Fostering Appropriate Behavior

Issues, Challenges, and Strategies for Foster Families Raising Children with Oppositional Defiant Disorder

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FOSTERING APPROPRIATE BEHAVIOR: ISSUES, CHALLENGES, AND STRATEGIES FOR FOSTER FAMILIES RAISING CHILDREN WITH OPPOSITIONAL DEFIANT DISORDER

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ABSTRACT

Foster care is a temporary arrangement in which children who are removed from their homes for a variety of reasons live in the homes of family members, group homes, private family homes, or therapeutic environments. Children in foster care have a variety of special needs, whether or not they have a disability. It is the duty of the foster care system and foster parents to meet those needs. Oppositional Defiant Disorder (ODD) is a childhood disruptive behavioral disorder characterized by disobedience, acting-out, and aggression. When a child has ODD, the entire family is affected by the disorder's negative influence on individuals, relationships, and family functioning. These negative influences extend to relationships among family members without ODD. ODD is relatively common in children in foster care with both biological and environmental correlates, yet few foster parents are trained to work with ODD. The interactions of foster families are affected by the behavior of a child with ODD in many of the same ways as those of biological families. Due to the negative impact of the disorder on family functioning, foster families dealing with oppositional and defiant behavior may not be able to meet the needs of their foster children, and thus the potential success of the foster care placement is threatened. Existing interventions, which have been shown to be effective for children with ODD, were not developed for alternative, non-biological, and non-permanent family settings. Interventions must be adapted to the unique situation of foster family care and clinicians, teachers, and foster parents must build collaborative partnerships in order to ensure consistency across environments. This project considers these issues and challenges from several perspectives including psychology, education, and social work and suggests strategies for professionals and families. Foster parent involvement in intervention, open communication, and early social service support for biological and foster families are considered as possible approaches to these adaptations. This project concludes that equal, collaborative partnerships are the vital first steps towards initiating a better future for foster children with ODD.
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Introduction: Issues, Challenges, and Strategies

Imagine you are in third grade. You are always getting in trouble at school. You rarely complete your assignments, you talk back to teachers, you start fights on the playground, and today you have been called to the principal’s office for stealing markers out of another student’s desk. Last year, you were diagnosed with a disruptive behavioral disorder called Oppositional Defiant Disorder, and since then you have been receiving services from a special education teacher, the school psychologist, and the school social worker. However, you have had trouble making progress. You haven’t been living with your parents for the past few years, and you’ve lived in several foster homes. You seem to get in trouble at home a lot as well. Each foster home has different rules, and it’s hard for you to remember to follow all of them. In fact, two foster families decided they could not deal with your behavior, and you were moved. You have only been living with your new foster parents for a few days, and they haven’t met your teachers or service providers. Today, your teachers and the principal decide they need to call in your foster parents, who are also at a loss as to what to do about your behavior.

Unfortunately for many children, situations like this one are not rare. Oppositional Defiant Disorder (ODD) is a disruptive behavioral disorder that is relatively common in children living in foster care. While several interventions have been developed to improve the behavior of children with ODD, they are largely inaccessible to foster families. This project explores the issues and challenges facing foster families raising children with ODD as well as strategies that foster families and professionals may be able to use to increase intervention success for these children. Chapters One through
Four describe the issues and challenges faced by foster families raising children with ODD. Chapter One, “Oppositional Defiant Disorder in Today’s Children,” gives a detailed description of ODD, the issues surrounding it, and the children affected by it. Each case of ODD is unique, and each family impacted by ODD is unique. The individualized nature of the disorder makes causes difficult to determine and symptoms difficult to identify. Children with ODD have a variety of poor prognoses for the future that can be avoided if the disorder is successfully controlled. Thus, early and effective intervention is crucial for the positive development of the child and the family.

Chapter Two, “Interventions for Oppositional Defiant Disorder” provides an overview of several approaches to intervention for ODD. A variety of interventions have been found effective for children with ODD, and several characteristics of successful interventions have been identified. Interventions are best when they are individualized to the needs of the child and the family. However, due to the rigid requirements of the interventions and the wide variety of family needs, some of the most effective interventions are difficult to individualize to non-traditional families. In Chapter Three, “Today’s Children in Foster Care,” the current state of the foster care system and those involved in it is discussed. The chapter gives an overview of the system, children in foster care, and those people who choose to become foster parents. In addition, current issues concerning the system are discussed. The chapter then returns to children with ODD. Children in foster care have a variety of special needs, regardless of whether or not they have a disability. Foster children with disabilities, however, find it difficult to make full use of the available services. The interventions commonly implemented for children with ODD rely on involvement of the family, intervention in multiple systems
(such as home and school), and consistency. The inconsistent structure and non-permanent nature of foster care make these elements difficult to achieve for foster children with ODD.

Chapter Four is titled “The Significance of Home-Based Interventions and Their Implications for Foster Families: A Family Systems Perspective.” This chapter explains the basic concepts of family systems theory and applies them to families with children with ODD and foster families with children with ODD. Family systems theory reveals how the disorder can negatively impact family functioning. Since family functioning and child behavior form a mutually reinforcing relationship, involving the family in intervention is crucial for improving both individual child behavior as well as family functioning as a whole. Family involvement in intervention is especially important for foster families in order to correct problem behavior, which will maximize the effectiveness of the foster placement for both the child and the family. However, as is discussed in earlier chapters, it is difficult to involve foster families in intervention due to short placements and a lack of information and communication.

The conclusion of this project, “Meeting the Needs of Foster Families of Children with Oppositional Defiant Disorder,” discusses possible strategies for these families and the professionals who serve them. Adjustments made to the psychological, educational, and social work approaches to behavioral intervention will increase their success for children with ODD in foster care. Psychological approaches to intervention must be adapted so that long-term results can be achieved in short-term foster placements. Psychologists should also consider the entire family when treating ODD and should work to create partnerships with families and other professionals in order to better serve
children and families. Collaboration between teachers, intervention specialists, school psychologists, school social workers, and foster parents as well as consistency between school and home will be crucial for strengthening the educational approach to intervention for children in foster care. Social workers should work at adapting and individualizing family therapy to foster families and providing foster families and children with appropriate supports for their behavioral and family problems. One way to accomplish this is for social workers to empower foster parents to advocate for themselves by creating equal partnerships with them. It is the role of the social worker to facilitate communication between foster parents, educators, and clinicians and to assume the parenting role on the collaborative team when foster parents are unable or unwilling to participate. When professionals cross the disciplinary boundaries and create collaborative partnerships between themselves, other professionals, and foster families, foster children with ODD will have a much better chance at success.

In sum, Oppositional Defiant Disorder impacts an entire family system through its negative influence on individuals, relationships, and family functioning. ODD is common in children in foster care due to both biological and environmental reasons, but a majority of foster parents don’t have the tools to deal with problem behavior. Existing interventions, which have been shown to be effective for children with ODD, were not developed for alternative, non-biological, and non-permanent family settings. Thus, foster parents must be educated about ODD and its consequences for the child and the family and should be trained and equipped to deal with oppositional-defiant behavior. To this end, interventions must be adapted to the unique situation of foster family care and clinicians, teachers, and foster parents must build collaborative partnerships in order to
ensure consistency across environments. This project considers these issues and challenges from several perspectives and, in suggesting strategies for professionals and families, takes the first step towards those adaptations.
Chapter One:  
Oppositional Defiant Disorder in Today’s Children

A woman is in line at the grocery with her 6-year-old son, Kevin. While they are waiting, Kevin runs his hands over the candy bars and magazines in the checkout aisle, knocking several of them to the floor. Kevin’s mother asks him to pick up what he has dropped, but he refuses. He asks if he can have a candy bar, and when she says “no,” he begins to whine and cry. His mother tells him to stop crying, but he only gets louder. Kevin then runs out of line, knocking people out of the way and begins to tear down the cereal display. When his mother finally gets a hold of him, he spits in her face and pushes her out the way. She threatens to punish him when they get home, and he falls into a full-blown tantrum.

Scenes like this are common. Young children often throw temper tantrums in public places, but general parenting wisdom promises that “it’s just a stage.” While most children do grow out of such inappropriate behavior, some continue to defy authority throughout their childhood and into adolescence. Children whose behavior is so inappropriate and atypical for their age are generally suspected of having a behavioral disorder. One such disorder is known as Oppositional Defiant Disorder, or ODD. Children with ODD behave in ways that antagonize others, especially authority figures. But when do the “terrible twos” turn into something more? When does an annoying child become classified as “disordered” and referred for professional intervention? Answers to these questions vary with the lens or perspective through which one attempts to view them. Psychologists, health professionals, parents, educators, and social workers approach these questions differently based on the assumptions of the perspective. This chapter explores the variety of approaches to such questions about ODD, including the diagnosis of ODD and a profile of children with ODD in today’s society.
Diagnosing Oppositional Defiant Disorder

When discussing ODD it is important to establish a definition of the disorder. Defining disordered behavior involves comparing “normal” and “abnormal” behavior and distinguishing between the two. Clinicians who diagnose ODD in children must decide if an individual’s behavior classifies as “abnormal” enough to warrant a diagnosis. However, this isn’t always the easiest decision to make. Of course, at the behavioral extremes, it is easier to distinguish between typical and disordered behavior. However, in the middle of the spectrum of behavior, the distinction is not so clear. Parents, teachers, peers, and others may have difficulty determining if a child’s behavior is part of a normal developmental pattern or should be considered disturbing enough to cause concern (Frick, 1998). To deal with this distinction, psychologists have developed systems for classifying ODD and other psychological disorders. However, there are many problems with the classification system and there is even debate over whether psychological disorders should be diagnosed at all.

Should Psychological Disorders be Diagnosed?

Mental health is a central issue in today’s society. It is currently estimated that 46% of the population will suffer from at least one mental disorder (Butcher et al., 2007). Despite the prominent presence of mental illness, there was no consistent system for classifying disorders until relatively recently. Communication between researchers, patients, clinicians, and other health professionals was extremely complicated. However, with the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM, 3rd edition) in 1980, an organized method of assessment and communication
arose. Krueger and Piasecki (2002) assert that “through their influence on our field, the recent DSMs have brought order to chaos in the description of psychopathology” (p. 486). The ability to classify and diagnose mental disorders has not only brought organization to the fields of clinical psychology, social work, and even education, it has also enhanced research and treatment. With all of its advantages, however, psychological diagnosis has drawbacks. The diagnostic system itself leaves room for error in application, and the act of labeling individuals as “disordered” causes stereotyping and stigmatization.

**Advantages.** The diagnostic system has been and continues to be beneficial to psychological research as well as to individuals for clinical use. The DSM allows mental health professionals to classify disorders in an organized manner. When information is organized, it is easier to study the different disorders and learn more about their causes and potential treatments (Butcher et al., 2007). Classification is important because it gives researchers common terms and goals. Communication between researchers is essential for the proper study of causes and treatments, and consistency is crucial for communication. The classification system is also central to the definition of what is considered “abnormal.” As disorders are classified in the DSM, they are defined so that professionals may recognize and diagnose them (Butcher et al., 2007). Without a line between what is considered normal and what is pathological, diagnoses would be vague. That line not only separates the normal from the abnormal, but also allows for comparison between pre-treatment and post-treatment. A definition of disorder is important because it innately provides a definition of health. Another general advantage of the diagnostic system is that it is practical for issues such as insurance (Butcher et al.,
Insurance companies require a formal diagnosis before reimbursing the cost of treatment, and only a consistent and organized classification system can provide such a diagnosis.

A more specific benefit of the DSM is its clinical utility, or its usefulness in clinical decision-making. Individuals in the field of mental health make much use of the diagnostic system, and the DSM is designed especially for this purpose. Clinicians use the DSM in order to make a variety of decisions. For example, a clinician will use a DSM diagnosis to plan a course of intervention for a client including the method, setting, and duration of the treatment (First et al., 2004). Without a classification system involving specific diagnoses, clinicians would not be able to make informed decisions and would not be able to help their clients as effectively.

Clients themselves also benefit from psychological diagnosis. The first step toward recovery is for patients to know what they are dealing with. Experiencing unknown discomfort, especially psychological discomfort, can be very frustrating and frightening. A diagnosis can help alleviate some of this tension. In fact, patients who receive clinical feedback including a diagnosis improve just from having more information (Butcher et al., 2007). A diagnosis is also important for those suffering from mental disorders because it may inform future behavior. Once individuals have some perspective on their disorders, they can seek appropriate treatment, explain their situation to others, and learn to avoid potential triggers (First et al., 2004). In these ways, the label assigned by diagnosis is critical in one’s journey toward positive mental health.

Revisions were made to the DSM to increase its clinical utility in the fourth edition. For example, diagnostic criteria were simplified, subtypes of disorders were described, and
the clinical significance criterion (the requirement that symptoms must significantly distress or impair the patient) was added (First et al., 2004; Spitzer and Wakefield, 1999).

The general benefits to the field of mental health and specifics of clinical utility are important advantages of diagnosing psychological disorders.

**Disadvantages.** For all its advantages, however, the current diagnostic system is costly in several ways. The system itself is flawed and can sometimes be unreliable, and there are several negative clinical and social consequences of assigning a diagnostic label to an individual. Flaws in the general system, and the DSM in particular, can result in incorrect diagnoses. Efforts to increase the clinical utility of the DSM have led to an increase in false positives, or a diagnosis of a disorder in an individual who does not actually have the disorder, according to Spitzer and Wakefield (1999). They studied the effect of the clinical significance criterion in reducing the number of false positives, and found that it does. However, they found that its efficacy is dependent on human interpretation. Also, they found that while the definition of mental disorder involves psychological impairment, the criterion demands social impairment. This discrepancy can lead to false negatives, or an absence of a diagnosis where there should be one. For example, a person experiencing an irrational fear of snakes may be clearly psychologically distressed by the fear, but if his social interactions are normal, he may not receive a diagnosis.

Another cause of misdiagnosis is the arbitrary nature of the number of criteria needed for diagnosis. For example, for individuals to be diagnosed with a major depressive episode, they must display at least five of nine symptoms. While this number is based in research, a person exhibiting four symptoms may be experiencing an episode,
while a person who has five may not. This is another area in which diagnosis is often
dependent on interpretation and can therefore be incorrect. In addition, the diagnostic
system does not account for clinical realities such as comorbidity, or the occurrence of
more than one disorder in a single individual (Krueger and Piasecki, 2002). Such a
flawed diagnostic system is worrisome because an incorrect diagnosis can lead to
inappropriate treatment and poor outcomes for the patient (First et al., 2004). However,
patients can suffer consequences of a diagnosis, even when it is correct.

Classification of psychopathology serves to simplify problems so that they can be
better understood. However, simplification of the situation can often lead to
simplification of the patient. Personal details about the person with the disorder, such as
hobbies or past experiences, are lost as a result of such simplification (Butcher et al.,
2007). One consequence of this simplification is the diagnostic label assigned to the
patient. While labels can be helpful in the ways described above, they can also be
problematic and at times devastating. Krueger and Piasecki (2002) write that “the use of
categorical DSM diagnostic labels fosters the belief that disorders are ‘in the person’
rather than functional problems” (p. 495). As a result, others may make stereotypical and
stigmatizing assumptions about people with mental diagnoses. Link et al. (1999) studied
the social effects of diagnostic labels by describing individuals to participants. The
participants were quick to label the individuals as mentally ill, especially when they were
given the option of assigning a specific diagnosis. Moreover, participants admitted to
wanting to avoid social contact with individuals whom they had determined to be
mentally ill. This study reveals that a diagnostic label often creates a stereotype of
dangerousness and a desire in others for social distance. This can be detrimental to the
well-being of an individual who may already feel isolated from society by illness. The effects of the label are long lasting, often persisting through treatment and recovery (Butcher et al., 2007). Thus, flaws in the system and the negative social effects of labeling are disadvantages of the diagnostic system.

Suggestions for Change. The current system of classification is problematic. However, since research, diagnosis, and treatment are nearly impossible without classification, the system cannot be dropped altogether. There are several areas in which the system could be improved to increase clinical utility and validity, including the specification of diagnostic criteria, and making the criteria sets easier to apply (First et al., 2004). These goals could be achieved by including descriptions of typical and atypical cases of each disorder so professionals could compare their clients with more specific examples. The social consequences of diagnostic labels may also be reduced. Butcher et al. (2007) suggests the use of person-first language in society. This type of language recognizes a person with a disorder, rather than a disordered person, and reflects a society that is more accepting of difference. With changes such as these, the classification system could be improved to benefit professionals and clients alike.

