Oppositional Defiant Disorder

A Developmental and Clinical Perspective

By

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Preface

During the course of development, some children may exhibit more intense, resistant, stubborn, or authority-sensitive behavior than others. Particularly those described as "stubborn," "disobedient," or "oppositional" often pose significant challenges for both parents and educators. When these behaviors exceed the bounds of ordinary developmental patterns, the diagnosis of *Oppositional Defiant Disorder* (ODD) may be considered, requiring a thorough evaluation of the child.

This book aims to facilitate the understanding, assessment, and development of effective approaches for children with oppositional defiant disorder. In addition to presenting a diagnostic framework, it offers a practical roadmap filled with scientifically grounded strategies that are both applicable and accessible to parents.

At the heart of this book lies a fundamental principle: a child's behavior can be changed and transformed. What is required is accurate knowledge, a patient approach, and evidence-based intervention tools. Within this framework, the book explores the underlying dynamics of behaviors such as stubbornness, anger, defiance of limits, constant arguing, and resistance to authority. It also offers qualified and sustainable recommendations on how to set healthy boundaries, teach emotional regulation, and structure functional limits within the family context. Furthermore, the book includes real-life case studies, designed to help readers internalize theoretical knowledge while gaining insight into how to respond to situations they may encounter in practice. Each case study provides an analysis of the child's behavioral patterns, suggested

interventions, and the transformation achieved over the course of treatment.

Stubbornness and defiant behavior are often a child's way of calling for help. These behaviors may reflect unexpressed needs that the child cannot yet articulate verbally. For this reason, the appropriate response is not one of punishment, suppression, or control—but rather an understanding, guiding, and boundary-setting approach that fosters growth. This book serves as a guide for parents, teachers, and professionals in the field of child mental health, with the goal of supporting this constructive approach.

We hope that, through the insights provided in this book, many children will continue their development as more peaceful, functional, and socially healthy individuals. Parents, in particular, will see that it is indeed possible to set limits, maintain discipline, and foster mutual understanding without harming the bond they share with their children.

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Introduction

Childhood is a developmental period in which individuals strive to gain autonomy, establish their identity, and define boundaries in their interactions with the surrounding environment. During this process, behaviors such as stubbornness, temper tantrums, and occasional aggression may be observed in children. However, not all such behaviors indicate a psychopathological condition. What truly matters is the frequency, severity, duration, context, and the impact on the child's functional capacity. Therefore, it is essential to distinguish between Oppositional Defiant Disorder (ODD) and developmentally normative stubborn or transient aggressive behaviors.

Oppositional Defiant Disorder is an externalizing behavioral disorder that typically begins in childhood or adolescence and is characterized by persistent defiance, anger, argumentativeness, and resistance to authority figures. Behaviors associated with ODD can be interpreted as pathological expressions of otherwise typical developmental processes, such as striving for autonomy and testing limits, which become maladaptive due to insufficient support from emotional and social regulation skills (Dodge et al., 2022).

ODD usually begins in childhood or early adolescence and is marked by oppositional attitudes toward authority figures, frequent arguing, resistance to rules, and deliberate provocation. These behaviors affect not only the individual but also disrupt the functionality of the family, teachers, and broader social environment. The disorder frequently co-occurs with Attention-Deficit/Hyperactivity Disorder (ADHD), Conduct Disorder (CD), and anxiety disorders (Waller et al., 2021).

As classified by the American Psychiatric Association in the DSM-5-TR, ODD can significantly impair a child's or adolescent's functioning at home, at school, and in social environments, thereby adversely affecting both the individual's developmental trajectory and interpersonal relationships (American Psychiatric Association, 2022).

In educational settings, ODD manifests as a difficulty in adhering to classroom rules, frequent challenges to teacher authority, and behaviors that disrupt the learning environment. Poorly defined classroom boundaries and inappropriate teacher responses can further exacerbate the severity of the disorder (Martel et al., 2021).

