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Parenting styles for children with oppositional defiant disorder: Scope review

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Abstract:

Behavioral and emotional problems are the most common form of child psychiatric pathology. Parenting styles are one of the factors affecting the formation of children's personality and the use of inefficient styles can lead to several negative consequences such as behavioral problems. The aim of the present article is to describe a variety of parenting styles and their relationship with children behavioral problems. The present study reviews a variety of parenting styles including Kazdin's Parent Management Education Model, Barclay's Parent Training Program, Adler and Dreikurs Approach, and Positive Parenting Program. Finally, based on reality theory, parenting is neglected to be one of those styles. Therefore, it is imperative to do a research based on reality theory with existential psychotherapy and with the view that everyone chooses to behave, external pressure is always an imposition, the children learn from their mistakes, and everyone is responsible for his own happiness.

Keywords:

Oppositional defiant disorder, parenting, reality theory

Introduction

Children's defiance occurs as an inevitable stage in their growth. The most striking oppositional behaviors appear in children aged 18 and 24 months and reach its peak in age 3. This disorder appears as a pathological phenomenon that finds abnormal status in terms of continuity or severity and its frequency becomes more significant. In other words, this disorder becomes pathological when it is not associated with children's age and growth conditions.[1] When these behaviors are repeated and overwhelming, they become a kind of disorder called oppositional defiant disorder (ODD).[2,3] ODD is one of the most common clinical disorders appearing in children and adolescents.[4] This disorder is categorized in disruptive behavior disorder group that those suffering from are one of the largest groups of patients referring to children's mental health clinics.[5,6] Based on the definition of the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM5), Barclay (2013) stated that ODD is a negative consistent pattern, disobedience, stalking, hostility, and rebellion against owners of power.[7] Psychologists believe that several factors contribute to the formation of consistent patterns of ODD, including biological, mood (intrinsic, in-kind), learned factors. In addition, psychologic risk factors (risk factors) for aggressive behaviors in adolescents include childhood abusive behaviors such as physical abuse and sexual abuse, negligence, emotional abuse, and over-rigorous, punishment-oriented training.[6] The American Psychiatric Association's DSM-5 has divided ODD into three types: angry/irritable mood, argumentative/defiant behavior, and vindictiveness.[8]

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Methods

The present study reviewed papers and books addressing different parenting styles, symptoms, and prevalence rate for ODD children and briefly described the Kazdin, Adler and Dreikurs, Barkely, and positive parenting approaches. Finally, the issue of the position of parenting based on the choice theory among these parenting approaches for children with ODD was dealt with.

Oppositional defiant disorder symptoms

ODD symptoms can also be partly addressed in people without this disorder; several important points whether behaviors are ODD symptoms are as follows: first, the diagnostic threshold of four or more symptoms within 6 months must be met and second, the continuity and frequency of symptoms must go beyond what is normal in terms of age, sex, or culture.[8] Symptoms of this disorder are often part of a pattern of problematic interactions with others. In addition, individuals with this disorder often do not consider themselves angry, defiant, or disobedient.[9] Related characteristics that confirm the ODD diagnosis is that in the ODD is more common in children and adolescents living in families in which caring for the children is disrupted by the substitution of caregivers, or in families with violent childcare, instability, or negligence.[10,11] Individuals with ODD show symptoms only in relation to family members; younger children consider their parents as owners of power, while older ones usually view parents, teachers, and other adults as owners of power. However, the incidence of symptoms is an indicator of the severity of this disorder.[8,9] ODD symptoms may be limited to a limited position which is often referred to as home. Individuals who show enough symptoms to meet the diagnosis threshold, even if they are at home, may be very disadvantaged in their social function. However, in more severe cases, the symptoms of this disorder are present in many situations. Considering the fact that symptoms are an indicator of the severity of this disorder, it is important that the individual's behaviors are assessed in different situations; since those behaviors are common among siblings, they should be observed during interactions with persons other than the siblings. Moreover, since ODD symptoms are usually more obvious when children interact with adults or peers who are well known to them, they may not be apparent at a clinical examination.[8] ODD, if chronic, is almost always problematic in interpersonal relationships and academic performance. Children with ODD are usually rejected by peers and classmates, and they may be isolated and alone. In spite of their intelligence, the children with ODD may not have good academic skills at school because they do not cooperate and participate in classroom work and cannot accept help from others. These problems, in turn, cause children's self-esteem to fall; they cannot tolerate failure, become depressed, and show anger explosions.[3,6] ODD is also predictive of a wide range of compatibility problems.[12] Compatibility is a change in behaviors or cognitive processes, enabling individuals to adaptively cope with the changes in their abilities.[13]

Prevalence rate

According to the some researchers the prevalence of ODD among children and adolescents is between 3% and 6%, according.[14,15] In addition, evaluations and reports indicate that the prevalence rate of ODD ranges 2%–16% for males who have not yet reached maturity, but and after puberty, the prevalence rate for girls and boys is the same. The prevalence rate of ODD decreases in boys and girls over the age of 12 years.[6] Research on the etiology of ODD shows a combination of characteristics of children's genetic or biological biases, inadequate parenting practices, and environmental conditions which have been described.[16,17] Research results have illustrated that children with ODD are largely lacking in cognitive, social, and emotional skills needed to handle elderly demands,[18-20] do not have good progress at school,[21] are inefficient in making interpersonal relationships,[22] and have significant problems and impairment in executive functions.[23,24] which may result in low self-esteem, low tolerance for failure, depression, and anger.[25] In addition, in children with ODD, ethical judgment may be adversely affected.[26] The prognosis of this disorder is undesirable and the children are at high risk of juvenile delinquency, anti-social behavior, substance abuse, and school dropout and disorders such as behavior, antisocial behavior, mood disorders, and anxiety.[27-30] Children with ODD have emotional regulations, poor self-regulation, and behavioral problems. They also have more hostile interactions with their peers and show anger and aggression.[31] Emotional regulation strategies are among the psychological components having led to extensive research on the issues of childhood and adolescent disorders.[32-34] Emotional regulation refers to strategies by which individuals affect what emotions they experience, when they experience emotions, and how they express them.[35] Emotional regulation strategies are an intrinsic part of trends related to emotional responses. According to Garanefski, the strategies of emotional regulation are actions that indicate ways to cope with stressful situations or unpleasant events.[36] Various studies have shown that children and adolescents with extraneous disorders and behaviors such as aggression, disobedience, and hyperactivity are more likely to use maladaptive regulation strategies[37,38] and are defective in applying adaptive emotional regulation strategies.[39] ODD is directly related to the way children and adolescents regulate their emotional processing (aged 6–11 years). A child with ODD behaved less well in their emotional