Classifications of Oppositional Defiant Disorder

DSM-IV-TR. There are three main methods for assessing ODD in children and adolescents. The first is the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR, American Psychological Association, 2000), which takes the psychological perspective on diagnosis. DSM-IV-TR defines ODD as “a pattern of negativistic, hostile, and defiant behavior.” This pattern must last at least six
months to warrant a diagnosis, and must include at least four of eight listed behaviors: losing temper, arguing with adults, actively defying or refusing to comply with adults’ requests or rules, deliberately annoying others, blaming others for mistakes or misbehavior, touchy or easily annoyed, angry or resentful, spiteful or vindictive. DSM-IV-TR also specifies that each of those behaviors must occur more frequently than they would in a typically developing child of the same age, and that “the disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.” The problem behavior cannot be identified as being a result of ODD if it occurs only during the course of a psychotic or mood disorder. DSM-IV-TR also distinguishes ODD from Conduct Disorder (CD) and antisocial personality disorder (APD), and notes that if the criteria are met for either of these, the child or adolescent cannot be considered for ODD diagnosis.

**ICD-10.** The second method for diagnosis takes a medical health perspective: the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10, World Health Organization, 1992). In contrast to DSM-IV-TR, which distinguishes ODD from CD, ICD-10 refers to ODD as a type of Conduct Disorder that afflicts children at a younger age than the typical age of onset of Conduct Disorder. It defines ODD by “the presence of markedly defiant, disobedient, provocative behavior and by the absence of more severe dissocial or aggressive acts that violate the law or the rights of others.” Rather than listing characteristics of ODD, ICD-10 provides a description of the typical child with ODD:

> Children with this disorder tend frequently and actively to defy adult requests or rules and deliberately to annoy other people. Usually they tend to be angry, resentful, and easily annoyed by other people whom they blame for their own mistakes or difficulties. They generally have a low
frustration tolerance and readily lose their temper. Typically, their defiance has a provocatively quality, so that they initiate confrontations and generally exhibit excessive levels of rudeness, uncooperativeness, and resistance to authority.

It is also noted in ICD-10 that these characteristics must be markedly more disruptive than for the typically developing child in the same social context and that the diagnosis does not include children who are merely mischievous or naughty. ICD-10 also acknowledges that ODD might be evident in a clinical interview because it typically manifests in interactions with peers or familiar adults.

In addition to the formatting of the diagnosis, ICD-10 and DSM-IV-TR have one essential difference: the manner in which they treat the relationship between ODD and CD. While their lists of criteria are similar for both conditions, DSM-IV-TR considers the disorders separately while ICD-10 joins the two. This can lead to a difference in identification by the two methods. Some children diagnosed with ODD subtype of CD under ICD-10 remain completely undiagnosed under DSM-IV-TR (Rowe et al., 2005). This is problematic because the behavior of these children may be severely disordered, but they are excluded from diagnosis according to DSM-IV-TR, meaning that they would not receive the benefits of diagnosis discussed above including appropriate treatment.

**IDEA.** The last method of diagnosing ODD is through educational assessment. The Individuals with Disabilities Education Improvement Act (IDEA, 2004) mandates the diagnosis of a disorder that must apply for a child to receive educational services in the form of special education. In order to receive mental health services, a child must have a psychological or medical diagnosis based on the criteria from DSM-IV or ICD-10, but to receive educational services, that same child must also qualify under the criteria for IDEA. IDEA classifies ODD under the category of “severe emotional disturbance,”
which is marked by one or more of five characteristics: an inability to learn that isn’t explained by intellectual, sensory, or health factors; an inability to build or maintain interpersonal relationships with peers and teachers; inappropriate behavior or feelings in normal situations; a general mood of unhappiness or depression; and a tendency to develop physical symptoms or fears associated with personal or school problems. The characteristics must persist over a long period of time (although it is not specified how long) and must adversely affect a child’s educational performance. IDEA does specify that children who are deemed “socially maladjusted” do not qualify for services under this category, unless they have a separate emotional disturbance. As a result, children who are identified with ODD under DSM-IV-TR or ICD-10 may not be identified for services under IDEA unless they present one or more of the characteristics listed above.

Educational assessment is particularly difficult due to its subjective nature. There are several assessment techniques including behavior rating scales, structured diagnostic interviews, behavioral observations, and unstructured clinical interviews (Frick, 1998), some of which may be more objective, but all of which have elements of subjectivity. It is important to involve several different people in the assessment process, including the child, family, teachers, and anyone else who comes in contact with the child on a regular basis to ensure that as much information as possible is included in the assessment (Horne and Sayger, 1990). It can be especially difficult for parents to decide when it is time to have their child assessed.

Not all parents are able to clearly define their children as having behavioral problems because many do not define fighting, disobeying, or poor school habits as problems; rather these are seen as normal conditions of children from their familial or socioeconomic background. The teachers of their children, however, are usually quite capable of identifying the disruptive behavior. Teachers have a large sample of
students to observe annually and, from this group, recognize the range of problem behaviors. It is often behavioral problem children who receive special attention from teachers. Teachers are also the people most likely to point out to parents that their children demonstrate behavioral disorders and suggest referrals to professional services. (Horne and Sayger, 1990 p. 3)

Thus, educational assessment can be an important starting point for health or mental health diagnoses, because teachers may alert parents to a problem they hadn’t considered to be significant. In this way, an educational assessment can lead to a DSM or ICD diagnosis, which can, in turn lead to more educational assessment for services. While each of these diagnoses is independent, a child who qualifies under multiple methods will clearly receive the most services.

**What Causes Oppositional Defiant Disorder?**

There is not one known cause of ODD in children and adolescents. In fact, ODD is a result of several interrelated factors, both biological and environmental.

**Biological Factors.** There are two categories of biological causes of ODD: those that are genetically inherited and those that are not genetically inherited. Genetic causes of ODD are also common factors in the development of other behavior problems such as simple difficult behavior and Conduct Disorder. Intelligence factors contribute to behavior problems in that low intelligence is associated with a risk for developing ODD and other behavior problems (Frick, 1998). Alvarez and Ollendick (2003) also list an intellectual deficit as a risk factor for ODD and add that a difficult temperament, which they define as the inherited aspect of personality, is an important factor in the development of disordered behavior.
There are also biological factors that are not inherited that can put a child at risk for developing ODD. Sex is an important predictor of the development of behavior problems, with boys being at higher risk than girls. Also, the prenatal environment is significant as maternal smoking during pregnancy increases the risk that the child will develop behavioral disorders such as ODD (Slutske et al., 2003). Individual neuropsychological and neuroendocrine differences can also be causal factors of ODD, according to Pihl et al. (2003). They claim that the way the brain processes rewards and punishments, as well as levels of satiation, can influence whether or not children have behavior problems.

**Environmental Factors.** Like biological causes, there are two categories of environmental causes of ODD. The first consists of the environmental causes with which the child interacts directly. Some of the most influential environmental factors include stressful living conditions such as family dysfunction or violence (Turnbull et al., 2004). Family interactions can also put a child at risk for developing ODD. For example, O’Reilly (2005) describes a type of reciprocally reinforcing interaction between parent and child that can produce a coercive relationship in which a controller and controllee behave in ways that are mutually reinforcing. In families with children with ODD, the parents may feed into the misbehavior and unknowingly hand control over to their child. Certain school factors such as lack of teacher and administrative support can encourage the development of disruptive and disordered behavior as well (Turnbull et al., 2004).

Another important risk factor for behavioral problems that affects the child directly is peer rejection. Children who are rejected by their peers, as well as children who become
affiliated with deviant peer groups are at possible risk for developing ODD and other behavioral disorders (Alvarez and Ollendick, 2003).

Factors in the environment can influence the development of ODD even when the child doesn’t interact directly with them, however. Such environmental stressors can be as close to the child as socioeconomic status, poverty, and living in high crime neighborhoods, but can also be as removed as the focus on violence in today’s society (Frick, 1998). These indirect influences on problem behavior impact a child through direct influence on other factors that do interact with the child (Gorman-Smith, 2003). For instance, urban neighborhoods and socioeconomic status influence communities, schools, families, and peer groups and put children at risk for developing ODD.

**Interactions Between Factors.** It is important to note that any number of these risk factors can be present in a child’s life without the child developing ODD or any other behavioral disorder. Biological and environmental risk factors interact with each other in different ways for every child. For example, children with more genetic predispositions for ODD may be more susceptible to the influence of a deviant peer group. Environmental factors can also influence the presence of biological factors. For instance, socioeconomic status can influence the prenatal environment through maternal nutrition and access to prenatal care. The main reason an understanding of the causes of ODD is important is so at-risk populations and individuals can be identified and provided with early intervention.
Children Who Have Been Diagnosed with Oppositional Defiant Disorder

As mentioned earlier, one advantage of diagnosing psychological disorders is that a classification system provides information about the specific disorders. The diagnostic label “ODD” helps psychologists, educators, social workers, and parents collect information about children who experience this type of behavior problem. This section describes such information including the prevalence and comorbidity with other disorders, the symptoms of ODD, and what the future holds for children with ODD.

Prevalence and Comorbidity

It is difficult to find the exact prevalence rate for ODD since so many cases go undiagnosed or are masked by other emotional or behavioral disorders. It is estimated that between six and sixteen percent of U.S. boys and between two and nine percent of U.S. girls have acting-out behavior problems. What’s more, nearly seventy percent of adolescents engage in some sort of delinquent behavior (Nelson et al., 2006). But how many of these children actually meet the diagnostic criteria for ODD? According to Markward and Bride (2001), ODD is prevalent in two to sixteen percent of children and is usually diagnosed before the child is eight years old, which distinguishes it from Conduct Disorder, which is usually diagnosed after age eight. Boys generally have more behavioral problems that girls and are in fact three times more likely to be diagnosed with ODD (Lumley et al., 2002; Markward and Bride, 2001). This difference is deceiving, however, as it indicates that more boys actually have ODD, which may not be the case. Boys may be diagnosed with ODD more often because of diagnostic or referral bias. For
example, teachers may be less patient with boys than with girls and may be more likely to refer them for evaluation.

Comorbidity is an important issue for children with ODD as comorbid disorders can mask behavior problems as well as guide the course of intervention. Twenty-seven percent of children with ODD are also diagnosed with attention deficit hyperactivity disorder (ADHD), and twenty-seven percent of children with ODD also have a mood disorder. ODD is also comorbid to significant degrees with anxiety disorders and substance use (Essau, 2003). It is important for parents and educators to be aware of the common disorders that occur in partnership with ODD because a child’s problem behavior may be influenced by other psychological issues. It is also important that children receive services for all of their problems, and so interventions must be individualized for children with more than one disorder. Certain interventions (see Chapter Two) are designed with comorbidity in mind, while others may not be appropriate for children with multiple disorders.

**Symptoms: What Does Oppositional Defiant Disorder Look Like?**

According to IDEA (2004), children with a severe emotional disturbance exhibit two types of behaviors: internalizing and externalizing. Internalizing behaviors include disordered eating, self-injury, and depressive behaviors while externalizing behaviors include being disruptive, delinquent, and harmful to others. Children with ODD generally exhibit externalizing behaviors, which is what makes their behavior so noticeable and frustrating for parents, teachers, and peers. The basic features of ODD include a “recurrent pattern of negativistic, defiant, disobedient, and hostile behavior
toward authority figures, which leads to impairment” (Burke et al., 2003, p. 62).

Behavioral problems associated with ODD, CD, aggression, and delinquency involve a failure of the child to behave in a way that is expected by authority figures, in line with societal norms, or respectful of other people. These types of behaviors can range from oppositionality and noncompliance to violations of societal norms to violations of the rights of others (Frick, 1998). Children with ODD generally have conflicts with authority figures due to their defiant, noncompliant behavior, but do not behave in ways that inflict serious physical or emotional harm on others.

Children with ODD exhibit problem behavior that disrupts other people and environments. Children with ODD typically lose their temper, argue with adults, actively defy or refuse to comply with adults’ requests or rules, deliberately annoy people, blame others for their mistakes or misbehavior, are touchy or easily annoyed by others, are angry or resentful, and are spiteful or vindictive (Markward and Bride, 2001). They may also have severe temper tantrums because of a low tolerance for frustration and may talk back and behave in a passive-aggressive manner. The course of ODD can vary in severity, and the presence of aggression in kids with ODD signifies a more severe course of the disorder (Burke et al., 2003). In addition, children who have another disorder such as an anxiety disorder or ADHD will have concurrent symptoms of both disorders. Further, the symptoms of ODD, especially when accompanied by another psychological disorder can lead to higher-than-average rates of family and social dysfunction (Greene et al., 2002). Chapter Four describes the impact that these symptoms have on family and social functioning.
Moving Forward: The Future for Children with Oppositional Defiant Disorder

Since children are generally diagnosed with ODD before the age of eight, they have a very long future of uncertainty that is, of course, a major concern to their parents, clinicians, educators, and, eventually the children themselves. While not all children with behavior problems have negative outcomes, it is very common for ODD to be only the beginning of a psychological struggle. In fact, about eighty percent of children with acting-out behavior problems develop a psychiatric disorder in the future (Nelson et al., 2006). The most common disorder that children with ODD eventually develop is Conduct Disorder (CD). While not all children with ODD go on to develop CD, nearly all adolescents with CD had at one point been diagnosed with ODD. Onset of CD is four times higher in children with ODD than in children without a history of ODD (Burke et al., 2003). This has led researchers to question whether ODD is a reliable predictor, or even a cause, of CD. “About 90% of the clinically referred children diagnosed with CD also meet the criteria for ODD…Among those with both disorders, ODD generally occurs before CD. Studies have also reported that a subset of children with ODD generally advance to CD. These findings have led to the postulation…that ODD is a precursor of CD” (Essau, 2003, p.48). It is significant to understand the relationship between ODD and CD because CD is itself associated with negative outcomes.

Individuals with CD do behave in ways that infringe on the rights of others and often cause harm. Such behaviors include delinquency and criminal activity (Frick, 1998). In addition, CD can cause problems in every aspect of an individual’s life. Eighty percent of boys with early-onset CD go on to have problems of social dysfunction such as disrupted friendships, problems with intimate relationships, and vocational problems
(Nelson et al., 2006). In addition, CD has the possibility of developing into Antisocial Personality Disorder, which can affect individuals into adulthood (Burke et al., 2003). Of course not all children with CD develop such negative problems. There are certain qualities of the individual and the course of the disorder that can predict future problems with behavior and psychopathology including early onset of severe conduct problems, high numbers and great variety of conduct problems, aggressive conduct problems, presence of ADHD, low intelligence, a parental history of chronic antisocial behavior or criminality, dysfunctional family environments, and economic disadvantage (Frick, 1998).

It is important to note that although future behavioral and psychological problems are common for children with ODD, that is not always the case. Children with ODD can learn to control their behavior and lead normal lives. This demonstrates the importance of appropriate and effective intervention for children with ODD. For example, intervention with oppositional-defiant children in kindergarten or first grade can help prevent the development of more serious behavioral and social problems (Markward and Bride, 2001). The next chapter discusses a variety of interventions most commonly implemented for children with ODD.
Chapter Two: 
Interventions for Oppositional Defiant Disorder

Effective and appropriate intervention is essential for children with ODD if they hope to overcome their behavioral difficulties and participate fully in their families, communities, and society. However, at best, only ten to thirty percent of children with behavior problems receive appropriate mental health services (Markward and Bride, 2001). This can be due to several reasons including misdiagnosis and inappropriate treatment implementation. There are many classes of intervention for behavioral disorders including ODD, and each has its own advantages and disadvantages. The most important element of an intervention is its potential for individualization. Every child is different, and therefore every case of ODD is different and in need of individual attention. That said, there are certain characteristics, according to Horne and Sayger (1990), that promote a more effective intervention:

1. Assessment that defines the problem and establishes goals for treatment
2. Involvement of the multiple systems involved
3. Use of effective intervention skills including changing the environment and positive expectations
4. Processes for developing self-control for the whole family
5. Processes for defining disciplinary approaches that lead to positive changes for all involved
6. Processes for enhancing prosocial behaviors
7. Programs for intervening in other systems
8. Processes for developing maintenance skills (p. 41)

Each of these characteristics involves considering the individual and unique nature of each case of ODD. It is also important to note that an effective intervention plan will not only implement change, but will also encourage the maintenance of positive
behavioral change. Another significant element of many interventions is the focus on the family. As is discussed in the previous chapter, family dysfunction can encourage defiant behavior in children. In addition, as is discussed in Chapter Four, families and family members are often affected by a child’s disordered behavior. Thus it is essential to involve parents, siblings, and other family members in the process of intervention and expect positive changes for them as well. The following sections describe several interventions that have been effective for children with ODD and their families.