Symptoms of ODD typically emerge in the preschool years and evolve into more complex behavioral patterns over time. Core manifestations include constant arguing, intentionally annoying others, persistent rule-breaking, and blaming others for one's own mistakes (Waller et al., 2021). Clinical findings indicate that ODD is more prevalent among boys; however, the gender gap tends to narrow during adolescence (Ghandour et al., 2023).

From a developmental psychopathology perspective, ODD is understood not merely by the presence of symptoms but through their progression over time, interaction with contextual factors, and individual differences (Dodge et al., 2022). Indeed, ODD may serve as a precursor to more severe psychiatric conditions such as Conduct Disorder or Antisocial Personality Disorder in later life. In this context, early diagnosis and intervention are crucial both for enhancing the quality of life of the individual and for reducing the long-term social and economic burden.

Recent neuroscientific studies have revealed that children with ODD often exhibit significant difficulties in executive functioning

and emotional regulation. Functional differences observed in brain regions such as the prefrontal cortex and amygdala contribute to a deeper understanding of the neurobiological mechanisms underlying the disorder (Beauchaine et al., 2020). Moreover, stressors in the school environment, peer relationship problems, and the influence of digital technologies necessitate a renewed contemporary examination of ODD (Martel et al., 2021).

This book aims to provide a comprehensive overview of Oppositional Defiant Disorder from developmental, clinical, familial, and educational perspectives. It seeks to present effective assessment and intervention strategies for children, families, and professionals. By incorporating up-to-date research, real-life case examples, and evidence-based practices, the book aspires to enrich the reader's theoretical knowledge and practical competence alike.

Chapter 1

The Scope of Oppositional Defiant Disorder

Abstract

Oppositional Defiant Disorder (ODD) is an externalizing behavioral disorder observed during childhood and adolescence, characterized by persistent patterns of anger, defiance, argumentativeness, and vindictiveness. While the DSM-5 and ICD-11 classifications share similar core diagnostic criteria, there are certain distinctions in their evaluative approaches. In diagnosis, the persistence, severity, and functional impairment caused by symptoms are taken into account, and it is also clinically important to differentiate ODD from other behavioral disorders and to identify potential comorbidities.

Differentiating ODD from other externalizing disorders—particularly Conduct Disorder (CD) and Attention-Deficit/Hyperactivity Disorder (ADHD)—is essential for accurate diagnosis and effective intervention. Differential diagnosis is based on the distinctive features of symptoms and their developmental appropriateness, whereas comorbidity refers to the co-occurrence of multiple disorders, which plays a crucial role in shaping individualized treatment planning.

In the assessment process, standardized rating scales such as the *Child Behavior Checklist (CBCL)*, *Oppositional Defiant Disorder Rating Scale (ODDRS)*, and *Disruptive Behavior Disorder Rating Scale*

(DBDRS) play a significant role. These tools enable the objective identification of the severity and patterns of ODD symptoms by integrating data from multiple informants, including parents, teachers, and the child themselves.

A Case Study

Can is a child raised in a nuclear family with a middle socioeconomic status. His mother is a stay-at-home parent, while his father works irregular shifts in a factory. The communication style within the family is predominantly directive and interrogative. The mother reported that Can has been "stubborn" since early childhood but stated that his behavior has become "completely unmanageable" over the past two years. Mother's statement: *"He constantly opposes me. Whatever I say, he does the opposite. He hits his younger sibling, and when I tell him to apologize, he gets even angrier."*

His teacher reported that Can frequently disrupts the classroom, refuses to follow instructions, and engages in loud verbal arguments with the teacher. Teacher's statement: *"He refuses to collaborate during group activities. He wants to be the leader but does not follow the rules. He especially struggles with authority figures."*

During clinical observation sessions, Can displayed behaviors indicative of a strong need for control. He avoided eye contact when reminded of rules and often responded with verbal defiance. At the beginning of one session, he stated: *"I do whatever I want here; no one can force me."* He rejected game rules and resisted participation. His behavior was assessed not merely as reactive, but as part of a deliberate pattern of opposition.

