial personality disorder.

If the child meets at least four of these criteria, and they are interfering with the child's ability to function, then he or she technically meets the definition of Oppositional defiant.

Oppositional defiant disorder often occurs along with other behavioral or mental health problems such as attention-deficit/hyperactivity disorder (ADHD), anxiety or depression. The
symptoms of ODD may be difficult to distinguish from those of other behavioral or mental health problems.

It's important to diagnose and treat any co-occurring illnesses because they can create or worsen irritability and defiance if left untreated. Additionally, it's important to identify and treat any related substance abuse and dependence. Substance abuse and dependence in children or adolescents is often associated with irritability and changes in the child or adolescent usual personality.

Steps to Develop a Treatment Plan:

The foundation of a good treatment plan is based on the gathering of the correct data. This involves following logical steps the built-in each other to help give a correct picture of the problem presented by the client or patient:

The mental health clinician must be able to listen, to understand what are the struggles the client faces. this may include:

- issues with family of origin,
- current stressors,
- present and past emotional status,
- present and past social networks,
- present and past coping skills,
- present and past physical health,
- self-esteem,
- interpersonal conflicts
- financial issues
- cultural issues

There are different sources of data that may be obtained from a:
clinical interview,
Gathering of social history,
physical exam,
psychological testing,
contact with client’s or patient’s significant others at home, school, or work

The integration of all this data is very critical for the clinician’s effect in treatment. It is important to understand the client’s or patient’s present awareness and the basis of the client’s struggle, to assure that the treatment plan reflects the present status and needs of the client or patient.

There five basic steps to follow that help assure the development of an effective treatment plan based on the collection of assessment data.

Step 1, Problem Selection and Definition:

Even though the client may present different issues during the assessment process is up to the clinician to discern the most significant problems on which to focus during treatment. The primary concern or problem will surface and secondary problems will be evident as the treatment process continues. The clinician may must be able to plan accordingly and set some secondary problems aside, as not urgent enough to require treatment at this time. It is important to remember that an effective treatment plan can only deal with one or a few problems at a time. Focusing in too many problems can lead to the lost of direction and focus in the treatment.

It is important to be clear with the client or patient and include the client’s or patient’s own prioritization of the problems presented. The client’s or patient’s cooperation and motivation to participate in the treatment process is critical. Not aligning the client to participate my exclude some of the client’s or patient’s needs needing immediate attention.

Every individual is unique in how he or she presents behaviorally as to how the problem affects their daily functioning. Any problems selected for treatment will require a clear
definition how the problem affects the client or patient.

It is important to identify the symptom patterns as presented by the DSM-5 or Diagnostic and Statistical Manual or the International Classification of Diseases (ICD).

**OPPOSITIONAL BEHAVIORS BEHAVIORAL DESCRIPTORS:**

1. Blames others for own mistakes or misbehavior.
2. Is resentful or angry toward others.
3. Desires to be vindictive on those that called his or her attention.
4. Poor social or academic functioning.
5. Argues with adults most of the time.
6. Refuses to follow or comply with requests and rules, even when reasonable.
7. Likes to annoy people and gets easily annoyed by others.
8. Behaves negatively, hostile manner, and is defiant toward most adults.
9. View parents, teachers, and other authority figures as her or his enemy.
10. Erupts in temper tantrums (screaming, throwing objects, thrashing on ground, or refusing to move) in defiance of if confronted with a negative behavior.

**Step 2, Long Term Goal Development:**

This step requires that the treatment plan includes at least one broad goal that targets the problem and the resolution the problem. These long term goals must be stated in non-measurable terms but instead indicate a desired positive outcome at the end of treatment.

**LONG TERM GOALS FOR OPPOSITIONAL BEHAVIORS:**

1. Reduce frequency of hostile and defiant behaviors toward adults or children.
2. Increase the level of respect and cooperation toward adults.

3. Learn to deal with conflict without relying on anger, hostility, and defiance.

4. Reduced tension, increased satisfaction, and improved communication with family and authority figures.

5. Stop temper tantrums with a respectful compliance to authority figures.

6. Increase interactions with adults in a mutually respectful manner.

7. Increase social behaviors within socially acceptable standards.

Step 3, Objective or Short Term Goal Construction:

Objectives or short term goals must be stated in measurable terms or language. They must clearly specify when the client or patient can achieve the established objectives. The use of subjective or vague objectives or short term goals is not acceptable. Most or all insurance companies or mental health clinics require measurables objectives or short term goals.