**Behavioral Approaches to Intervention**

Behavioral approaches to intervention for ODD are focused on changing behavior and are based on the principles of operant conditioning. In operant conditioning, the learner learns to associate particular behaviors with their consequences, and as a result will either repeat the behavior (reinforcement) or not repeat the behavior (Alberto and Troutman, 2006). Methods of intervention based on behaviorism include Applied Behavior Analysis (ABA), Positive Behavior Support, and contingency management.

**Applied Behavior Analysis**

ABA, as described by Alberto and Troutman (2006), is a behavioral intervention based on operant conditioning, modeling, and shaping. Both modeling and shaping are used to bring about a desired change in behavior. Modeling is the demonstration of behavior while shaping uses reinforcements of successive approximations to the desired behavior. Appropriate behavior is modeled and children are rewarded each time their behavior gets closer to the goal. The reinforcement system used in ABA is operant
conditioning. After each desired or undesired behavior, a stimulus (pleasant or unpleasant) is either added or removed, which either encourages or discourages repetition of the behavior. ABA expands on operant conditioning in its use of punishment to discourage behavior. Examples are given in the following table:

<table>
<thead>
<tr>
<th>Behavior Encouraged</th>
<th>Stimulus Added</th>
<th>Stimulus Removed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive Reinforcement (e.g. verbal praise, physical attention, prizes)</td>
<td>Negative Reinforcement (e.g. removing chores/curfew for good behavior)</td>
</tr>
<tr>
<td>Behavior Discouraged</td>
<td>Positive Punishment (e.g. spanking)</td>
<td>Negative Punishment (e.g. time out)</td>
</tr>
</tbody>
</table>

Before ABA intervention can begin, the undesirable behavior must be identified and a behavioral objective must be prepared that describes the desired result of intervention. The behavioral objective must be specific and clearly stated so that everyone involved can understand. Next, the person performing the intervention (usually a clinician or educator) collects baseline data about either the presence of undesired behavior or the absence of desired behavior. That person also conducts a functional behavior assessment and analysis through observations and interviews (with the child, parents, teachers, and others) to determine the function of the inappropriate behavior. An intervention plan is then constructed based on the hypothesized function of behavior and a review of relevant literature. The goal of intervention is to replace inappropriate behavior with appropriate behavior that fulfills the same function. The plan is based on the concepts of modeling, shaping, and operant conditioning. During the intervention period, data are collected and compared to the baseline data. If the intervention is effective compared to baseline, attentions shift toward generalizing and maintaining the behavioral change. If the intervention is not effective, another functional behavior
assessment is conducted and the person implementing the intervention makes another hypothesis as to the function of the inappropriate behavior. The intervention is then altered and attempted again.

**Positive Behavioral Support with Families**

According to Lucyshyn et al. (2002), Positive Behavioral Support with families is child- and family-centered. It is “a collaborative, assessment-based approach to developing effective, individualized interventions for people with problem behavior. Behavior support plans emphasize the use of proactive, educative, and reinforcement-based strategies to achieve meaningful and durable behavior and lifestyle outcomes” (p. 7). Positive Behavioral Support (PBS) is founded in ABA and applies family theories to the processes of ABA. Thus, PBS makes use of assessment to make hypotheses about the function of inappropriate behavior and operant procedures to go about changing behaviors. The inclusion of family theories helps to involve the family in the process of intervention and is based on the assumption that family functioning plays a role in child behavior.

There are twelve key features of PBS with families, according to Lucyshyn et al. (2002). Clinicians or educators implementing PBS with families should:

1. **Build collaborative partnerships with families and others who serve the child**
2. **Adhere to family-centered principles and practices**
3. **Help families identify and achieve meaningful lifestyle outcomes for child and family**
4. **Recognize that problem behaviors are primarily problems of learning**
5. **Understand that communication is the foundation of positive behavior**
6. **Conduct functional assessments to understand the functions of the problem behavior and the variables that influence behavior**
7. Develop individualized, multi-component support plans to make problem behaviors irrelevant, ineffective, and inefficient
8. Ensure that PBS plans are a good contextual fit with family life
9. Utilize family activities for analysis and intervention so families can include interventions in their everyday lives
10. Provide implementation support that is individual for each family’s needs
11. Engage in a process of continuous evaluation of outcomes for child and family
12. Offer support to families and others sincerely (p. 13).

Each of these guidelines reveals that individuals who implement PBS with families consider both the theoretical basis of PBS and the individual practical concerns that arise when dealing with unique families. PBS acknowledges that it is important for intervention plans to fit well with each individual family so that families can integrate the plans into their everyday lives. The goals of PBS are improvement in the child’s behavior and lifestyle and the quality of family life, a decrease in problem behavior and an increase in health and safety of the family, and improvement in functional skills, stress reduction, advocacy skills and family happiness.

**Contingency Management**

The goal of contingency management is simply to increase positive behaviors and decrease negative behaviors (Frick, 1998). Contingency management is based on the assumption that behavior problems arise, in part, because of the child’s inability to modulate his own behavior. Operant procedures are implemented to help the child learn what is appropriate and how to control his own behavior. There are several advantages of contingency management. First of all, it is not necessary that it be implemented by a psychologist or social worker. In fact, nearly anyone can implement a contingency
management plan, including teachers, parents, and even peers, as long as they know how to deliver reinforcement for desired behavior and minimal punishment for undesired behavior. This allows a degree of flexibility not provided by other behavioral interventions. Since almost anyone who interacts with the child can implement the intervention, intervention can take place almost anywhere. This makes generalization, or the ability of children to improve their behavior in a variety of settings, less of a problem than it is when the intervention takes place only in an office, at school, or at home. However, Frick (1998) also acknowledges the limitations of contingency management. The plans are more complex than they seem at first and can be difficult to implement correctly. They also require planning, monitoring, and consistency, which actually limit their flexibility.

**Parent Training Interventions**

These interventions focus not on the child, but rather on teaching the child’s parents how to deal effectively with problem behavior. Parent training teaches parents how to fix current maladaptive behaviors and prevent future behavior problems. In addition, parents are encouraged to alter their own behavior towards their children to create positive parent-child interactions, which strengthens prosocial behavior.

According to Horne and Sayger (1990), there are three stages to parent training. During the first stage, parents learn the concepts of behavioral theory, as described above. In the second stage, parents learn to define deviant behavior and monitor and record its occurrence. Finally, parents learn to target one or two of the child’s problematic behaviors and modify them. After these stages have been completed and the parents have
successfully improved their child’s behavior, further training can help parents address other specific concerns. Limitations of parent training include problems with generalization and maintenance and getting family members fully committed to and involved in the process of intervention. Similar interventions include teacher training and child training, which help to increase and generalize the positive outcomes of parent training (Webster-Stratton et al., 2004). The following sections describe two types of parent training: Parent Management Training (Frick, 1998) and Helping the Noncompliant Child (McMahon and Forehand, 2003).

**Parent Management Training (PMT)**

Parent Management Training (PMT) teaches parents how to develop and implement structured contingency management programs in their homes (Frick, 1998). Parents are trained to teach their children to modulate their own behavior through the use of consistent consequences to both positive and negative behavior patterns (operant procedures). As a part of the training program, parents learn how to successfully use both positive reinforcement strategies to encourage good behavior and negative consequence discipline (also referred to as punishment) to discourage poor behavior. PMT has been shown to be successful because parents are actively involved in their child’s behavioral intervention and contingency management can be used to target maladaptive family processes that encourage problem behavior. There are several limitations of PTM, however. PTM has been found to be less effective for older children and children with more severe conduct problems. It is also not an option when the child is not living with his parents or when the family is so dysfunctional that the parents are
not willing or able to participate. PTM also neglects to address influences other than the family on problem behavior, such as the child’s peers and school.

**Helping the Noncompliant Child**

Helping the Noncompliant Child (HNC) is a parent training program developed by McMahon and Forehand (2003). In HNC interventions, parenting skills are gradually shaped through teaching, practice, and generalization, and parents must satisfactorily learn one skill in order to move on to the next. Modeling and role-playing are both used as teaching methods for parents, and the intervention is most effective when both parents and any co-parents (other adults such as grandparents, uncles, aunts, siblings, or friends who play a parenting role in the child’s life) attend every training session.

HNC is implemented in two phases. Phase I, titled “Differential Attention,” teaches parents to increase social attention to their child and reduce competing verbal behavior. For example, parents should give their children hugs rather than tell them what to do. Parents are also taught to increase positive attention, decrease verbal behaviors that encourage child behavior problems, and ignore inappropriate behaviors. In other words, parents should reinforce positive behavior and refrain from reinforcing problematic behavior. To this end, parents are taught how to use positive reinforcement effectively in the form of verbal or physical attention and to make it contingent on good behavior. In order to practice these skills parents are instructed to play the “Child’s Game” at home, which gives them an opportunity to interact with their child in a positive, fun setting. At the end of Phase I, parents make a list of their child’s behaviors they
would like to increase. This is different from other interventions in that the focus is on increasing positive behaviors rather than decreasing negative behaviors.

Phase II of HNC is titled “Compliance Training.” During this phase, parents learn how to use clear instructions to increase child compliance and work at making the behavioral changes they had set as goals at the end of Phase I. In Phase II, parents practice skills using the “Parent’s Game,” which gives them the opportunity to practice giving clear instructions and rewards for compliance or punishments (in the form of time-outs) for noncompliance. Going through both phases gives parents the tools to deal with their children’s behavior, both positive and negative. McMahon and Forehand do point out a few limitations of HNC, however. Some child and family characteristics may limit the effectiveness of HNC, such as the severity of the child’s problem behavior, inconsistent parenting, maternal depression, and low marital satisfaction. That said, HNC has been shown to be quite effective when families are fully committed to positive behavioral change.

**Family Therapy**

Family therapy, according to DeRoma (2006), is based on the belief that an understanding of family interactions is the “most powerful avenue for understanding individual behavior” (p. 49) and assumes a reciprocal influence among family members. Thus, family therapists believe that interventions to improve family interactions will also improve a child’s behavior. The goal of family therapy is to promote cohesion and adaptability in the family. These two characteristics would give families the ability to deal with future family stressors and crises, including a child’s problem behavior (see
Chapter Four for more detail). The length of family treatment is relatively short, lasting about twelve sessions, at which point families are thought to be equipped to handle future problems on their own. According to DeRoma, it is essential that the entire family is present for all therapy sessions and the most effective person to conduct an intervention is a therapist with intense training in dealing with families. Thus, this intervention is only available and effective for families that are willing and able to be completely involved and able to afford sessions with a professional therapist.

**Cognitive Interventions**

There are several interventions for ODD based on concepts of cognitive psychology. Cognitive therapies assume that behavior is a result of cognition, and so behavioral change can only follow from cognitive change. According to the cognitive-behavioral perspective, the way individuals interpret events influences the way they react to them. For example, a woman who sees her divorce as an opportunity for increased freedom will react more positively than a woman who sees her divorce as a personal failure. Cognitive therapists work with their clients to identify inefficient or unhealthy cognitive processes and design plans for change (Butcher et al., 2007). Two common types of cognitive therapy are Cognitive-Behavioral Therapy (CBT) and Cognitive-Developmental Treatment (CDT).

**Cognitive-Behavioral Therapy**

Cognitive-Behavioral Therapy (CBT) for ODD is a child-focused intervention based on the cognitive-behavioral perspective. During CBT sessions, children learn to
conceptualize events in ways that will produce prosocial behavior. Children are also taught to think about the ways they interact with others and identify their own interactions as effective or ineffective. One specific type of CBT, Cognitive-Behavioral Skills Training, is designed to help children “develop and use specific skills to change a maladaptive interpersonal style” (Frick, 1998, p. 106). Children also learn cognitive skills, such as decision-making, and how to use them in interpersonal settings. CBT gives children the tools to change their own behavior for the better. CBT also helps to connect children with each other, as it is often implemented in a group therapy format (Frick, 1998). This also gives children in this type of treatment the opportunity to practice their new cognitive skills and behavioral styles with each other.

Although the behavioral change for children with ODD undergoing CBT is statistically significant, it is often not clinically significant (Southam-Gerow, 2003). There are several reasons for this discrepancy. Firstly, CBT is most successful in children with internalizing behaviors rather than externalizing behaviors, and most children with ODD exhibit externalizing behaviors (see Chapter One). CBT also ignores contextual factors that influence disruptive behavior and other problems (such as attention, learning, or anxiety) that children with ODD often have (Southam-Gerow, 2003). In addition, children undergoing CBT have a difficult time generalizing the new cognitive skills to environments and situations outside the therapy sessions. Further, the behavioral changes achieved through CBT are not usually significant enough to bring a child’s behavior into the “normal” range (Frick, 1998). For all its disadvantages, however, child-focused CBT may be the best option for children with ODD whose parents are unable or unwilling to participate in treatment. Ideally, CBT is implemented
as one part of a multifaceted treatment plan (Southam-Gerow, 2003). Such multisystemic interventions are discussed later in this chapter.

**Cognitive-Developmental Treatment**

Cognitive-Developmental Treatment (CDT) has a dual focus on both the child and the family. It focuses on developing emotional regulation skills, addressing pre-existing beliefs that poor behavior is appropriate and adaptive, improving social problem-solving skills and motivation, enhancing children’s perceptions of efficacy and control, addressing pre-existing beliefs that others are unreliable, punitive, and uncaring, and improving the quality of the parent-child relationship. The parent-child relationship is central to successful implementation of CDT. According to the cognitive-developmental perspective, a secure parent-child relationship is crucial for correcting and sustaining behavior. Therefore, establishing that secure relationship should be the first step in any cognitive-developmental intervention. As part of that secure relationship, parents are trained in specific therapeutic techniques and become “co-therapists” and are expected to help children complete therapeutic homework assignments. Another important aspect of treatment is a therapeutic relationship between therapist and client that involves warmth, responsiveness, reliability, consistency, nurturance, and predictability. CDT also involves a large time commitment, as treatment generally lasts about six months (Reinecke, 2006). Thus, CDT is most effective for children whose families are willing and able to commit their time and attention to intervention.
The Psychoanalytic Approach to Intervention

Some psychologists believe that the psychoanalytic approach is the most effective way to improve problem behavior in children. Psychoanalytic treatment focuses on the cohesion of the self, which allows the development of resiliency to help children deal with stressors in an adaptive and appropriate manner. However, the goal of psychoanalytic intervention for ODD is psychic growth rather than behavioral change. Thus, psychoanalytic intervention should be directed primarily at the child with the behavior problem. There are aspects of psychoanalytic intervention for ODD that can make it inaccessible for some children and families. Firstly, the intervention must be implemented by an analyst who can empathize with the patient since a close relationship between the child and therapist is an important factor in the success of psychoanalytic treatment. Secondly, treatment can take an exceptionally long time, even years, since treatment length is determined by the child’s rate of psychic growth as defined by the therapist (Liberman, 2006). Because of these reasons, the psychoanalytic approach to explaining and improving behavior has decreased in popularity, although some therapists still advocate its use for children with behavioral disorders.

Stimulant Medication

While medication is a popular treatment for several psychological and behavioral disorders, it is often overlooked as an option for children with ODD. Stimulants have the potential to be effective for treating ODD because they may increase children’s responsiveness to other interventions. Thus, they are useful as part of multisystemic treatment, as is discussed in the next section. Stimulants are most commonly used for
children with ODD who also have ADHD. However, not much evidence exists for their effectiveness in children without ADHD (Frick, 1998). The use of medication to correct behavior is highly controversial, especially for children, and parents should make sure to gather all available information before considering medication for their children with ODD.

**Multisystemic Treatment**

Multisystemic treatment (MST) is based in family systems theory (which is discussed in Chapter Four) and the theory of social ecology, both of which consider how the child is influenced by surrounding factors and how, in turn, the child influences those same factors. MST is implemented for three to five months by a therapeutic team made up of three to four therapists, a half-time supervisor, and an expert consultant. One member of the team is always on call, giving the family a feeling of security and trust in the team (Saldana and Henggeler, 2006). MST combines strategies from family therapy, behavioral parent training, and cognitive-behavioral therapy to address interpersonal, familial, and social factors that are known to contribute to the development of ODD and other behavioral disorders in children. Therapeutic teams also identify biological correlates to problem behavior in family members and combine pharmacological treatment with psychological treatment if needed. MST therapists understand that contributing factors are different for each case of ODD, so MST is designed to be flexible and easily individualized (Borduin et al., 2003).