Behavioral assessment tools indicated that Can's externalizing problem scores were at the clinical level, with prominent issues related to rule violations and aggressive behaviors. Based on DSM-5-TR criteria, a diagnosis of Oppositional Defiant Disorder (ODD) was made. The pervasiveness of his behavior at both home and school, chronic defiance of authority, rule-breaking, blaming others, poor anger regulation, and the persistent nature of his symptoms supported the diagnosis.

The intervention plan included initiating parent education based on positive parenting principles, focusing on consistent limit-setting, positive reinforcement, and avoidance of punitive responses. In individual sessions with Can, emotional regulation skills were targeted through anger management, social problem-solving, and cognitive-behavioral techniques. A collaboration was established with his teacher to implement a classroom observation form and a reward system based on prosocial behaviors.

After three months of intervention, Can showed a significant reduction in classroom outbursts, developed a more cooperative relationship with his teacher, and experienced fewer crises at home. His mother reported that Can apologized for the first time and began expressing his emotions more openly. Throughout the process, support was provided to the child, parents, and school personnel, resulting in a positive transformation in his behavioral patterns through early and comprehensive intervention.

1.1 The Scope of Oppositional Defiant Disorder

Oppositional Defiant Disorder (ODD) is one of the most common behavioral disorders observed in childhood. It can manifest with varying degrees of severity from the preschool period through

adolescence. Characterized by persistent arguments with authority figures, refusal to follow rules, deliberate annoyance of others, and avoidance of responsibilities, ODD is a significant mental health condition that impacts not only the individual but also the psychosocial functioning of family members, teachers, and peers.

As illustrated in the case of Can, such behavioral patterns in children not only intensify intrafamilial conflicts but can also lead to decreased academic performance, deteriorated teacher–student relationships, and increased social isolation. Can's consistent oppositional behaviors both at home and at school, frequent confrontations with authority figures, and difficulty in regulating anger reflect the disruptive impact of ODD on individual functioning.

The scope of ODD is not limited to children with a formal clinical diagnosis. Recent research has shown that even subclinical levels of oppositional behavior can significantly affect school achievement, social adaptation, and mental well-being. Factors such as increased screen exposure, poor family communication, inconsistent parenting styles, and stressful life events have been identified as significant risk contributors to the prevalence of this disorder (Brislin et al., 2023). Additionally, post-pandemic increases in behavioral regulation problems and authority conflicts have rendered this issue more visible at the societal level (Martel et al., 2021).

From a societal standpoint, early recognition and intervention for ODD are of critical importance. Without timely diagnosis, children with ODD are at increased risk of developing more severe psychiatric conditions in later life, such as Conduct Disorder and Antisocial Personality Disorder (Waller et al., 2021). Therefore, it is essential that the boundaries between developmentally normative

behaviors like stubbornness or anger and those reaching clinical levels be carefully evaluated by professionals.

As in Can's case, well-structured early interventions can positively alter the child's behavioral repertoire, strengthen family relationships, and support healthier social interactions. However, such transformation requires strong collaboration among parents, teachers, and clinicians, as well as a holistic understanding of the child's individual characteristics and environmental context.

ODD is a condition of significant relevance for both individual development and public mental health. Its rising prevalence necessitates not only effective treatment but also the expansion of preventive services, the dissemination of parental support systems, and the enhancement of educators' behavioral awareness. In childhood, ODD most notably disrupts the child's social, emotional, and academic development. Persistent rule-breaking, arguing with teachers, and engaging in peer conflicts hinder learning and social relationships. These children are at risk for school exclusion, stigmatization, peer victimization, or even perpetrating bullying. Such behavior patterns beginning in early childhood substantially increase the risk of progression to Conduct Disorder in later stages (Rowe et al., 2021).

Among adolescents with ODD, risk-taking behaviors may become more prominent. Adolescence is a critical period marked by emotional upheaval and identity exploration, during which behaviors such as substance use, school dropout, delinquency, and domestic violence may emerge. ODD can shape the adolescent's relational style through impulsivity and hostile attribution biases, often leading to conflicts with teachers, parents, and even legal

authorities. Peer isolation, emotional instability, and depressive symptoms are also common in this period (Pardini & Fite, 2019).