It is important to include the patient’s or client’s input to which objectives are most appropriate for the target problems. Short term goals or objectives must be defined as a number of steps that when completed will help achieve the long-term goal previously stated in non measurable terms. There should be at least two or three objectives or short-term goals for each target problem. This helps assure that the treatment plan remains dynamic and adaptable. It is important to include Target dates. A Target day must be listed for each objective or short-term goal.

If needed, new objectives or short-term goals may be added or modified as treatment progresses. Any changes or modifications must include the client’s or patient’s input. When all the necessary steps required to accomplish the short-term goals or objectives are achieved the client or patient should be able to resolve the target problem or problems.

If required all short term goals or objectives can be easily modify to show evidence based treatment objectives. The goal of evidence based treatment objectives (EBT) is to encourage the use of safe and effective treatments likely to achieve results and lessen the use of unproven, potentially unsafe treatments. To use EBT in treatment planning state restate short term goals in a way that steps to complete that goal and achieve results. For example, the short term goal “13. Increase positive self-descriptive statements.” Can be restated as; “By the end of the session the patient or client will list at least 5 positive self descriptions of himself or herself, and assess how they can help alleviate the presenting problem.” Remember, that it must be stated in a way one can measure effectiveness.
It is important to note that traditional therapies usually rely more heavily on the relationship between therapist and patient and less on scientific evidence of proven practices.

**EXAMPLES OF SHORT TERM GOALS FOR OPPOSITIONAL BEHAVIORS:**

1. Help parents develop new management techniques they are willing to try.
2. Show minor that he or she is able to play by the rules in a cooperative manner.
3. Help parents develop acceptable and unacceptable behaviors in the family and identify positive and negative consequences for each behavior.
4. Teach parents how to ignore inappropriate behaviors.
5. Have parents probe past manners of dealing with misbehavior and implement significantly different ways.

Step 4, Strategies or Interventions:

Strategies or interventions are the steps required to help complete the short-term goals and long-term goals. Every short term goal should have at least one strategy. In case, short term goals are not met, new short term goals should be implemented with new strategies or interventions. Interventions should be planned taking into account the client's needs and presenting problem.

**EXAMPLES OF INTERVENTIONS or STRATEGIES TO OBTAIN GOALS FOR OPPOSITIONAL BEHAVIORS:**

1. Teach the parents how to change their predictable response to establish control in positive, controlling, but creative ways.
2. Explore and resolve any parental conflict that underlies the minor's behavior.
3. Help minor gain a new systems perspective in the family unit.
4. Assist the parents in defining acceptable expectations and modes of responses.
5. Define unacceptable behaviors and develop consequences until the behavior is under control.
Step 5, Diagnosis:

The diagnosis is based on the evaluation of the clients present clinical presentation. When completing diagnosis the clinician must take into account and compare cognitive, behavioral, interpersonal, and emotional symptoms as described on the DSM-5 Diagnostic Manual. A diagnosis is required in order to get reimbursement from a third-party provider. Integrating the information presented by the DSM-5 diagnostic manual and the current client’s assessment data will contribute to a more reliable diagnosis. It is important to note that when completing a diagnosis the clinician must have a very clear picture all behavioral indicators as they relate to the DSM-5 diagnostic manual.

DSM V CODE Paired with ICD_9-CM Codes (Parenthesis Represents ICD-10-CM Codes Effective 10-2014):

Possible Diagnostic Suggestions for Children with Oppositional Behaviors:

313.81 (F91.3) Oppositional Defiant Disorder
Specify current severity: Mild, Moderate, Severe

312.34 (F6381) Intermittent Explosive Disorder
Conduct Disorder

Specify whether:
312.81 (F91.1) Childhood-onset type
312.32 (F91.2) Adolescent-onset type
312.89 (F91.9) Unspecified onset

Specify if: With limited prosocial emotions
Specify current severity: Mild, Moderate, Severe
301.7 (F60.2) Antisocial Personality Disorder
312.33 (F63.1) Pyromania
312.32 (F63.3) Kleptomania
312.89 (F91.8) Other Specified Disruptive, Impulse-Control, and Conduct Disorder
312.9 (F91.9) Unspecified Disruptive, Impulse-Control, and Conduct Disorder