There are nine treatment principles for MST:

1. *The purpose of assessment is to understand the fit between behavior problems and the broader systemic context*
2. Therapists emphasize the positive and use systemic strengths as levers for change
3. MST is designed to promote responsible behavior and decrease irresponsible behavior among family members
4. MST is present-focused and action-oriented, targeting specific and well-defined problems
5. MST targets sequences of behavior within and between multiple systems
6. Interventions should be developmentally appropriate and fit a child’s developmental needs
7. Interventions require daily or weekly effort by family members
8. Effectiveness of intervention is evaluated continuously from multiple perspectives
9. MST promotes treatment generalization and long-term maintenance of behavioral change (Borduin et al., 2006, pp. 306-307)

These treatment principles reveal that family involvement is crucial for the successful implementation of MST. Therapeutic sessions take place within the child’s social ecology (in the home) to increase generalization and maintenance. Similarly, “a fundamental assumption of the MST model is that caregivers are the keys to promoting and sustaining youth behavior change. Engaging caregivers in treatment, therefore, is primary and one of the initial goals of the therapist” (Saldana and Henggeler, 2006, p. 242). Other goals of MST are to give parents the tools they need to deal with their children’s behavior and to give children the skills to cope with stressors in an adaptive manner. These goals are carried out on three levels. First of all, at the family level, MST aims to remove barriers to effective parenting, enhance parenting knowledge, and promote affection and communication among family members. At the peer level, the goal is to decrease a child’s affiliation with delinquent peers and increase affiliation with prosocial peers. Finally, the goals at the school level are to help the family and child develop strategies to monitor and promote school performance, establish positive communication lines between school and home, and restructure after-school time to
promote academic efforts. Interventions are also used to enhance social perspective-taking skills, problem solving skills, and motivation (Borduin et al., 2003). While the strength of MST is that it addresses issues associated with multiple systems, its main limitation is that it requires the full involvement of individuals in those systems. Thus, children whose families are not able or willing to participate will not benefit from MST.

No one approach to intervention will work for every child with ODD. However, there are some interventions that have more potential to be successful because they have more characteristics of effective interventions. Positive Behavioral Support with families, parent training, family therapy, cognitive-developmental therapy, and MST all require the involvement of the child’s family, which makes an intervention more effective. Effective interventions also intervene in multiple systems, as MST does. Contingency management, Positive Behavioral Support with families, and MST are flexible and easily individualized, which is another important quality of an intervention. This evidence reveals that MST may be one of the strongest options for children with ODD. However, not all children with ODD have access to the resources required for success with MST or any other intervention. Children living in foster care do not have permanent parents or other family members to be involved in their interventions. They may also change homes, schools, and even communities several times a year, and their lives lack security and predictability. The next chapter discusses the foster care system and the children who live in it. Then, the above interventions are revisited and evaluated for their accessibility to foster children. Chapter Four further discusses the impact of ODD on family members and foster family members and finally, in the conclusion to this
project, the needs of foster families with children with ODD are discussed, and options for meeting those needs are explored.
Chapter Three:  
Today’s Children in Foster Care

When Jessica was three years old, her mother took her and left Jessica’s abusive father. Over the next five years, Jessica’s mother suffered from alcoholism and was eventually arrested and sent to prison for driving under the influence. At the age of eight, Jessica was removed from her home and became a ward of the state. Jessica is now fourteen years old. Since being removed from her home, Jessica has lived in six different places. She started off living with her grandmother, who had too many health issues to care for Jessica. Jessica has also lived in a group home and four different foster homes. Jessica has been to five schools in the last six years and has not been able to sustain friendships at any of them. She has trouble maintaining her grades and strongly dislikes school. Although a judge terminated Jessica’s father’s parental rights, a caseworker hopes to reunite Jessica with her mother upon her release from prison. Jessica, who has not seen her mother for several years, has mixed feelings about returning home.

There are thousands of children in the United States who, like Jessica, have been removed from their homes and placed in foster care. What is foster care and how does it work? Who are foster parents and how are they chosen? What special challenges do foster children and their families face? This chapter provides an overview of the foster care system, a description of foster parents and an explanation of how they become foster parents, and an exploration of current issues in foster care. Finally, the chapter returns to Oppositional Defiant Disorder (ODD) and discusses children with ODD who are living in foster care.

Overview of the Foster Care System

What is foster care? There are several definitions of foster care, but this project will make use of the following definition because it provides a general explanation:

Foster care, often misunderstood by professionals, policymakers, and the general public, is a generic term for children living in out-of-home care. Most foster children are wards of the state with histories of child abuse or neglect. Historically, foster care was referred to as “boarding-out.” The
term implied that foster parents, almost always nonrelatives, were reimbursed for the expenses of caring for dependent children in private households under the assumption that the arrangement was temporary. (Curtis in Curtis et al., 1999, pp.2-3)

That foster parents are generally nonrelatives and that placements are assumed to be temporary will be important in the below discussion of foster care and the experiences of foster children with ODD later in this project. The following sections discuss how the foster care system works, the various types of foster care, and the number of children and families involved in the system.

**How the Foster Care System Works**

There are several reasons children may be removed from their homes and placed in foster care. Generally, children are removed because they have been abused or neglected, are considered unmanageable, or have parents who have abandoned them or cannot care for them due to circumstances such as incarceration or illness (Blatt, 2000). As mentioned in the quote above, foster care is assumed to be temporary. The primary goal of foster care is for children to return to their biological families.

There are several different types of foster care, which are discussed in the next section. However, in general, foster children live with a family in a private home. Foster parents are reimbursed by the state depending on the age and special needs (such as a disability) of the child. Most foster parents receive enough money to cover the needs of their foster child, but very few actually make a profit (Wozniak, 2002). While foster parents provide daily care for children placed in their homes, they do not have legal rights concerning the child. While biological or adoptive parents have the rights to make
decisions for their children, foster parents answer to the state agency or the court that placed the child into their home (Turnbull et al., 2006). In fact, foster parents must keep caseworkers updated about even small changes in the home environment.

Most of the time, biological parents still have custody of their children who are placed in foster care. Sometimes, parents will willingly relinquish custody of their children, and in extreme cases, such as drug use or abuse, a judge may revoke custody from parents. Whether or not they retain custody of their children, parents lose control over decision making for their children while they are in foster care. “In many cases, even parents who voluntarily place their children…are not allowed to play a part in deciding the placement, are restricted to few visits with the child, may not be kept abreast of the child’s progress, may not be told when the child is moved from one foster home to another, and may not even be told the location of their child” (Cox and Cox in Cox and Cox, 1985, p.xv). Parents are kept in the dark concerning their children in order to preserve the objectives of the placement, namely healing time for both child and parents.

As mentioned above, most children enter foster care with the assumption that they will return to their original home. However, the biological family needs to meet the expectations of a judge before the child can be returned. For example, parents might take parenting classes, go to counseling, or improve their economic stability by getting jobs. This process is both guided and monitored by professionals in the system such as a social worker or probation officer. Those professionals then make recommendations to the court, and a judge decides when it is appropriate for the child to return home (Blatt, 2000). Unfortunately, however, families do not always make the necessary improvements and the child is not able to go home. In these cases, parents can
voluntarily terminate their parental rights and offer their children for adoption, or a court may decide to free the child for adoption (Blatt, 2000). Due to the lack of adoptive families, these children often remain in the foster care system for long periods of time.

On average, children stay in foster care for a year and a half. However, stays can vary in length from a few days to several years. It is also not uncommon for children to return to foster care after they have been released. In fact, 15 percent of children entering foster care have had a previous foster care placement (Blatt, 2000, p.3). There are three general paths for children who leave the system permanently. About two-thirds of foster children return to their natural homes, 10% are adopted by other families, and the rest are in foster care for so long that they leave at age eighteen to become independent (Blatt, 2000, p.3). Children’s exits from foster care vary by individual family and child, and by type of foster care.

**Types of Foster Care**

There are several different types of foster care. First of all, foster parents can specify if they are interested in fostering children of particular ages, or if they wish to be short-term (days to weeks) or long-term (months to years) foster parents. Parents can also apply to be considered an “adoptive risk home,” meaning they would foster children who may be later offered for adoption (Wozniak, 2002). Parents who choose this option are likely interested in caring for children for long periods of time and adopting them if they are unable to return home.

Types of foster care are generally classified by the care environment. There are four classic types of foster care: family (nonrelative) foster care, kinship (relative) care,
therapeutic foster care, and residential (congregate) group care (Curtis in Curtis et al., 1999).

**Family Foster Care.** Family foster care is the most common type of out-of-home care, accounting for 49% of children living in foster care (Curtis in Curtis et al., 1999, p.4). Family foster care involves individuals, couples, or families who take in children not related to them. They provide 24-hour supervision and care in their own home and must be licensed and monitored by child welfare agencies. As mentioned above, some parents adopt their foster children, but most placements are temporary. Families may foster one or several children, but most states limit the number of children of certain ages placed with each family (Curtis in Curtis et al., 1999).

**Kinship Care.** Twenty-three percent of children in foster care live with relatives in an arrangement termed “kinship care” (Curtis in Curtis et al., 1999, p.4). Most children in kinship care live with grandparents, but many live with aunts and uncles, cousins, or even adult siblings. These relatives still need to be licensed and monitored by child welfare agencies and are expected to provide the same level of care as nonrelative foster families (Curtis in Curtis et al., 1999). While some believe that relatives who take in foster children should not be compensated, most receive financial aid from the state so that they are better able to meet the needs of the children.

Kinship care has both advantages and disadvantages when compared to nonrelative care. Children who live with relatives are able to maintain a strong connection to their birth families and cultures of origin. However, “evidence shows that children in kinship care have longer placements and are less likely to receive needed health services. Licensing standards are less rigorous, and children are less carefully
supervised” (Hamner and Turner, 2001, pp.392-393). With all its disadvantages, however, courts generally assume kinship care is the option with the most potential for reunification and give preference to relatives willing to foster a child.

**Therapeutic Foster Care.** Only about 1.7% of foster children are placed in therapeutic foster care (Curtis in Curtis et al., 1999, p.4). In a therapeutic placement, children with severe behavioral, psychological, physical, or health problems receive the extra care and attention they need. In some cases, therapeutic foster care is considered an intervention option for children with severe behavioral problems who would not otherwise be removed from their homes. Parents who wish to provide therapeutic foster care must obtain a special license, receive extensive training, and are provided with additional support services from the state (Wozniak, 2002). “In addition, parents may be required to have a special background, such as teaching or health care, and one parent may be required not to work out of the home. A higher board rate is normally provided to therapeutic foster care parents than is provided to family foster care parents” (Curtis in Curtis et al., 1999, p.4). There are nine characteristics of therapeutic foster care that distinguish it from other types of out-of-home care:

1. Foster parents are considered professionals
2. Foster parents take care of only one or two children
3. Case managers have small caseloads
4. Foster parents are given special training
5. Foster parents implement the child’s treatment plan
6. Foster parents are provided with professional and emotional support
7. Crisis intervention services are available 24 hours each day
8. Assessment and fulfillment of each child’s educational needs are emphasized
9. Each child’s system of care is coordinated (Curtis in Curtis et al., 1999, p.3)
**Residential Group Care.** Fifteen percent of foster children live in group homes that are staffed by professionals 24 hours a day (Curtis in Curtis et al., 1999, p.4). These homes may resemble a dormitory or psychiatric hospital. Like a psychiatric hospital, group homes provide treatment for children with emotional and behavioral disturbances, but fewer medical professionals work in group homes, and the residents are less restricted than they would be in a hospital (Curtis in Curtis et al., 1999). Children who live in group homes are less likely to receive personal attention for attributes other than their mental health needs and are more likely to change placements than children living with families.

As mentioned above, the average length of time children spend in foster care is one and half years. However, the longer children spend in foster care, the more likely they are to experience several of the types of placements discussed here (Turnbull et al., 2006). There is one new type of foster care that aims at shortening the placement, maintaining ties with birth parents, and providing the means for birth parents to improve their chances of reunification. In what is called “shared family foster care” the entire biological family moves into the foster home. Foster parents provide care for the child and guidance for the parents, who can learn parenting skills by observation and have the chance to practice them in a safe environment. Shared family foster care is most common for single-parent families, where one parent (usually the mother) and one or two children would live in the foster home. Other biological parents that may benefit from shared family foster care are mothers who are young, have a cognitive disability, or have
used drugs. While little research exists on this new type of foster care, the outcomes are expected to be very good for both the child and the biological parents (Blatt, 2000).

**Numbers: Children and Available Families**

Currently, there are about 600,000 children living in foster care in the United States (Turnbull et al., 2006, p.32). Minority children are severely overrepresented in foster care. “Though ethnic minority children comprise 20% of the national population, they represent 61% of all children in out-of-home care” (Urquiza et al. in Curtis et al., 1999, pp.84-85). The special needs of minority children in foster care are discussed later in this chapter. Of the children in foster care, 15% enter the system as newborns (usually of young, poor, or substance-addicted mothers). One third of foster children are removed from their homes between birth and five years of age, one third are removed between six and twelve, and one third as teenagers (Blatt, 2000, p.3).

The number of children in foster care is always increasing. From 1982 to 1995 alone, the number of children in foster care increased by 63.2% (Curtis in Curtis et al., 1999, p.6). Despite the large numbers of children entering the system, there is a shortage of available foster families and good foster families are even more difficult to find. In fact, there are fewer families willing to foster children than in the past; the number of foster families in the United States has decreased by a third since the 1980s (Hamner and Turner, 2001, p.394). There are several reasons for this remarkable decline. First of all, while families are reimbursed by the state, the reimbursements often do not cover all of the child’s expenses. Thus, in order for families to appropriately provide for foster children, they must be both financially stable and skilled in working with children and
families. In addition to difficulties recruiting new foster parents, current foster parents often drop out due to a lack of training, support and respite care, and the amount of work and stress they experience dealing with the problems associated with foster children (Hamner and Turner, 2001). It is clear that for the system to fulfill its promise, there must be enough families to care for the increasing number of children removed from their homes. The next section discusses the families who provide that care.

Foster Parents

Foster care would be impossible without the involvement of individuals, couples, and families who voluntarily become foster parents. Who becomes a foster parent? While some foster parents are single, most foster families are two-parent households that already include one or more children. Oftentimes, the children are older and the parents now have more room in their home and time in their schedules to take in a foster child. It is not entirely uncommon for older couples that have launched all their children to become foster parents and return to childrearing. Many individuals who choose to become foster parents grew up with foster children in their own homes (Blatt, 2000). The quality of the foster placement depends greatly on the foster parents’ motivation, skills, and readiness to deal with all the issues that arise when raising a foster child.

Successful child placement occurs when foster parents have had prior experience; when they function as loving, caring substitute parents; when they are tolerant of children and allow them to function as individuals; when their motives for becoming foster parents are altruistic; and when they are reliable caretakers, bonding figures, and stable figures. In other words, they are ‘psychological parents’ to a child whose life has had no such person available in his family of origin. (Hamner and Turner, 2001, p.394)
The following sections discuss why individuals choose to become foster parents, and what happens after they have made that choice.

**Choosing to Foster**

There are several reasons people choose to become foster parents. In most cases, the motivation to foster children is altruistic. “Generally, people become foster parents because they feel that they have something to offer to these children. They accept the long hours of responsibility and attention. They receive enough money to take care of the child, but seldom make a profit” (Blatt, 2000, pp.6-7). However, there are other reasons for becoming a foster parent. Wozniak (2002) lists the top five reasons women decide to foster children, and while the first is “altruism and social and moral responsibility,” others include “family tradition,” “social action,” “the desire to increase the size of one’s family,” and “the need or desire for income or employment” (pp.35-36). As described above, foster parents whose motivations are altruistic and are loving and caring towards their foster children provide the best homes. However, with the shortage of foster parents, child welfare agencies do not have the luxury of discounting all parents with other motivations. That said, agencies do have procedures for selecting appropriate foster parents. While some agencies merely screen parents for certain qualities, others also provide training for potential foster parents.
Screening Versus Training

Once individuals or couples decide to become foster parents, they must apply for a license through a private or public child welfare agency. The agency then determines whether the individual would make an effective foster parent.