When left untreated, ODD can persist into adulthood, manifesting in maladaptive personality patterns and antisocial behavior. Adults with a history of ODD often present with Antisocial Personality Disorder, substance dependence, unstable work and family relationships, low emotional empathy, and high aggression levels (Burke et al., 2010). These individuals are prone to legal problems, difficulties in fulfilling social responsibilities, and persistent interpersonal conflicts. The course is especially risky among male individuals (Frick & Nigg, 2012).

From a developmental psychopathology perspective, the trajectory of ODD has the potential to influence not only the life of the individual but also that of the family, peer groups, and the overall psychosocial well-being of the community. Therefore, early identification of this disorder in childhood, psychoeducational support for parents, teacher involvement, appropriate therapeutic approaches, and preventive mental health services are of paramount importance.

1.2 Diagnosing Oppositional Defiant Disorder

Oppositional defiant disorder is a behavioral pattern in which there are no significant violations of social rules or the rights of others, but there is a persistent, negative, hostile, and oppositional attitude. There is a negative attitude toward adults, defiance, disobedience, noncompliance, disturbance, and verbal aggression. These attitudes are mostly observed in the home environment and especially in the child's relationships with adults or peers they know well (Rowe et al., 2021).

According to the DSM-5, the diagnosis of oppositional defiant disorder is determined by identifying at least four behaviors from three behavioral clusters that persist for at least six months (APA, 2022):

a – anger/irritability,

b – argumentative/defiant behavior,

c – vindictiveness

Symptoms must be evident in at least one setting such as home, school, or social environments and must impair the individual's functioning. Typical behaviors include frequent temper outbursts, defying rules, challenging authority, deliberately annoying others, and blaming others. General characteristics:

- Oppositional Defiant DisorderThey do not see themselves as defiant; they blame others for their own mistakes.
- Oppositional Defiant DisorderThey are easily annoyed and have a sensitive disposition.
- Oppositional Defiant DisorderIt generally begins before the age of 8 and continues until the end of adolescence.
- Oppositional Defiant DisorderThis disorder is more common in boys than girls before adolescence, but equalizes after adolescence.
- Oppositional Defiant DisorderSymptoms are similar in both genders, but behaviors are more overt and frequent in boys and tend to be more persistent.
- Oppositional Defiant DisorderThey see their oppositional behaviors as justified and appropriate responses.

> Oppositional Defiant DisorderConflicts with others are aimed at gaining control (Wakschlag et al., 2018).

The diagnostic process of oppositional defiant disorder requires a multidimensional assessment that considers not only observed behaviors but also their persistence, context, severity, and impact on the child's functionality. One of the main reference sources in diagnosis, DSM-5-TR (American Psychiatric Association, 2022), classifies oppositional defiant disorder under three subheadings:

In general terms, oppositional defiant disorder is a disruptive behavior disorder characterized by negative, hostile, provocative, defiant, and disruptive behavior patterns without violating social norms or the basic rights of others. In DSM-5, it is classified under the title "Disruptive, Impulse-Control, and Conduct Disorders," and eight symptoms are grouped into three categories: mood, behavior, and vindictiveness.

1. Mood: This group includes problems particularly related to emotional control and regulation. For example, intermittent explosive disorder is characterized by severe temper outbursts.

2. Behavior: This group includes disorders where there are problems in interactions with others and compliance with social rules. Conduct disorder, oppositional defiant disorder, and antisocial personality disorder are included in this group.

3. Vindictiveness: This group includes behaviors resulting from an inability to control impulsive actions. Disorders such as pyromania (urge to set fires) and kleptomania (urge to steal) are in this group.

At least four of these behaviors must be observed consistently with at least one person (excluding siblings) for at least six months. Additionally, these behaviors must negatively impact the child's social, academic, and interpersonal functioning.

When evaluating oppositional defiant disorder, factors such as the child's early temperament characteristics, attachment history, family history, trauma history, environment (in which environments is it more common?), and school process (teachers' views) should be taken into consideration (Figure 1).