Attention-Deficit/Hyperactivity Disorder Specify whether:

314.01 (F90.2) Combined presentation
314.00 (F90.0) Predominantly inattentive presentation
314.01 (F90.1) Predominantly hyperactive/impulsive presentation

Specify if: In partial remission
Specify current severity: Mild, Moderate, Severe

314.01 (F90.8) Other Specified Attention-Deficit/Hyperactivity Disorder
314.01 (F90.9) Unspecified Attention-Deficit/Hyperactivity Disorder

Problems Related to Family Upbringing

V611.20 (Z62.820) Parent-Child Relational Problem
V61.8 (Z62.891) Sibling Relational Problem
V61.8 (Z62.29) Upbringing Away From Parents
V611.29 (Z62.898) Child Affected by Parental Relationship Distress

Other Problems Related to Primary Support Group
V611.03 (Z63.5) Disruption of Family by Separation or Divorce
V61.8 (Z63.8) High Expressed Emotion Level Within Family

Child Maltreatment and Neglect Problems Child Physical Abuse

Child Physical Abuse, Confirmed
995.54 (T74.1 2XA) Initial encounter
995.54 (T74.1 2XD) Subsequent encounter

Child Physical Abuse, Suspected
995.54 (T76.12XA) Initial encounter
995.54 (T76.1 2XD) Subsequent encounter

Child Sexual Abuse
Child Sexual Abuse, Confirmed
995.53 (T74.22XA) Initial encounter
995.53 (T74.22XD) Subsequent encounter

Child Sexual Abuse, Suspected
995.53 (T76.22)(A) Initial encounter
995.53 (T76.22XD) Subsequent encounter

Child Neglect, Suspected
995.52 (T76.02XA) Initial encounter
995.52 (T76.02XD) Subsequent encounter

Child Psychological Abuse
Child Psychological Abuse, Confirmed

995.51 (T74.32XA) Initial encounter

995.51 (T74.32XD) Subsequent encounter

Child Psychological Abuse, Suspected

995.51 (T76.32XA) Initial encounter

995.51 (T76.32XD) Subsequent encounter

Overall Integration of a Treatment Plan:

Choose one presenting problem:

This problem must be identified through the assessment process.

Select at least 1 to 3 behavioral definitions for the presenting problem. If a behavior definition is not listed feel free to define your own behavioral definition.

Select at least one long-term goal for the presenting problem.

Select at least two short-term goals or objectives. Add a Target Date or the number of sessions required to meet this short term goals. If none is listed feel free to include your own.

Based on the short-term goals selected previously choose relevant strategies or interventions related to each short term goal. If no strategy or intervention is listed feel free to include your own.

Review the recommended diagnosis listed. Remember, these are only suggestions. Complete the diagnosis based on the client’s assessment data.

Sample Treatment Plan:
Behavioral Descriptors of Problem:

1. Blames others for own mistakes or misbehavior.
2. Is resentful or angry toward others.
3. Desires to be vindictive on those that called his or her attention.

Long Term Goals:

1. Reduce frequency of hostile and defiant behaviors toward adults or children.
2. Increase the level of respect and cooperation toward adults.

Short Term Goals Objectives:

1. Explore minor’s perception toward rules and authority. Target Date 10-10-17
2. Use play therapy to teach a sense harmony. Target Date: 10-10-17

Strategy or Intervention for Goal 1:

1. Help minor gain a new systems perspective in the family unit.
2. Assist the parents and minor in defining acceptable expectations and modes of responses.

Strategy or Intervention for Goal 2:

1. Using play therapy increase minor’s awareness of consequences and a sense of internal control.
2. In play therapy define unacceptable behaviors and developing consequences until the behavior is under control.
Diagnostic Suggestions:

313.81 (F91.3) Oppositional Defiant Disorder
Severity Moderate

Conduct Disorder
312.81 (F91.1) Childhood-onset type

End of Treatment Plan-Review with Client or Patient-Parents if Appropriate

References:

The Child Psychotherapy Treatment Planner: Includes DSM-5 Updates, 5th Edition
Arthur E. Jongsma Jr., L. Mark Peterson, William P. McInnis, Timothy J. Bruce