**Screening.** Some agencies merely screen parents for certain qualities. Parents are first invited to an open house where they are informally assessed. If the agency believes they will be appropriate, the parents are given a formal assessment tool to determine their temperament and parenting style. Different agencies define “appropriate” in different ways, but generally they look for parents who will be able to put the child’s needs above their own and provide a loving environment. Other valuable qualities include flexibility, ability to work with the agency, and willingness to put forth effort in order to comply with agency requests (Wozniak, 2002). Once parents have been deemed “appropriate,” they are granted a license and await their first placement.

**Training.** Many agencies require foster parents to engage in training. While some training programs take place before a child is placed with foster parents, most programs offer training and support for parents who are already caring for children. After being selected, or screened, for foster parenting, parents attend educational classes on parenting children with the special needs brought out by foster care (Wozniak, 2002). There are two main types of training foster parents receive: parent skills training and support discussion groups. Parent skills training was originally developed for foster parents raising children with exceptionalities and aims to “teach child management techniques and communication and relationship skills” (Hampson in Cox and Cox, 1985, p.168). This type of training generally occurs in formal classes parents attend. On the
other hand, discussion and support groups are more informal and “help foster parents define and become comfortable with their roles as foster parents…and…provide continuing reinforcement and emotional support” (Hampson in Cox and Cox, 1985, p.174).

Training has been shown to have very positive outcomes for both foster children and foster parents. There is consistent evidence revealing that training “reduces the incidence of failed placements, increases desirable placement outcomes, and enriches the probability of retention of the child by the foster parents” (Hamner and Turner, 2001, p.394). In spite of research suggesting that training is beneficial to foster placement, not all agencies require foster parents to be trained. One reason for this may be the expense of providing training in an already under-funded system. The financial strain experienced by foster care agencies is currently a major issue associated with the system. The following section describes additional important issues in foster care today.

**Current Issues**

This section discusses three issues currently facing foster care: the debate over the purpose of foster care, problems within the system, and the special needs of children in foster care.

**Purpose of Foster Care**

There are two general positions on this issue. The first is that foster care exists primarily for the biological parents who need time and assistance to change their habits, make better choices, and improve their lifestyles. According to this viewpoint, children
are removed from the home to give parents the chance to correct the problems that make their homes unsuitable for children (Curtis in Curtis et al., 1999). By removing children from their homes, parents are able to concentrate on their own needs and seek help from social service professionals. Since the primary goal of foster care is reunification of the child and family of origin, it is essential for parents to address their own problems and make their homes safe and appropriate for their children.

The other position on this issue is that foster care exists primarily for the benefit of the child. According to this position, foster care exists to provide substitute homes for children who, for whatever reason, cannot live with their biological family. In an ideal situation, foster care provides the child with care and nurturing from a family that has special training, such as the training discussed in the previous section (Blatt, 2000). The safety of children is also a primary focus of the foster care system. A major intent of foster care is to remove children from environments in which they are at risk for harm and place them in safe environments (Krebs and Pitcoff, 2006). The safety and development of the child is the purpose of foster care according to many.

Whether foster care exists for the biological family or for the child, the purpose of foster care is not to provide childless couples with children. Many couples who hope to adopt begin as foster parents, but while adoption can be a positive outcome for children who can’t return home, the primary focus of foster care is to reunite children with their natural parents (Hamner and Turner, 2001). While foster care could not exist without foster parents, as discussed earlier in this chapter, placements are most successful when the motivation to foster is to help children and families in need rather than to gain family members.
Problems with the System

There are several problems within the foster care system, and this section discusses a few of them. One problem with the system is that there are too many children who stay in foster care for too long (Curtis in Curtis et al., 1999). As discussed earlier in this chapter, even though foster care is meant to be a temporary arrangement, many children stay in the system for much of their childhood. In addition, of those who do return to their families, many reenter the system (Goerge et al. in Curtis et al., 1999). The large numbers of children and their long durations in the system lead to overcrowding and other problems for caseworkers. Caseworkers who are inexperienced and have too many clients have a difficult time giving individual attention to families. In addition, the turnover rate for caseworkers is extremely high, and caseworkers may represent an entirely new clientele each year. The combination of the inexperience and the high turnover rate leads to a lack of continuity for children who may have several different caseworkers during their stay in foster care (Cox and Cox in Cox and Cox, 1985).

Another problem with foster care is that children are sometimes unnecessarily removed from their homes. When families have problems, welfare agencies often consider out-of-home care as the only option. This may be due to the fact that federal and state funding to welfare agencies is almost all allocated to foster care. Thus, instead of fixing family problems, agencies remove children. Another reason children may be unnecessarily removed from their homes is that there are no clear standards for removing children. Judges and social workers are usually the ones who decide when children should be removed, and so the decision is subjective and often influenced by professional and personal biases (Cox and Cox in Cox and Cox, 1985). When children are removed
from their homes when they shouldn’t be, the system becomes even more overcrowded and other issues arise.

Children who are removed from their homes are often placed in inappropriate settings that are far away from their parents’ homes. One reason for this, as discussed earlier in this chapter, is that there are not enough families willing to foster all the children in the system. Agencies have trouble finding placements close to the child’s original home, and sometimes have to place children in institutions because of the lack of available homes. Another reason children are sometimes placed in restrictive settings is that agencies are often unwilling to pay relatives to take children in as kinship care. However, many relatives would like to care for children but don’t have the financial resources to do so without compensation. While many providers of kinship care do receive compensation, there are those who care for children without any aid from the state (Cox and Cox in Cox and Cox, 1985). These circumstances lead to children being placed in restrictive settings far away from their families, friends, schools, and everything else familiar to them.

An additional problem with the foster care system is that children, especially those who spend extended stays in foster care, are unable to maintain ties with their biological families. As discussed earlier in the chapter, parents are often kept in the dark concerning their children. While this is meant to preserve the safety of the children, it often results in isolating them and preventing reunification with their families (Cox and Cox in Cox and Cox, 1985). Social workers and other professionals should make efforts to keep biological families involved and maintain ties between children and their parents.
This will help facilitate reunification and will ease the transition for both children and their parents.

Finally, foster care placements are often unstable, and children may experience several placements during their stay in foster care. One reason for this is that foster parents aren’t always ready or equipped to deal with the problems of foster children. “Foster children are often removed from stressful situations and may be frightened or resentful about being placed with strangers. The adjustment of these children to the foster home is frequently difficult. With virtually no training and little consultation, foster families are expected to deal with a variety of difficult and complex emotional responses in the child” (Cox and Cox in Cox and Cox, 1985, pp.xiv-xv). This is another example of why training foster parents is crucial, as a “lack of permanence in both the child’s residence and relationships may be disruptive to the child’s development” (Cox and Cox in Cox and Cox, 1985, pp.xiii-xiv). Children enter foster care with a variety of problems, and the instability of their placements can often intensify those problems. The unique needs of children in foster care are discussed more fully in the next section.

**Special Needs of Children in Foster Care**

Children in foster care generally come from troubled backgrounds and have questionable futures. They have a variety of special needs that should be met by agencies, social workers, and foster parents. While all foster children have special needs, there are certain populations of children with specific special needs. This section discusses two of those populations: minority children and children with mental health problems. Minority children are overrepresented in foster care, as discussed earlier in
this chapter. Children are not necessarily placed with foster parents of their own ethnicity, and minority children can have special difficulties transitioning to a foster home of a different culture. Children are not only removed from their homes and familiar surroundings, but are placed in homes where the behaviors, language, customs, and even food are unfamiliar. Foster parents can ease this transition by maintaining certain cultural practices (such as language, if possible), providing continuity in health care, nutrition, and hygiene, and helping the children to maintain a link with their ethnic community of origin (Urquiza et al. in Curtis et al., 1999). Caseworkers and foster parents who work with children and families of different ethnicities should receive special training in cultural competency.

While not all children in foster care have been diagnosed with a mental disorder, it can be argued that foster children have low levels of mental health. “Most studies of children living in foster care have shown that they exhibit problems requiring mental health assessment and intervention at a considerably higher rate than what would be expected from either normative data or from community studies” (Landsverk and Garland in Curtis et al., 1999, p.194). One reason for the increased rate of mental health problems is that many children in foster care have been abused or neglected by their biological parents.

The literature has consistently demonstrated that abused and neglected children experience a wide range of psychological and behavioral problems resulting from abuse or neglect…Thus, maltreated children who enter child welfare systems constitute a high-risk group for serious impairment in various mental health and developmental domains…For these children, the additional stressors of parental separation (even from abusive or neglectful parents), multiple out-of-home placements, lack of appropriate caretaking by foster parents or other caregivers, and a failure to identify or address medical and psychosocial issues may compound their preexisting problems…A clear understanding of the psychosocial
problems of children in foster care is essential in order to develop appropriate interventions. (Urquiza et al. in Curtis et al., 1999, p.84)

It is important for foster children with mental health problems to receive appropriate interventions so that they may avoid more serious psychological problems in the future, have easier and more manageable placements, and have better chances of being reunited with their biological family (Urquiza et al. in Curtis et al., 1999). Even children who have not already been diagnosed with a psychological disorder should receive counseling and be evaluated regularly to monitor their mental health status. Of the children in foster care with mental health problems, many have behavioral problems such as Oppositional Defiant Disorder (discussed in Chapter One). Children with ODD who are living in foster care are discussed in the next and final section of this chapter.

Children with Oppositional Defiant Disorder in Foster Care

Behavioral disorders are quite common in children living in foster care. In fact, “One sample of children in foster care identified nearly half as needing mental health services, and another study found that 75% to 80% of school-age children in foster care had emotional or behavior disorders” (Turnbull et al., 2006, p.32). Other studies have estimated that between one half and two thirds of children entering foster care exhibited behavior that was so problematic that intervention was needed (Landsverk and Garland in Curtis et al., 1999). Since ODD is difficult to diagnose, and so many cases go undiagnosed (with children written off as being either “naughty” or “bad seeds”), it is not easy to determine the number of children with ODD who are living in foster care. However, it can be assumed that many of the children with behavioral disorders (and many who haven’t been identified yet) do in fact have ODD. It is clear that children with
ODD present a unique challenge to the foster care system. The following sections discuss common problems faced (and caused) by foster children with ODD and revisit the interventions for ODD (Chapter Two) in light of the information on foster care presented in this chapter.

**Common Problems**

Most foster children face (and cause) some problems during their placements, specifically during the school and adolescent years. Children in foster care tend to “have high rates of absenteeism, midyear changes from one school to another, discipline suspensions from school, and a need to repeat one or more grades” (Turnbull et al., 2006, p.32). These problems are often exacerbated by ODD, and children with ODD in foster care have a variety of school, social, and behavioral problems. These problems can lead to serious placement issues resulting in many placement changes. The following quote is from a former foster child who has ODD:

> Every time they moved me, I made it my job to cause trouble…It got to be like a game. With each move, I’d stay in a foster home a shorter time. Then I got to a foster home where the family said I didn’t need to go. They said they liked me a lot, even though my behavior was terrible. You know I continued to act bad for almost two years? Somehow, my foster parents put up with it. Now I’m in junior college. (Blatt, 2000, p.132)

It clearly takes a lot of work and dedication from foster parents to successfully raise a child with ODD. While all foster parents should receive general training, parents who care for children with ODD should receive specialized training in dealing with the problem behaviors these children exhibit.

There are several reasons foster children may have ODD at higher rates than the general population. In general, ODD in foster children results from the way they have
grown up. Biological parents may not have provided children with the guidance, love, and attention they needed in order to learn how to interact effectively with other people. Parents also may not have taught children appropriate manners, or the children may have already been removed by the time they should have learned manners. There may have been little to no discipline in the natural home. In addition, children may have learned from experience that being well behaved did not work when they tried to fulfill personal needs and may have difficulty expressing their fears or worries constructively (Blatt, 2000). In working with foster children with ODD, foster parents and professionals should consider the child’s background. Part of helping these children is teaching them a new behavioral vocabulary.

Revisiting the Interventions

Chapter Two discussed a variety of interventions that have been effective for children with ODD. Recall that there are several characteristics that make interventions highly effective. This section focuses on three of those characteristics that are difficult for foster children to achieve: involvement of the family, intervention in multiple systems, and consistency in intervention.

Involvement of the family. Foster children have two sets of family members that should be involved in intervention. It is often difficult to involve biological families in intervention due to the geographical and emotional separation that takes place during foster care placement. As discussed earlier in this chapter, children are often placed far away from their parents’ homes and parents are often not allowed contact with their children while they are in placements. If they are allowed contact, it is generally in the
form of short, infrequent visitation. In addition, biological parents have their own issues they must address before they can be reunited with their children, and may not have the time, energy, or personal resources to participate in intervention for ODD.

Foster parents are difficult to involve in intervention for two reasons. First of all, foster parents often do not have a complete history of children’s backgrounds and behavior. Thus, foster parents may not fully understand where the children are coming from and why they behave the way they do. This makes interventions difficult, especially behavioral interventions, which rely on finding the motivation behind poor behavior. The second reason foster parents are not fully able to participate in intervention is that children, especially those with behavioral problems, can change placements as often as every few days. Thus, children may have several foster parents and may not have time to form the types of meaningful relationships that increase the effectiveness of intervention.

**Intervention in Multiple Systems.** Most intervention specialists agree that interventions are more effective when they intervene in the multiple systems with which the child has contact. These systems include home, school, social groups, and any other activities. It is not easy to intervene in multiple systems for children in foster care because each system is in a constant state of flux. Children change homes, schools, activities, and friends quite often. As with foster parents, children in foster care have difficulties creating connections with others and thus do not have consistent, identifiable systems in which to intervene. In addition, professionals performing the intervention may not have access to all the systems. For example, the biological and extended
families may not be available, and teachers may be unwilling to commit time to intervention for children that may not be in their class the following week.

**Consistency in Intervention.** As mentioned in the previous sections, one of the main challenges foster children with ODD face is that they change placements very often. This presents several difficulties for intervention. As discussed in Chapter Two, in order for children to generalize new behaviors to situations outside the treatment environment, intervention must be consistent across a variety of environments. In other words, parents, teachers, and clinicians need to communicate to ensure that the child receives consistent information and consequences at home, school, and in treatment. For children in foster care, who have very little consistency in their everyday lives, consistency in intervention is nearly impossible to achieve. When children attend several schools in one year, or stay with several families with several different parenting and discipline styles, inconsistency is certain. This confuses children and reduces the effectiveness of intervention.

It is clear that all children in foster care, whether or not they have a behavioral disorder, have a variety of special needs that must be met by the system and individuals within that system. Children with Oppositional Defiant Disorder have many special needs and face several challenges at home and at school. Interventions for ODD are not designed for children living in the foster care system. Interventions rely on several characteristics, including involvement of the family, intervention in multiple systems, and consistency in intervention in order to correct disordered behavior. The inconsistent structure and non-permanent nature of foster care make these elements difficult to achieve for foster children with ODD. The next chapter provides an overview of family
systems theory and explains how ODD and other behavioral disorders impact the family. The information presented is then applied to foster families, specifically those raising children with ODD.
Chapter Four:  
The Significance of Home-Based  
Interventions and Their Implications for  
Foster Families: A Family Systems  
Perspective

What is a family? According to the U.S. Census Bureau a family consists of “a group of two or more people related by birth, marriage, or adoption who reside together.” This definition is quite limiting. By this definition, a biological mother and her child in foster care are not family because they don’t live together, while that same child and his foster parents are not family because they are not related by birth, marriage, or adoption. Clearly, when discussing alternative families, it is important to conceive another, more inclusive definition. Turnbull et al. (2006) offer a definition for just this purpose. According to them, “Families include two or more people who regard themselves as family and who carry out the functions that families typically perform. These people may or may not be related by blood or marriage and may or may not usually live together” (p.7). Under this definition, the mother and her child in foster care as well as the child and his foster parents are considered family. It is important that these individuals be considered family so that they may be discussed using family theories, which can be used to explain the experiences of foster families with children with Oppositional Defiant Disorder.

When a child has ODD, the entire family is impacted. Family members experience stress while the whole family can become dysfunctional. This phenomenon is explained by family systems theory, which views the family as a dynamic, interconnected
system. For foster families, the impact of ODD can compromise the efficacy of the placement. Thus, involving the family in intervention is essential for both the child’s progress (see “Family Therapy” in Chapter Two) and the family’s well being. This chapter discusses the importance of home-based interventions that target both the child and the whole family for enhancing the placement. The chapter firsts give an overview of family systems theory and then applies the theory to explain how ODD influences individual and family functioning. The focus then returns to foster families and discusses the importance of home-based interventions to improve placement quality for children and families.