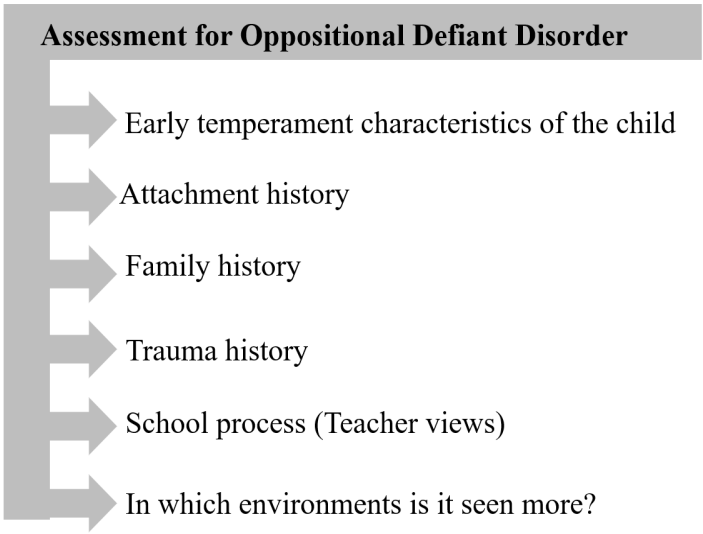

Figure 1 *Features taken into consideration in the assessment of oppositional defiant disorder*

In the diagnosis of oppositional defiant disorder, the child's possible traumatic experiences (neglect, abuse, divorce, losses, migration, disaster experience, etc.) should be thoroughly questioned, and how these events affect the child's behavioral patterns should be analyzed in a multidimensional manner. The environments in

which behavioral symptoms emerge more intensely (e.g., only at home, only at school, or in both settings) are determinative in terms of assessment. In addition, the frequency, severity, and persistence of the behavior, how disproportionate it is to the child's developmental age, and the impact of the symptoms on the child's academic, social, and family functioning should also be analyzed in detail. In addition to these, the school process should be evaluated, particularly through teacher observations. Information such as how the teacher defines the child in the classroom, what types of difficulties the child experiences in group relationships, and to what extent the child complies with the rules supports the diagnostic process. When necessary, the opinions of the guidance service, school psychological counselor, and special education specialists should also be obtained.

The evaluation should not only focus on the symptom level; it should also be addressed together with contextual variables such as the child's psychosocial environment, family dynamics, parental consistency, understanding of discipline, and modeled behaviors. This holistic approach both reduces the risk of misdiagnosis and facilitates the determination of appropriate intervention strategies, ensuring early intervention (Wakschlag et al., 2018). The assessment steps in the diagnosis of oppositional defiant disorder are summarized in Table 1.

Clinical Interview and Anamnesis	The child's family history, the initial onset of problematic behaviors, their frequency, context, and progression over time are thoroughly explored. Information is obtained from the family and, if possible, from the teacher. Parents are evaluated in terms of their disciplinary strategies, boundary-setting styles, and patterns of family interaction.
Observation	The child's behaviors are directly observed across different settings. Particular attention is paid to therapeutic play sessions, where the child's attitude toward rules, responses to authority, and emotional regulation are recorded.
Behavioral Rating Scales	Structured instruments are used to support the diagnostic process, including: • CBCL (Child Behavior Checklist) • TRF (Teacher Report Form) • DBDRS (Disruptive Behavior Disorders Rating Scale) • SNAP-IV – Oppositional/Defiant Subscale These tools enable the collection of quantitative data based on both parent and teacher reports.
Clinical Differential Diagnosis	ODD frequently co-occurs with other disorders. Therefore, differential diagnosis is critical in the assessment process. Conditions to consider include: • ADHD (Attention-Deficit/Hyperactivity Disorder) • Conduct Disorder • Anxiety Disorders • Autism Spectrum Disorder • Post-Traumatic Stress Disorder For instance, impulsivity is more prominent in ADHD, whereas ODD involves more systematic defiance toward authority. In conduct disorder, rule violations are more severe and often involve violation of the rights of others.
Context Dependence and Generalization	Behaviors that occur exclusively at home or only at school are not sufficient for diagnosis. It is important that the behaviors be observed consistently across multiple settings. Additionally, whether the behaviors are disproportionate to the child's developmental level must be evaluated.
Developmental Perspective	The degree to which behaviors align with developmental norms should be considered during diagnosis. Particularly during early childhood and adolescence—periods where boundary testing is developmentally expected—the intensity and disruptive impact of the behavior must serve as the primary criteria for evaluation.