**Overview of Family Systems Theory**

Traditionally, families are viewed as groups of individuals who, when added together, make up a family. However, according to family systems theory, “the parts of a family make a whole that is more than the sum of its parts” (Lamanna and Riedmann, 2006, p.66). The main assumption of family systems theory is that when something happens to one family member, it touches every family member. “A family systems perspective rejects the view that linear relationships characterize family life and that the only important relationship is that between a mother and her child. Instead, families are viewed as interactive, interdependent, and reactive; that is, if something occurs to one member in the family, all members of the system are affected” (Seligman and Darling, 2007, p.17). As with all systems, a family system works constantly to maintain equilibrium. Therefore, when the environment or one member experiences change, the system adjusts and tries to return to equilibrium (Lamanna and Riedmann, 2006). Thus,
when a child has a disability, especially a disruptive behavior disorder such as ODD, every member of the family feels the impact of the disorder. Like a pebble dropped into a pond, ODD creates ripples in the family structure and functioning until the family can learn to readjust and restore equilibrium. There are four elements of family systems theory that, according to Turnbull et al. (2006), further clarify these ideas: family characteristics, family interaction, family functions, and family life cycle.

**Family Characteristics**

A family’s characteristics are the inputs into the system. The characteristics of a family inform every interaction between the members and every interaction with the outside environment (Turnbull et al., 2006). There are several types of characteristics that influence a family’s interaction. One such characteristic is the size and form of the family, which includes the number of members and where they live. The cultural background, including cultural and microcultural characteristics, immigration status and language, and differences in cultural values can also contribute to a family system. In addition, a family’s socioeconomic status and geographic location (such as urban or rural environments) are important characteristics. The characteristics of individual members and special challenges faced by the family (such as homelessness, members with disabilities, or foster care) cannot be ignored when considering inputs into a family system (Turnbull et al., 2006).
Family Interaction

If family characteristics are inputs to the system, family interaction is the response of the system to those inputs. This response produces outputs, which are the family functions, discussed below. As families interact, “the system must be understood as a whole and cannot be understood by one or more of its parts, or members” (Turnbull et al., 2006, p.29). Family interaction can be better understood by looking at the dynamics among family members as each small interaction contributes to the family’s interaction pattern.

Family Subsystems. Family interaction can be described through the subsystems that make up the family. The martial subsystem consists of the interaction between husband and wife, same-sex partners, or a cohabiting couple. The parental subsystem includes the interaction between parents and their children. This subsystem can be extended to include non-biological stepparents, adoptive parents, foster parents, and non-related parental figures. Interactions between the children in the family constitute the sibling subsystem, which can include full siblings, half siblings, stepsiblings, foster siblings, or even friends who consider themselves siblings. The extended family subsystem is perhaps the largest and most flexible subsystem and describes the interactions between members of the nuclear family, other relatives, and others who are considered family, such as friends, teachers, or other professionals.

Alternatively structured families also contain subsystems, but the subsystems may or may not be as clear-cut as those described above. For example, a teenage mother living in her parents’ home may be in a sibling subsystem with her own child, as they are
being raised by the same set of parents. A man can be in a parental subsystem with his ex-wife while at the same time being in a marital subsystem with his cohabiting girlfriend. Foster families contain the same subsystem as typical families, but the extended family subsystem may be bigger and include caseworkers, social workers, or agency workers. Additionally, the child belongs to two parental subsystems: one with the biological parents and one with the foster parents. Regardless of the number or form of subsystems in a family, “boundaries exist between family subsystems, resulting from the interaction of family members with each other and from the family unit as a whole in its interactions with outside influences” (Turnbull et al., 2006, pp.29-30). These boundaries can be rigid or flexible, which influences other aspects of a family’s interaction: cohesion and adaptability. The subsystem explains who in a family interacts, and the concepts of cohesion and adaptability describe how they interact.

**Cohesion.** Cohesion is influenced by the boundaries between family members.

“Family cohesion refers to family members’ close emotional bonding with each other and to the level of independence they feel within the family system. Cohesion exists across a continuum, with high disengagement on one end and high enmeshment on the other” (Turnbull et al., 2006, p.43). Highly enmeshed family members are intensely involved in one another’s lives. They spend lots of family time together, even after the children have left the home. Members who don’t live together may speak on a daily basis, and parents may make decisions for their young and adult children. Highly disengaged families have rigid boundaries between members and behave in ways that are independent of one another. Decisions are left up to individuals, and while family members may feel affection toward each other, they may not express it openly.
**Adaptability.** On the other hand, adaptability is influenced by the boundaries between families and their environments. It is also influenced by the cultural values and background of the family. “Adaptability refers to the family’s ability to change in response to situations and developmental stress...[it] can be viewed on a continuum: at one end are families who are unable or unwilling to change in response to stress; at the other end are families who are constantly changing, so much so that they create significant confusion” (Turnbull et al., 2006, p.44). Adaptable families have more flexible boundaries with the outside world, while families low in adaptability have rigid boundaries with their surroundings. Most families fall somewhere in the middle of the continuum, but it is clear that families need a balance of adaptability and consistency to deal with children with disruptive behavior disorders such as ODD.

**Family Functions**

Recall the definition of “family” at the beginning of this chapter. In order to be considered a family, a group of people must fulfill functions that families typically perform. What is the significance of these functions? As mentioned above, families interact in ways that respond to system inputs, which are the family characteristics. That interaction produces outputs, which are the family functions. The way a family responds to inputs will determine its ability to fulfill these functions. There are countless functions families perform, and every family fulfills a unique variety of functions, but Turnbull et al. (2006) list the most common: affection, self-esteem, spirituality, economics, daily care, socialization, recreation, and education.
Families may concentrate on certain functions according to their characteristics or special circumstances. For example, families of children with ODD may concentrate more on daily care, socialization, and education until the disorder is under control, at which point they may begin to address spirituality and recreation. Another important factor in meeting family functions is time. Families often don’t have the time to fulfill every function every day. A very busy family may need to concentrate on daily care and economics until they have more time to concentrate on other, less immediate concerns. Recall from Chapter Three that foster families are expected to fulfill most of the functions that typical families meet. The most important functions for foster families to fulfill are daily care, economics, socialization, and education, but others such as affection and self-esteem are also crucial for effective placement. The significance of meeting family functions in foster families is discussed later in this chapter.

The Family Life Cycle

Just as individuals go through developmental life stages, all families go through predictable stages which, when added together in chronological order, are referred to as the family life cycle (Turnbull et al., 2006). The family life cycle begins when a couple gets married or establishes an independent residence. This stage is referred to as the “newly established couple stage” and ends when the couple has their first child. The family then experiences the “families of preschoolers stage,” the “families of primary school children stage,” and then the “families with adolescents stage.” Couples who do not have children (by choice or necessity) do not go through these stages and maintain a couple focus during these years. As children grow up and begin their own adult lives, the
family enters the “families in the middle years stage.” Finally, families experience the “aging families stage” during the retirement years, when health issues may be of concern (Lamanna and Riedmann, 2006).

When families move from one stage to the next, they experience a period of transition (Lamanna and Riedmann, 2006). Transitions bring uncertainty about the future as families move on to a stage they have never experienced before. In addition, families may experience additional stress when transitions come at unexpected times, such as an unplanned pregnancy or sudden death. Families that are high in adaptability (as discussed above) are better equipped to handle such stress. Foster parents often return to stages they have already completed if they choose to foster after their own children have left the house. These foster families, as well as other types of families, can exist in multiple stages as once.

Family systems theory helps explain how families are dynamic and ever changing. Families respond to their characteristics through interactions between members and subsystems and their levels of cohesion and adaptability. This interaction helps families meet their functions as they move through the stages of the family life cycle. It is important to understand each of the elements of family systems theory so that the impact of ODD on the family may be discussed. As mentioned above, one of the main concepts in family systems theory is that when one family member experiences a change, all family members are affected. The next section discusses how and why a child with ODD impacts different family members.
The Impact of Oppositional Defiant Disorder on the Family

It is clear that, from a family systems perspective, a child with ODD has a tremendous impact on family life. In addition to individual family members, ODD impacts the family as a whole. The family must readjust to the needs of the child with ODD, and as each individual member is affected, the family is, in turn, further impacted. This section discusses how a child with ODD impacts the parental subsystem and individual family members. Then, the reasons for these changes in family functioning are discussed.

Who is Affected by Oppositional Defiant Disorder?

Historically, only the child and the mother were considered to feel the influence of ODD, or any other disability (Seligman and Darling, 2007). However, with the rising popularity of family systems theory, other family members are now the focus of studies. A child with ODD touches all family members: parents, siblings, grandparents, aunts, uncles, and extended family members. This section discusses the impact of ODD on the parental subsystem and on individual mothers, fathers, and siblings.

The Parental Subsystem. All parental subsystems are influenced by parental characteristics as well as child characteristics. Parents develop their parenting styles based on their own values, ideas, and behaviors and the temperament, personality, or special needs of their children. A child with a disruptive behavior disorder influences parenting behaviors. While some parents are able to adjust their parenting styles to accommodate the needs of a child with ODD, many experience a decrease in positive parenting. A child’s ODD symptoms have been found to be related to parental
intrusiveness and negative discipline, parental social distress, and decreased parental warmth and positive involvement (Kashdan et al., 2004). This negative impact may be due to an impact on parents’ other relationships.

By definition, child ODD is a function of relationships with children and adult figures...Therefore, it is not surprising that ODD was significantly associated with parent-child relationships. However, the fact that ODD was significantly associated with parental distress suggests that ODD disrupts parents’ lives in other ways...these results are consistent with emerging awareness of the negative impact of child problem behaviors on parental mental health. (Kashdan et al., 2004, p.177)

Every aspect of a parent’s life is touched by a child with a disability (discussed in detail below), which can also influence a negative change in parenting style.

Children with ODD can also cause parents a lot of stress, and this stress can influence the interactions between parents and children.

Empirical evidence has consistently indicated that parenting stress has a tremendous impact on the parent-child system...Although all parents experience stress as their children develop, the presence of certain child-related factors (e.g., hyperactivity, defiance...can intensify stress levels at home...Unfortunately, if left untreated, prolonged parenting stress often increases a parent’s potential for child abuse and neglect (Ross and Blanc, 1998, p.93)

Of course, not all parents with high stress levels abuse or neglect their children, and not all abusive parents experience parenting stress. However, the correlations between ODD and parenting stress and parenting stress and abuse may contribute to the high incidence of ODD among children removed from their homes.

**Mothers.** Mothers carry “a disproportionate share of the emotional and material burdens” of having a child with school-related or behavioral problems (Dudley, Marling, 2000, p.83). Mothers of children with ODD experience a lot of stress associated with parenting and other aspects of their lives. The stress is magnified if the child has a dual
diagnosis of another disorder such as Attention Deficit Hyperactivity Disorder, Conduct Disorder, or another disruptive behavioral disorder (Ross and Blanc, 1998). One cause of maternal stress is that having a child with any disability can be confusing and frightening. One mother recounts how she felt just after her child was diagnosed with a disability: “I wasn’t sleeping. It consumes you when you are afraid, when you are so afraid for your kid. It consumes you and you feel so useless and there’s not anything you can do. Like we tried to do everything we could do…I was angry. I was scared. I was terrified” (Dudley-Marling, 2000, p.89). Studies have also shown that single mothers experience even more stress because they are treated differently and find the education system more difficult to navigate than married mothers (Dudley-Marling, 2000).

In addition to stress, mothers of children with ODD can experience high levels of depression. In fact, “Depressive symptoms are greater in mothers of children with disruptive behavior disorders…than in comparison to normal mothers” (Kashdan et al., 2004, p.169). One woman describes what it felt like to be defied by her son, Chris:

My son, though intelligent and articulate, was also very easily distracted and incapable of sitting still and staying on task. No matter what I asked him to do, his answer was a defiant, ‘No.’ He was verbally aggressive and yelled at me routinely. During his fits of rage, everything but the kitchen sink came out of his mouth. And every time, it felt like someone was putting a knife in my heart. (Kaplanek, 2002, p.28)

This depression may result from a feeling that the child’s behavior problems are her fault (Dudley-Marling, 2000). In addition, as mentioned above, parental depression and anxiety can negatively influence parent-child relationships. Therefore, mothers who experience depression and stress as a result of parenting their child with ODD may feel their relationship with that child is further deteriorated. Foster mothers would likely experience the same sense of stress and depression as biological mothers of children with
ODD. Further, foster mothers may even have a more difficult time parenting a child with ODD because they may not feel the biological connection that most natural mothers feel with their children and may already experience the stress associated with the difficulties of foster parenting (see Chapter Three).

**Fathers.** The impact of a child’s disability on fathers was not studied until very recently. Even now, there are few studies and they are flawed in several ways (Seligman and Darling, 2007). The most reliable research on fathers has explored the influence of general disability of a child, rather than ODD or other behavioral disorders in particular. This section examines the findings of those studies and applies them to fathers of children with ODD. In general,

> Fathers tend to be more concerned than mothers about the adoption of socially acceptable behavior by their children—especially their sons—and they are more anxious about the social status and occupational success of their offspring. As a result, fathers are more concerned about the long-term outcomes of their children with disabilities than mothers are, and they are probably more affected by the visibleness of the disability. (Seligman and Darling, 2007, p.223)

This worry can be very real for fathers of children with ODD. As discussed in Chapter One, children with ODD have trouble making and keeping friends and have difficulties with their interpersonal skills because their behavior can push others away from them. As a result, children with ODD are often socially rejected by their peers. Fathers of these children, especially if they are boys, may feel anxiety about their child’s long-term social status. Foster fathers may or may not have the same anxieties as biological fathers because they may not have the same investment in the child’s long-term outcomes. Additionally, fathers’ attitude toward children with disabilities set the tone for the rest of
the family (Seligman and Darling, 2007). For example, if fathers are more accepting, the
family is more likely to be accepting of a child’s disability.

**Siblings.** Siblings are also impacted by a child with ODD. One obvious way
siblings (and foster siblings) feel the burden of having a brother or sister with any
disability is that they may be required to provide care. This is especially so for older
siblings of children with severe disabilities (Seligman and Darling, 2007). Although
children with ODD may not seem like they need a lot of direct care, such as assistance
with feeding, bathing, or other daily care activities, they do tend to need constant
supervision, which is often provided by older children in the home. In addition, parents
may put additional pressure on their non-disabled children, have higher expectations for
them, or even take out their frustrations on them (Seligman and Darling, 2007; Dudley-
Marling, 2000). Further, studies have shown that siblings of children with disabilities,
particularly disruptive behavior disorders, also have trouble making and keeping friends
due to the stigma associated with disability. This can all cause children to feel angry or
guilty about their siblings with disabilities, which can cause tension within the sibling
subsystem (Seligman and Darling, 2007).

Younger siblings of children with ODD have slightly different reactions to the
disorder. Younger children are often confused about why a disabled sibling is different
from them, and may not understand all the information they are given about the disorder
(Seligman and Darling, 2007). Young children may also experience anxiety and stress if
parents are not able to spend one-on-one time with them due to the needs of their sibling
with ODD (Dudley-Marling, 2000). Foster siblings likely have the same issues as
biological siblings of children with ODD. Whether the sibling is a biological child of the
foster parents or another foster child in the home, he or she is still a member of the sibling subsystem and has to “compete” for parental attention.

Why Does Oppositional Defiant Disorder Affect Family Members/
Foster Family Members?

It should be clear from the above discussion that ODD has a variety of impacts on individual family members and an entire family as a whole. But why is that? All family members discussed above experience heightened levels of stress due to interacting with a child with ODD. Seligman and Darling (2007) discuss five categories of psychosocial stresses that are associated with childhood disability. The first type of stress is intellectual stress, which arises when family members receive information about the disability. They must try to understand the scope of the disability and learn about the causes, symptoms, and treatment options. Next, family members experience instrumental stress associated with the daily care and treatment for the child. This is the type of stress older siblings may feel when they have to supervise children with ODD, as mentioned above. Emotional Stress is the “response to the demands of caregiving that might include lack of sleep, loss of energy, and excessive worry and anxiety” (p.41). The fourth category of psychosocial stress is interpersonal stress, which involves tension between family members, professionals, friends, and others. This type of stress can make families of children with ODD feel isolated from their communities, which, in turn, creates more interpersonal stress for families. The final type of stress, existential stress refers to “the family’s ability to construct an explanatory meaning framework for its experience”
Families may reduce this type of stress by choosing to believe that it was “God’s will” that their child has a disability.