Table 1 *Evaluation steps in the diagnosis of oppositional defiant disorder*

The diagnostic process of oppositional defiant disorder is not merely limited to the classification of the child's externalized symptoms. The assessment headings presented in Table 1 allow for a holistic consideration of the cognitive, emotional, and environmental factors underlying the child's behavioral patterns.

Clinical interviews, observations, and scale implementations are not only critical for documenting symptoms but also for understanding the context in which the behaviors emerge and identifying individual differences. In this process, the child's temperament, attachment history, traumatic experiences, and environmental triggers should be evaluated together. Moreover, the diagnostic process offers a reflective opportunity not only for the individual but also for the family. Parents' boundary-setting styles, communication patterns, and understanding of discipline play a determining role in shaping the child's behaviors. Clinical evaluation should not only aim to reach a diagnosis but also to structure intervention strategies that will support the child's psychosocial development. Therefore, the assessment should be conducted through a multilayered approach that considers normative development, contextual variables, and psychodynamic processes. Figure 2 presents a form that facilitates the diagnostic process of oppositional defiant disorder during the clinical interview.

ASSESSMENT FOR OPPOSITIONAL DEFIANT DISORDER

Client Name: .....
Date of Birth: .....
Date of Assessment: .....
Clinician: .....
Referral Source: .....
Setting (School/Home/Clinic): .....

Reason for Referral:

.....
.....

Presenting Behaviors (as observed or reported):

☐ Frequent temper loss
☐ Argumentative with adults
☐ Actively defies or refuses to comply
☐ Deliberately annoys others
☐ Blames others for own mistakes
☐ Angry and resentful
☐ Vindictive or spiteful
☐ Easily annoyed

Severity Level (based on DSM-5-TR criteria):

☐ Mild (Symptoms in one setting)
☐ Moderate (Symptoms in at least two settings)
☐ Severe (Symptoms in three or more settings)

Clinician Notes:

.....
.....
.....

Figure 2 *A form that will facilitate the process of diagnosing Oppositional Defiant Disorder in the clinical interview*

This multidimensional assessment process not only facilitates accurate diagnosis but also lays the groundwork for developing an effective and sustainable clinical intervention plan tailored to the child's individual needs, familial dynamics, and environmental factors.

1.2.1 Diagnostic Criteria in DSM-5 and ICD-11

Oppositional defiant disorder is a significant diagnosis among externalizing behavioral disorders, included in both the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) by the American Psychiatric Association and the International Classification of Diseases, 11th Revision (ICD-11) by the World Health Organization.

According to DSM-5, oppositional defiant disorder is a persistent disorder observed particularly in children and adolescents, characterized by negative, hostile, and oppositional behaviors. The diagnostic criteria are based on the child frequently exhibiting temper outbursts, argumentative behaviors, defiance, and deliberate disobedience for at least six months. Additionally, these behaviors must cause significant impairments in social, academic, or occupational functioning. DSM-5 classifies the disorder into mild, moderate, and severe levels based on the severity of symptoms and the contexts in which they appear.

ICD-11 also defines oppositional defiant disorder under the heading "Oppositional Defiant Disorder" and emphasizes similar behavioral criteria. However, ICD-11 focuses more on the broader time span of symptoms and their evaluation according to societal norms when establishing a diagnosis. Compared to DSM-5, ICD-11 draws clearer boundaries between mood disorders and behavioral

disorders, and clinical emphasis is placed on distinguishing oppositional defiant disorder from other externalizing disorders (e.g., Conduct Disorder) (Ezpeleta et al., 2021).