These psychosocial stresses can cause problems for families. Families who experience high levels of stress find it more difficult to fulfill their family functions. With both parents working, and children engaging in multiple extracurricular activities, along with societal pressures for success, today’s families find themselves busier than ever before. Behavioral and school-related troubles can intensify tension in already busy, over-burdened households and can cause fights between children and parents and among married couples (Dudley-Marling, 2000). Chris’s mother recalls the toll of stress caused by his ODD on family functioning:

Chris and I weren’t the only ones having a hard time communicating. The constant stress also took a toll on my relationship with my husband and my younger son. I yelled a lot, my husband was certain I was being an inappropriate mother, and Chris was confused about the level of respect between his mother and father. We were a family falling apart. (Kaplanek, 2002, p.28)

Chris has a very severe form of ODD. The severity of the disorder often determines the level of impact it has on the family (Turnbull et al., 2006). While children with mild ODD certainly cause family stress, families dealing with more disruptive behavior generally experience higher levels of stress.

When stress builds up in a family, it is possible for the family to experience a crisis. Raising a child with ODD can be seen as a stressor that can lead to a family crisis. Common stressors that precipitate a crisis include addition of a family member, loss of a family member, ambiguous loss (such as to divorce, army service, or foster care), sudden change, ongoing family conflict, caring for a dependent, ill, or disabled family member, demoralizing events, and daily family hassles (Lamanna and Riedmann, 2006). Families
with children with ODD, as well as foster families experience several of these stressors. When the stressors build up and become too much to deal with, families experience stressor overload. People don’t generally realize they are overloaded with stress, but an abundance of stress can lead to a crisis. A family crisis forces families to reevaluate their situation and readjust so they more effectively fulfill their family functions (Lamanna and Riedman, 2006).

There are certain characteristics that help families deal with crisis in an effective way. Families with a positive outlook, spiritual values and support groups, open and supportive communication, high levels of adaptability, informal social support, an extended family, and community resources are more likely to successfully tackle a crisis (Lamanna and Riedmann, 2006). Interventions for ODD that involve family members help families acquire these characteristics and avoid or get through family crises sparked by ODD. However, as discussed in Chapter Three, these interventions are not very accessible to foster families. The following section discusses the importance of home-based interventions for improving foster placement.

**Home-Based Interventions**

Home-based interventions are interventions that are, generally, carried out in the home and involve families in the intervention process. Of the perspectives on intervention reviewed in Chapter Two, Positive Behavior Support with Families, Parent Training, and Family Therapy are all home-based interventions. While some of these interventions may be carried out in a professional’s office, for the purposes of this project they are considered home-based interventions if parents are able to conduct therapeutic
practices in the home. Home-based interventions are significant for families of children with ODD because they work at restoring the family functions that are lost in the midst of crisis. Home-based interventions address the entire family system and work at returning the equilibrium for which all systems strive. They also assume that a child’s oppositional defiant behavior is both an input and output of the family system. Thus, the intervention is aimed at correcting both the behavior of the child and the functioning of the family.

As mentioned before, home-based interventions are difficult for foster families to implement for several reasons. A foster child can change placements quite often, and may not get the chance to bond with each family. Foster families may not feel involved in the child’s intervention or may not have enough time to contribute to the intervention. However, regardless of the time a child with ODD spends in a foster home, the foster family is likely to experience the stress associated with raising a child with ODD. This section discusses the importance of foster parents’ involvement in home-based behavioral interventions and the implications for maximizing the benefits of foster placements.

Foster Parent Involvement in Intervention

As discussed in Chapter Two, parental involvement is a key factor in the success of an intervention. A major reason is that parents form the bridge between children and professionals.

Parents, and especially parents of young at-risk or disabled children are likely to be the most stable influence in the lives of their children over the years. They will be the major persons helping to maintain a continuity of healthy experiences and needed professional services...Parents who feel empowered and believe in their right to be involved can have a positive impact on the professionals in the picture. (Fine and Gardner in Walsh and Williams, 1997, p.152)
While this quote refers to biological parents, it is also crucial to empower foster parents. Based on the length of placement, foster parents may or may not be “the most stable influence in the lives of their children over the years,” but they are likely to be small islands of stability in the tumultuous lives of children in the foster care system. Children with disabilities benefit greatly from having adults (teachers, parents, and professionals) who are willing to advocate for them and support them through evaluation and intervention (Turnbull et al., 2006). Involving foster parents in intervention empowers them to become advocates for children with ODD, who need all the support they can get, especially if they are living in out-of-home care.

It is also important to involve foster parents in intervention for ODD so that the family system, in addition to the child, benefits from intervention. As discussed in Chapter Three, foster parents are expected to maintain safe, healthy, and loving environments for their foster children. As a system, foster families are just as prone to stressor overload when raising a child with ODD, and thus should be considered in need of intervention to preserve family functioning. Just as home-based interventions can help typical families build resiliency against crises, they can equip foster families to better deal with the stress associated with raising a child with ODD. The implications of a foster family system’s ability to restore equilibrium and fulfill family functions are further discussed below.

**Implications**

It is imperative that foster families of children with ODD are able to restore healthy functioning so that the foster placement may be successful. This section revisits
two issues discussed in Chapter Three, the purpose of foster care and the special needs of children in foster care, and applies those issues to foster families raising children with ODD.

**The Purpose of Foster Care.** Chapter Three discusses two possible purposes of foster care. The first is that foster care exists to give biological families the chance to restore their own functioning and fix the problems that led to the removal of the child in the first place. The second is that foster care exists for the care and safety of the child. Foster family functioning is important for fulfilling both of these goals. In terms of the latter purpose, foster families are expected to provide loving and caring homes for children. In order to provide an adequate substitute home, foster families should fulfill the same functions as typical families. However, as discussed above, a crisis forces families to readjust so that they can better meet their family functions. Thus, if the foster parents and siblings are experiencing stress or a crisis in response to a child with ODD, they will not be able to meet those expectations. As discussed in Chapter Three, a successful foster care placement is one that places children in need with nurturing foster parents who are able to provide stability, safety, and affection. In order to ensure that children with ODD experience successful foster placements, foster families should be involved in home-based interventions so that they are better able to fulfill typical family functions.

Foster family functioning is also crucial for the fulfillment of the first purpose of foster care: to restore the functioning of the biological family. As discussed in Chapter One, ODD and family functioning form a reciprocal relationship. ODD causes family stress and may reduce functioning, while family dysfunction may contribute to the
development of the disorder. Families whose children have been removed are most likely vulnerable to stress and future crisis, and therefore returning a child with ODD who has not had successful intervention will likely upset positive changes a family has made. Since the success of an intervention is largely influenced by involvement of the family, it is important that foster families be involved in intervention, for the sake of the child, the foster family, and the biological family.

**The Special Needs of Children in Foster Care.** Recall from Chapter Three that children in foster care tend to have lower levels of mental health than the general population of children. Those children are often vulnerable to more serious psychological problems because they have often been neglected or abused. Appropriate and effective interventions for children with ODD can give them a better chance at avoiding even more serious psychological problems, having successful foster placements, and being reunited with their biological families (Urquiza et al. in Curtis et al., 1999). Further, as discussed in Chapters One and Two, early and effective interventions for children with ODD can improve their future. Since it is clear that involvement of the foster family is an important factor in the success of behavioral interventions, foster families who participate in intervention help to fill the special needs of their foster children. Thus, they can significantly improve the placement quality and give their foster children the opportunity for a better future.

Family systems theory provides insight into the lives of families of children with Oppositional Defiant Disorder. According to family systems theory, families are in a constant state of flux, where each member influences and is influenced by the others.
Families work to maintain equilibrium, and when that balance is threatened, they must reevaluate their lifestyles to restore stability. As a stressor that can upset family system equilibrium, ODD affects individual family members as well as the family system as a whole. ODD can therefore be an obstacle in the way of families fulfilling their essential family functions. While it is important for all families to fulfill these functions, a foster family’s ability to meet family functions has serious implications for the appropriateness of foster placement. Foster families must fulfill typical family functions, not only for the stability of their own system, but also so that they can better meet the needs of foster children and prepare the children to successfully return home. Thus, home-based interventions that involve families and give them the tools to restore functioning should be made available and accessible to foster families raising children with ODD.

Up until this point, this project has demonstrated the problems faced by children with ODD who are living in out-of-home care. These children exhibit behavior that can disrupt their own development as well as the functioning of their biological and foster families. The interventions that have been shown to be effective for ODD are difficult to implement for foster children because the nature of the system (including short placements, inconsistency, and lack of individual attention) make involving foster families in intervention, intervening in multiple systems, and providing consistency in intervention difficult to achieve. The conclusion of this project explores how to adapt interventions for children in foster care from three perspectives: psychology, education, and social work.
Conclusion:
Meeting the Needs of Foster Families of Children with Oppositional Defiant Disorder

Recall the stories of Kevin and Jessica earlier in this project. Kevin was the six-year-old with Oppositional Defiant Disorder and Jessica was the fourteen year old who had been in the foster care system for much of her life. While both of these children have difficult paths ahead of them, imagine what would happen if their situations coincided. Imagine what would happen to Kevin if his parents could no longer care for him and he entered foster care. Imagine how Jessica’s life may have changed if she had exhibited disruptive behavior. As many as 75 to 80% of children living in foster care have ODD or another emotional or behavioral disorder (Turnbull et al., 2006, p.32). However, there are virtually no existing intervention programs designed for foster children with ODD. As discussed in Chapter Three, the programs that have been found to be effective for treating ODD are largely inaccessible to foster families for three reasons: it is difficult to involve foster families in intervention, intervention in multiple systems is tricky, and foster placements often lack consistency that is necessary for the success of an intervention. Chapter Four discussed the impact of childhood ODD on the family system and explained the significance of involving families, especially foster families, in intervention. Foster families that are involved in intervention for a foster child with ODD improve the chances for successful intervention as well as the quality of placement.

But how can professionals involve foster families? How can interventions for ODD be made more accessible to children in out-of-home care? In this conclusion, several suggestions are made for adapting ODD interventions to make them more
effective for foster families. In order to successfully meet the needs of foster families raising children with ODD, the problems they face must be considered from several perspectives. Possible strategies from the perspectives of psychology, education, and social work are discussed below. An interdisciplinary approach to intervention, involving a partnership among these three perspectives, will be the best option for professionals working with foster families of children with ODD.

Psychological Perspectives

There are several issues concerning the psychological view of intervention for behavioral disorders. Traditionally, only the child with the disorder has been the focus of psychological therapy. While in recent years, the family has received more attention from psychologists and other mental health professionals, the focus remains on the individual (see Chapter Two). This is problematic considering the information discussed in Chapter Four, which explains that an intervention for ODD has a much better chance at success if the entire family system is involved. In addition, as discussed in Chapter Two, psychological interventions can take extended periods of time, even years in some cases. Children in foster care, who change placements multiple times and spend as little as a few days in each placement, do not have the opportunity to engage in long-term therapy. This section discusses these issues in more detail and proposes methods for overcoming them.

Foster families cannot benefit as much from interventions that focus only on the individual with the disorder. Foster family functioning can be damaged by the system’s reaction to the stresses associated with childhood ODD, and the foster family needs to be an additional target of intervention in order to improve foster placement quality.
However, psychological therapies for behavioral problems generally focus on the child with the disorder. The discipline of psychology has recently started to integrate the concepts of family systems theory into clinical practice. One such therapy is structural family therapy, which is actually based on family systems theory. The first task of the therapist is to gather information about the family through observation and interviews. Then, the whole family is involved in treatment. “An important goal of structural family therapy is changing the organization of the family in such a way that the family members will behave more supportively and less pathogenically toward each other” (Butcher et al., 2007, p.634). Structural family therapy recognizes that a child’s ODD is a family problem in addition to an individual problem. Therapeutic programs like structural family therapy can work more effectively in improving foster placement by intervening in both the child’s behavior and family functioning.

However, even if foster parents are targeted for intervention, they may be unwilling or unable to participate based on the short periods of time children spend in their home. While some foster children remain in one placement for several years, others can stay as little as a few days in each home. Psychological therapy can take weeks, months, or even years to complete. In addition, progress may be slow and interruptions in therapy (such as a placement change) can delay positive outcomes. The key for psychologists working with foster children with ODD is to adapt long-term therapies so that they can be more effective in short-term placements. This may involve making the intervention plan more flexible to accommodate the needs of foster families as well as integrating psychological therapy with educational and family interventions so that the effect of a short intervention may be more lasting. One way to accomplish this is to
include a child’s psychologist in all educational meetings. This would help facilitate communication among professionals to improve the chances of consistency in intervention. In addition, if the child changes schools, the psychologist may still be constant and be able to inform the new educators and help all involved professionals build a team.

There is one program from the perspective of psychology that may be effective for foster families. The Child and Adolescent Service System Program, sponsored by the federal government, involves a *partnership* between psychologists and families. “In this model, parents are acknowledged to be experts about, and advocates for, their children. Parental involvement has been encouraged through mutual support or self-help groups, joint service planning, and increased recognition by professionals of the constraints on families by their social and cultural environments” (Seligman and Darling, 2007, p.353). In addition, this program focuses on flexible service delivery designed to meet each family’s need. Foster families can benefit from the flexibility and parent-support aspects of this model. Foster parents may be more willing to engage in behavioral intervention if professionals acknowledge their contribution and support them through the process. The mutual support and self-help groups may also be attractive to foster parents, who may feel that they do not have enough social or professional support to dealt with a child’s disruptive behavior. By opening up to the concepts of family systems theory, as well as being flexible in method and timeline of therapy, psychological approaches to intervention may become more accessible to foster families. A psychologist who considers the perspectives of families and educators will be more likely to successfully intervene in the lives of foster families of children with ODD.
Educational Perspectives

Education is another area of a child’s life that may be interrupted by foster placement. Children may have to change schools when they change homes, and may have several teachers who may or may not be involved in behavioral intervention. This can contribute to the inconsistency that inhibits the efficacy of intervention. One way to increase consistency between placements and between home and school is collaboration.

Collaboration is a dynamic process in which educators, students, and families share their resources and strengths to solve problems in a creative and responsive way. Collaboration builds on the expertise, interests, and strengths of everyone involved in the educational process: students, parents...teachers, related service providers, paraprofessionals, school staff, administrators, and community members...The ultimate goal of collaboration is to improve teaching and learning so that all students, including those with exceptionalities, can progress in the general curriculum. By acknowledging that each of these people can participate meaningfully in problem solving, collaboration creates opportunities for each of these people to solve problems jointly. (Turnbull et al., 2004, p.80)

In a collaborative relationship, teachers, parents, children, and other people involved in the child’s case come together to solve problems. They communicate in order to ensure consistency across environments for children, which is especially important for children with behavioral disorders. For example, if at school children are expected to clean up their own workspaces while at home foster parents clean their rooms for them, children will be confused as to what is expected of them. Similarly, if the consequence for yelling at an adult at school is losing a thirty-minute recess period while at home it is a short scolding, children will not learn that the behavior is inappropriate as quickly as they would with a consistent consequence. Thus, effective collaboration is dependent on good communication between all parties involved.
One way to think about the relationship between teachers and parents (or foster parents) is presented by Holditch (in Dowling and Osborne, 1985). According to Holditch, teachers and schools fulfill much of the “parenting” role during school hours, and thus should be in line with the child’s natural or acting parents. All adults who act as parents of one child should be on the same page concerning that child. That way, expectations and discipline are consistent, improving the child’s chance for successful intervention. This is especially important for foster children, whose lives are often rife with inconsistencies. Another way to view collaboration is through family systems theory. The family system can be extended to include the school, and the school system can be extended to include the family. This can be achieved through the creation of trusting relationships between foster parents and teachers, as discussed below. Foster parents and teachers must view themselves as within the same system and must have their own parent-teacher subsystem in order to effectively collaborate (Johnston and Zemitsh in Walsh and Williams, 1997). Frequent meetings and telephone conferences can help foster parents and teachers keep each other informed about concerns, achievements, and new developments. Another form of communication that can be very useful for foster parents of children with ODD is a traveling notebook. Foster parents and teachers can write back and forth to each other daily and the notebook can even follow the child to a new home or school so that new foster parents and teachers are aware of the child’s past experiences.