In both classification systems, for a diagnosis of oppositional defiant disorder, the behaviors must be developmentally inappropriate, persistent, and contrary to social norms in children and adolescents. Moreover, the symptoms must not be solely attributable to the effects of another psychiatric disorder. On the other hand, DSM-5 specifically highlights that the symptoms are usually directed toward authority figures, whereas ICD-11 emphasizes the overall impairment in social functioning as a contributor to the diagnosis (Keenan & Wakschlag, 2020).

Although DSM-5 and ICD-11 use common fundamental behavioral criteria in defining oppositional defiant disorder, they show slight differences in assessment and classification. In clinical practice, familiarity with both systems allows for the development of a holistic approach in diagnosis and treatment planning (APA, 2022).

According to DSM-5, oppositional defiant disorder is characterized by the frequent presence of at least four of the behavioral patterns listed below over a period of at least six months. The disorder includes subdimensions such as anger/irritability, argumentative/oppositional behaviors, and vindictiveness. These behaviors usually emerge in conflict with another person (most often parents, teachers, or other authority figures) or the surrounding environment (Table 2).

A	At least four of the characteristic anger, argumentative/oppositional behaviors, and revengeful behaviors:
	1. Easily irritated or angered.
	2. Easily angered and expresses anger.
	3. Often moody or irritable.
	4. Argues with people in authority (e.g., adults).
	5. Deliberately defies or refuses requests or rules from people in authority.
	6. Deliberately irritates others.
	7. Refuses to assume responsibility for others.
	8. Often blames others or blames others for his/her own mistakes.
	9. Often holds grudges or acts vindictively.
B	These behaviors cause clinically significant impairment in the individual's social, academic, or occupational functioning.
C	These behaviors are inappropriate for the individual's developmental level and occur more frequently than is normatively expected.
D	These behaviors are not attributable to another psychiatric disorder (e.g., mood disorder, psychosis, conduct disorder) or the direct effects of substances.

Table 2. *Oppositional defiant disorder DSM-5 Diagnostic Criteria*

Classification according to severity of symptoms:

- Oppositional Defiant DisorderMild: Symptoms are present in one setting (e.g. home).
- Oppositional Defiant DisorderModerate: Symptoms are present in more than one setting (e.g. home and school).
- Oppositional Defiant DisorderSevere: Symptoms are present in three or more settings (e.g. home, school, circle of friends).

ICD-11 classifies oppositional defiant disorder as an externalizing disorder characterized by anger, argumentativeness, opposition-

ality, and vindictiveness that are prominently and persistently observed in a child's or adolescent's core social relationships, especially in contexts such as family and school. These behaviors represent patterns that are developmentally inappropriate and exceed normative expectations, negatively affecting social adjustment. According to ICD-11, the following features are required for diagnosis:

- **Persistence**: The behaviors persist for at least 6 months.
- **Behavioral Pattern**: The child or adolescent frequently displays temper outbursts, argumentative or defiant attitudes toward adults or peers, and often behaves disobediently in response to rules or demands.
- **Social Functioning**: These behaviors cause clinically significant impairment in social, academic, or occupational functioning.
- **Contextual Pervasiveness**: Symptoms are observed in more than one context (e.g., home, school, social environment).
- **Differential Diagnosis**: The behaviors do not occur solely as a primary manifestation of other mental or neurodevelopmental disorders.

Compared to DSM-5, ICD-11 places particular emphasis on evaluating behaviors according to developmental norms and ensures a clear distinction between behavioral disorders and mood disorders. In the diagnostic process, the frequency, severity, and impact of the behaviors on functioning are key factors guiding clinical judgment (Klein & Waschbusch, 2020).

1.2.2.Assessment Tools and Scales Used for Diagnosis

Oppositional defiant disorder diagnosis, follow-up, and intervention processes utilize numerous standardized assessment tools and scales to support clinical evaluation. These instruments are designed to quantitatively measure the severity of symptoms and to detail behavioral patterns, aiding differential diagnosis. Commonly preferred tools in oppositional defiant disorder assessment analyze children's and adolescents' behavioral problems from multiple perspectives, based on reports provided by parents, teachers, and sometimes the individuals themselves.

Child Behavior Checklist (CBCL)

One of the most widely used tools is the Child Behavior Checklist (CBCL), developed by Achenbach. The CBCL assesses externalizing and internalizing behaviors based on parent reports and, through its oppositional defiant disorder-specific subscales, provides high sensitivity in evaluating oppositionality and anger symptoms. The Teacher Report Form (TRF), completed by teachers, and the Youth Self-Report (YSR), completed by the children themselves, serve as complementary components of the CBCL assessment system (Achenbach & Rescorla, 2021).

The Child Behavior Checklist, developed by Thomas Achenbach, is a commonly used psychometric tool designed to evaluate behavioral and emotional problems in children and adolescents. The CBCL, completed by parents, provides comprehensive information about the child's social, emotional, and behavioral functioning. It has two versions targeting different age groups: 1.5–5 years (CBCL/1.5-5) and 6–18 years (CBCL/6-18).

The CBCL includes subscales measuring internalizing behaviors (e.g., anxiety, depression) and externalizing behaviors (e.g., aggression, oppositionality). In the assessment of oppositional defiant disorder, the "Externalizing Problems" scale and the items under "Oppositional Defiant/Disobedient" are particularly important. The CBCL is widely used in clinical diagnostic processes and research to determine the severity and type of behavioral problems in children and adolescents.

Advantages of the CBCL include its standardization, robust validity and reliability studies, and multicultural normative data. Moreover, CBCL forms obtained from different informants (parents, teachers, self) allow for multidimensional assessment. The CBCL is a reliable tool for diagnosing oppositional defiant disorder and for detailed clinical profiling through its subdimensions in symptom monitoring (Ivanova et al., 2020).

Oppositional Defiant Disorder Rating Scale (ODDRS)

The Oppositional Defiant Disorder Rating Scale (ODDRS) provides reliable data in both clinical and research settings by detailing the frequency, severity, and functional impact of oppositional defiant disorder symptoms in accordance with DSM and ICD diagnostic criteria. Based on DSM-5 criteria, the ODDRS measures the frequency and severity of behaviors such as anger, argumentativeness, defiance, and vindictiveness in children and adolescents. It has versions that can be completed by both parents and teachers, and is used for clinical assessment as well as monitoring symptom profiles and treatment-related changes before and after interventions. The ODDRS demonstrates high internal consistency and validity, making it a trusted tool for early diagnosis of behavioral disorders and for evaluating intervention effectiveness.

Additionally, its applicability across different cultures has been tested, allowing for the assessment of symptoms independently of cultural differences.

Disruptive Behavior Disorder Rating Scale (DBDRS)

The Disruptive Behavior Disorder Rating Scale (DBDRS) enables the simultaneous assessment of symptoms commonly observed alongside oppositional defiant disorder (ODD), such as conduct disorder and attention-deficit/hyperactivity disorder (ADHD), within the same scale. Behavioral observation methods also play a significant role in the evaluation of ODD. Structured observations conducted during clinical sessions, such as play or interactions, allow for the naturalistic monitoring and measurement of oppositional and defiant behaviors. These methods provide direct behavioral data that enhance the comprehensiveness of the assessment compared to relying solely on reports.

The DBDRS is a standardized scale developed to assess the diagnosis and severity of externalizing behavioral disorders, particularly measuring symptoms of oppositional defiant disorder and conduct disorder. It can be completed by both parents and teachers and includes behaviors such as anger, defiance, argumentativeness, aggression, and rule-breaking, consistent with DSM-5 criteria. Additionally, it covers symptoms of attention-deficit/hyperactivity disorder, making it a crucial tool for identifying comorbid conditions.

The psychometric properties of the DBDRS are supported by high internal consistency, test-retest reliability, and validity. It is frequently preferred in clinical practice and research for comprehensive symptom assessment and monitoring treatment effects.