Collaboration, however, is not an easy task. Turnbull et al. (2004) identify five practices that must be in place for successful collaboration:

1. **Face-to-face interaction among team members on a frequent basis**
2. A mutual “we are all in this together” feeling of positive interdependence
3. A focus on the development of small-group interpersonal skills in trust building, communication, leadership, creative problem solving, decision making, and conflict management
4. Regular assessments and discussion of the team’s functioning in setting goals for improving relationships and effectively accomplishing tasks
5. Methods for holding one another accountable for agreed-on responsibilities and commitments (pp.90-91)

These practices require large amounts of effort on the part of all involved. Members of the collaborative team, particularly teachers and foster parents, must be willing to devote the time and energy necessary to being equal members of the team. While this is not possible for all foster parents, especially if they have multiple foster children, it is important that they be as involved as possible. Some families, based on their interaction patterns and family boundaries (as discussed in Chapter Four) may not be open to collaboration. “Families vary in the degree to which their boundaries are open or closed to educators or any other nonmember. This affects how much the family will collaborate with educators or others. Some boundaries are porous; others are not” (Turnbull et al., 2006, p.30). The role of the caseworker (discussed in the next section) is key in assuming the role of parent and advocate on the collaborative team of a foster child with ODD.

It is important for members of a collaborative team to work together, rather than in opposition of each other. For example, educators should remember to focus on family strengths rather than weaknesses when addressing behavioral problems in school (Johnston and Zemitzch in Walsh and Williams, 1997). Families and schools should create partnerships where foster parents, children, teachers, and other professionals are all equal members in the relationship (Turnbull et al., 2006, emphasis added). Open and
honest communication between teachers and foster parents helps them to build trusting relationships. Educators should invite foster parents to every meeting concerning the child and encourage them to share their own concerns and ideas, regardless of the length of placement. Foster parents should feel comfortable asking questions and advocating for their foster children. To this end, both foster parents and educators must be sure to follow through on their responsibilities toward the child and intervention. This ensures commitment from all members and consistency in intervention across environments. Foster parents will be more willing to collaborate with teachers who acknowledge them as equal partners rather than people who, by law, are required to attend meetings. In addition, teachers will be more willing to collaborate with foster parents who are willing to act as partners by engaging in intervention both at home and at school. Foster children with involved foster parents and teachers have more consistency in intervention. Further, when foster parents and educators work together, the intervention has a better chance at addressing the needs of multiple systems, such as the family and the school. Thus, educational collaboration is an essential element in intervention for foster children with ODD.

**Social Work Perspectives**

From the perspective of social work, most issues for foster families of children with ODD arise because of a perceived inequality between social workers, teachers, and foster parents. This traditional view is referred to as the status inequality perspective (Seligman and Darling, 2007). Teachers believe they have more status than social workers, while social workers believe they have more status than foster parents. These
relationships then become focused on fulfilling what the person of highest status needs rather than on what the child needs. One foster mother, Lillian Rosebud, expressed her frustration at the relationship between foster parents and social workers:

They see you as a caretaker. The whole agency sees you as a temporary caretaker. You’re being paid to take care of that kid, feed ‘em, and clothe ‘em and that’s as far as it goes. You’re not supposed to love ‘em, not supposed to get attached to ‘em. If you get attached to the child and try to advocate on the child’s behalf, the department will step in and take that child out of there. (Wozniak, 2002, p.55)

This dynamic seems ironic considering that one purpose of foster care is to provide children with a loving, nurturing, albeit temporary, home when they cannot live with their natural parents. Regardless of the ideal, perhaps social workers and caseworkers become cynical of the goals of foster care when the placement change rate is so high, and children become stuck in the system. Whether most social workers look down on foster parents or not, when foster parents are hesitant to love a child for fear of separation, that child’s placement quality is compromised. In addition, in the case of foster children with ODD, parents who are afraid to become deeply involved in the lives of those children will be unwilling to participate in intervention, thereby decreasing the efficacy of treatment.

It is clear that the status inequality perspective is not only outdated, but also detrimental to foster families and children (with or without ODD). In some areas, the perspective of social work is shifting to a partnership model, much like the one advocated above. When social workers, biological parents, and foster parents, as well as teachers, psychologists, and other professionals work together as partners, the child’s support is magnified and chances for successful intervention (and a successful future) are increased. Some social workers are going even beyond creating partnerships with families.
A major component of newer, social system approaches in social work has been the concept of empowerment…based on a number of underlying principles including the following:

- People empower themselves: social workers should assist
- Social workers should establish and “I and I” (partnership) relationship with clients
- Social workers should encourage the client to say her own word (and not use the language of the oppressor)
- The worker should maintain a focus on the person as a victor and not victim
- Social workers should maintain a social change focus (Seligman and Darling, 2007, p. 351)

Empowering foster families in this manner not only encourages them to participate in intervention, it also gives them the tools to effectively advocate for themselves and their foster children.

Just as it is important for educators to focus on child and family strengths when creating partnerships, social workers should also avoid language and practices that emphasize and reinforce child and family weaknesses. Sometimes, even being considered a “client” can damage a foster family’s morale, and may even discourage them from seeking help. One way to focus on family strengths is for social service agencies to provide support to families before they encounter problems (Seligman and Darling, 2007). For example, community centers, agencies, and hospitals can offer parenting classes geared towards foster parents so that they are equipped to deal with some of the problems that may arise. In addition, an increase in foster parent training and support groups (as discussed in Chapter Three), especially for foster parents raising children with ODD and other disruptive behavior disorders, would connect foster parents with each other and enable them to share ideas and resources. Although these programs may be expensive, they would be good investments as they would eventually decrease foster parent dependency on social services during difficult placements. This model
would benefit all foster families, but especially those who foster children with special needs. If a foster family of a child with ODD receives support from the beginning, they will probably be more likely to participate in intervention and be able to handle the stresses of parenting a child with disruptive behavior. Further, if social service agencies provide support to at-risk families before they exhibit problems that warrant the removal of a child, the need for foster care could decrease. Thus, positive family support from social service agencies would benefit children, biological families, and foster families.

What is the role of the social worker in all of this? First of all, the social worker (or caseworker, in some instances) is an indispensable member of the collaborative team. As mentioned above, the social worker often takes on the role of “parent” in educational or intervention-focused meetings. When a child has not spent extended time with any set of foster parents, the social worker’s involvement is even more important. In fact, for foster children, the social worker is often the most permanent fixture in their lives. This is complicated, though, by the high turnover rate of caseworkers discussed in Chapter Three. Foster children may go through caseworkers as quickly as they go through foster homes. However, it is the duty of the social worker to engage in the child’s life, which, for children with ODD, includes intervention. When foster parents are unable or unwilling to cooperate in intervention, it is the responsibility of the social worker to assume the parenting role and collaborate with educators to represent the child’s family system (Holditch in Dowling and Osborne, 1985). Additionally, social workers have responsibilities toward families and foster families. The role of the social worker is to support parents and foster parents in their parenting role and to guide the parenting of children who come in contact with social services (Holditch in Dowling and Osborne,
Another important task belonging to the social worker is to facilitate collaboration by teaching foster parents and educators how to communicate with one another. Effective communication is essential for abandoning status inequalities and embracing partnerships.

Recall the three elements of intervention discussed at the end of Chapter Three: parent involvement, intervention in multiple systems, and consistency in intervention. In general, due to the long periods of time spent away from natural parents coupled with the short-term placements in foster homes, foster children with ODD do not have access to those elements that increase the success of behavioral intervention. Without early and proper intervention, children with ODD are at risk for future psychological and social problems including Conduct Disorder, delinquency, and criminality. Children in foster care are already at risk for future problems, as are children with ODD. When the two circumstances occur in the same child at the same time, that child is even more vulnerable. Further, disruptive behavior can cause a lot of family stress, and foster families raising children with ODD are vulnerable to stressor overload that may lead to a family crisis. A family in crisis is unable to fulfill all of its functions, which, for foster families, decreases the quality of placement for both family and child. In order to avoid crisis, foster families must be given tools to better handle the stress associated with raising a child with ODD. One way to achieve this is for foster families to be involved in behavioral intervention. With short-term placements and professionals who view them as caretakers rather than parents, though, foster families are not able to fully participate in existing interventions.
There is hope for foster children with ODD and their foster families, however. From the perspectives of psychology, education, and social work, it is clear that the first step towards meeting the needs of these families is to create partnerships between all individuals involved. In these relationships, each member is an equal partner with valid concerns and opinions. In order for partnerships to be created, family systems theory must be applied to the child’s situation and expanded to include every professional involved in the child’s life. Effective communication between all members is crucial for creating collaborative relationships. Professionals in the fields of psychology, education, and social work are beginning to realize they must cross the disciplinary boundaries in order to effectively serve all clients and families. However, full collaboration based on equal partnerships between all professionals, families, and children is essential for foster families of children with ODD. Once such partnerships are established, interventions for ODD will be more accessible to foster children and their families. When foster parents are empowered partners in children’s lives, they will be more able and willing to participate in intervention. Partnerships among foster families, educators, and social service professionals will help the intervention cross into multiple systems including the family, school, and social systems to which the child belongs. Collaboration among equal partners is essential for ensuring consistency in intervention, which makes the outcomes of intervention stronger and longer lasting. Further, such partnerships will help foster families build resiliency against possible crises and will restore foster family functioning for the benefit of the family and the child. Equal, collaborative partnerships are the vital first steps towards initiating a better future for foster children with ODD.
Glossary

Adaptability- The family’s capacity to change in response to shifts in the surrounding environment.

Antisocial Personality Disorder (APD)- A personality disorder characterized by “a pervasive pattern of disregard for and violation of the rights of others” (American Psychiatric Association, 2000).

Anxiety Disorder- Characterized by “excessive and hard to control worry and anxiety occurring persistently...There may be associated tension, fatigue, insomnia, and impaired concentration” (American Psychiatric Association, 2000).

Applied Behavior Analysis (ABA)- A behavioral intervention based on operant conditioning, modeling, and shaping.

Attention Deficit Hyperactivity Disorder (ADHD)- A disorder, primarily diagnosed during childhood, that is characterized by varying levels of inattention, hyperactivity, and impulsivity (American Psychiatric Association, 2000).

Behavior Rating Scale- An assessment tool that allows professionals to compare individual behavior with typical, age-appropriate behavior.

Behavioral Observation- An assessment strategy in which professionals observe individual behavior in multiple settings.

Clinical Interview- A formal interview between a professional and an individual used to assess the individual’s psychological state (see diagnostic interview).

Clinical Significance Criterion- The requirement in the DSM that symptoms must significantly distress or impair the patient to warrant a diagnosis.

Clinical Utility- The usefulness of a particular tool in clinical decision-making.

Cognitive-Behavioral Therapy (CBT)- A child-focused intervention based on the cognitive-behavioral perspective in which children learn to conceptualize events in ways that will produce prosocial behavior and think about the ways they interact with others and identify their own interactions as effective or ineffective.

Cognitive-Developmental Treatment (CDT)- Focuses on developing emotional regulation skills, addressing pre-existing beliefs that poor behavior is appropriate and adaptive, improving social problem-solving skills and motivation, enhancing children’s perceptions of efficacy and control, addressing pre-existing beliefs that others are unreliable, punitive, and uncaring, and improving the quality of the parent-child relationship.
**Cohabitation**- The practice in which sexual partners (with or without children) live together without being married.

**Cohesion**- The level of family members’ emotional closeness (enmeshment) to each other or independence (disengagement) from one another.

**Collaboration**- A practice in which educators, students, families, and professionals combine resources and ideas to solve problems in new, innovative ways.

**Comorbidity**- The simultaneous occurrence of more than one disorder in an individual.

**Conduct Disorder (CD)**- “A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated” (American Psychiatric Association, 2000).

**Contingency Management**- An intervention based on the assumption that behavior problems arise, in part, because of the child’s inability to modulate his own behavior; operant procedures are implemented to help the child learn what is appropriate and how to control his own behavior.

**Diagnostic and Statistical Manual of Mental Disorders (DSM)**- A handbook published by the American Psychiatric Association used by professionals.

**Diagnostic Interview**- A formal interview between a professional and an individual used to assess the individual’s psychological state (see clinical interview).

**Disruptive Behavior Disorder**- A blanket term for disorders including Oppositional Defiant Disorder, Conduct Disorder, and Attention Deficit Hyperactivity Disorder.

**Extended Family Subsystem**- Describes the interactions between members of the nuclear family, other relatives, and others who are considered family, such as friends, teachers, or other professionals.

**Externalizing Behaviors**- Behaviors that include being disruptive, delinquent, and harmful to others.

**Family (Nonrelative) Foster Care**- An arrangement in which foster children live in a private family home belonging to people who are not related to them.

**Family Systems Theory**- Views families as being made up of interdependent individuals who cannot be understood outside the context of the family (see full discussion in Chapter Four).

**Family Therapy**- An intervention that involves the entire family and is aimed at increasing family cohesion and adaptability.
**Foster Care**- A general term that refers to children living out of their biological or natural home in a group home or private family home (see out-of-home care).

**Foster Parent Training**- Offered by some agencies to foster parents before and/or during placement to teach parenting and coping skills.

**Helping the Noncompliant Child (HNC)**- A parent training program developed by McMahon and Forehand (2003) in which parenting skills are gradually shaped through teaching, practice, and generalization.

**Home-Based Intervention**- Interventions that are, generally, carried out in the home and involve families in the intervention process.

**Individuals with Disabilities Education Improvement Act (IDEA)**- The U.S. law that mandates special education services for eligible children with special needs.

**Internalizing Behaviors**- Behaviors that are harmful to the person exhibiting them, but are not harmful to others, including disordered eating, self-injury, and depressive behaviors. These behaviors are usually a result of individuals focusing stressful responses on themselves.


**Kinship (Relative) Foster Care**- An arrangement in which foster children live with relatives such as grandparents, aunts and uncles, or adult siblings.

**Launched**- Adult children who have left their parents’ home.

**Marital Subsystem**- Describes the interactions between husband and wife, same-sex partners, or a cohabiting couple.

**Modeling**- Demonstration of behavior to encourage mimicry.

**Mood Disorder**- A category of psychological disorders affecting a person’s mood; includes depressive disorder, bipolar disorder, and disorders caused by substance abuse.

**Multisystemic Treatment (MST)**- combines strategies from family therapy, behavioral parent training, and cognitive-behavioral therapy to address interpersonal, familial, and social factors that are known to contribute to the development of ODD and other behavioral disorders in children.

**Non-traditional Family**- Refers to any family that does not consist of one mother, one father, and their children.
Operant Conditioning- A learning process in which the learner learns to associate particular behaviors with their consequences, and as a result will either repeat the behavior (reinforcement) or not repeat the behavior.

Oppositional Defiant Disorder (ODD)- A disruptive behavior disorder characterized by defiant, disobedient, and hostile behavior (see Chapter One for a full description).

Out-of-home Care- A general term that refers to children living out of their biological or natural home in a group home or private family home (see foster care).

Parental Subsystem- Describes the interactions between parents and their children.

Parent Management Training (PMT)- An intervention designed to teach parents how to develop and implement structured contingency management programs in their homes.

Positive Behavior Support (PBS)- An intervention that makes use of assessment to make hypotheses about the function of inappropriate behavior and operant procedures to go about changing behaviors

Psychoanalytic Treatment- Therapy, based in psychoanalytic theory, that focuses on the cohesion of the self, which allows the development of resiliency to help children deal with stressors in an adaptive and appropriate manner with a goal of psychic growth rather than behavioral change.

Psychotic Disorder- A category of psychological disorders involving delusions, hallucinations, and a general disconnect from reality.

Punishment- A consequence designed to discourage undesired behavior.

Reinforcement- A consequence designed to encourage desired behavior.

Residential Group Foster Care- An arrangement in which foster children live in group homes staffed by professionals.

Resiliency- The quality of a family or individual that enables them to avoid or survive a crisis.

Reunification- The goal of foster care; when children are allowed to return to their families of origin.

Screening- The process in which child welfare agencies determine individuals’ or couples’ ability to be appropriate foster parents.

Shaping- Reinforcement of successive approximations to a desired behavior.
**Shared Family Foster Care**- An arrangement in which whole families live with foster families in order to provide support and healing while maintaining children’s ties with their families of origin.

**Sibling Subsystem**- Describes the interactions among children in the family.

**Stressor Overload**- A buildup of stressors including addition of a family member, loss of a family member, ambiguous loss (such as to divorce, army service, or foster care), sudden change, ongoing family conflict, caring for a dependent, ill, or disabled family member, demoralizing events, and daily family hassles that lead to family crisis.

**Structural Family Therapy**- A type of family therapy based in family systems theory that focuses on reorganizing the family to heal interactions.

**Therapeutic Foster Care**- An arrangement in which foster children with severe behavioral, psychological, physical, or health problems live with adults who have been specially trained and licensed to meet their special needs; sometimes considered an intervention option for children who would not otherwise be removed from their homes.
References