regulation and processing than their normal counterparts.[40] The results of studies have shown that students with behavioral problems experience more emotions than their peers, have more difficulties in adapting emotions to social problems than their peers, are more likely to watch an anger triggering program, feel angry, use symptoms to identify their feelings, do not respond to the peers' answers, and not only tend to focus on negative aspects of the location but focus on exciting their emotions.[41,42] According to researchers, there is a link between parenting styles and the ability of children to express and excite their emotions.[43] Instead of working directly with children, psychologists can provide more help to children if they provide parents with counseling or direct education; the way parents and careers interact with children depends on the stress and flexibility available in each particular family.[31] Parents interact with children; focus on direct education, selective empowerment, and expressive expression; affect the children's growth of emotion regulation through modeling and analogy; control the children's environment to limit or extend the opportunities for experiential experience; and teach children to control their emotions.[31] Due to the number and variety of problems among those children in different areas, different educational and therapeutic approaches have been proposed.[44,45] Research on the teaching of ODD in children confirms the view that parents' appropriate and contingent responses to child behaviors are an important factor in the establishment and continuation of positive child behaviors.[16] Different studies have shown that many homosexuals play a role in causative disorder/coping disorder. These factors include childbearing or parenting practices, parent's mental harm, marital problems, and differences between brothers and sisters.[45-47] In this regard, Costin and Chambers state that among the family factors explaining ODD in children, most studies are related to inefficient parenting styles.[47] The most important educational programs for ODD are interventions based on cognitive and social skills training for children, behavioral parent training, behavior parent management, and parent–child interaction training for parents.[48-51] Parent management training simply means experiencing a new way of learning to influence and modify parent–child behaviors. Those changes in behaviors can bring us closer to the goal of treatment.[52] This method focuses its attention entirely on the clinical causes of the problem, and the conceptual model emphasizes children's behaviors to know "what to do for treatment."[45] Parent management training can be employed to neutralize and quit certain behaviors and start some other behaviors in parents. The challenge of training is that a therapist, while doing things, also takes into account the views of the parents, maintains their respect, and does not discourage them from training children.[52] Kazdin designed a parent–child management program for children aged 2–14 years.[52] The program is presented individually and collectively, the method of presentation is determined by the severity and type of the problem of children and the insufficiency of family functioning. The training consists of 12 sessions and each session lasts from 45 to 60 min. Between the sessions, therapists ask parents to provide assistance and support for practicing parenting skills at home. An ongoing assessment of the progress of the child and parents is important by using the role-play method taken by parents and children. Optional sessions are also held to strengthen the skills that children or parents have weakened.[52] There are many approaches to parent's training; in some approaches, cognitive and interactive management is proposed. Those approaches oppose principally the use of behavioral techniques such as punishment, reward, and reinforcement. On the other hand, the principles of learning and training psychology are used in behavioral parent approaches, such as Kazdin and Russell Barclay's programs and the parent management program that addresses the problems at home and school; in fact, behavioral parent programs are theoretically constructive of behaviors and learning and use learning techniques based on task analysis and operant conditioning.[7,52] Reality theory is a process emphasizing the choice, accountability, and evaluation of an individual. This theory considers the individual responsible for choices and implicating them and tries to inform he/she about his/her needs by focusing on external factors and moves him/her from the disclaimer against him/her toward self-focus on his/her abilities and greater accountability.[53] Generally speaking, the theory of choice is based on the view that every individual's behaviors are his/her choices to satisfy his/her needs. These purposive behaviors are rooted more in internal stimuli and motivations than the external factors and motives. This view is doubtful that the individual's behaviors are at any time the best attempt to control the world around him/her and also himself/herself as part of this world. Therefore, the individual should always behave in a way and choose to best meet his/her needs. According to this theory, the individual's attitude at any time is his/her best attempt to satisfy his/her needs. This effort may not actually be effective or useful. However, they are his/her best efforts; therefore, reality theory attempts to help patients to evaluate their behavior from this aspect whether the behaviors they have now respond to their needs or whether their wishes have come true or not.[54] According to reality theory, the reason for people's different perceptions of reality is related to a desirable world specific to each individual which involves individuals, objects, and systems of beliefs that most of all represent the best way to meet the individual's needs. This theory considers that behavior includes four components of function, thinking, emotion, and physiology. Its

underlying emphasis is on thinking and function because of individuals' ability of direct control and on emotion and physiology because of their indirect control. The fundamental principle of reality theory is that "The only person whose behavior we can control is our own."[53] Reality theory focuses on the improvement of current relationships. Its success depends on the relationship between the patient and counselor. Reality theory is a system helping individuals to identify specific demands related to their own needs, also called genetic structures, to evaluate their behaviors, and to design objective designs to satisfy their needs.[55] In reality theory, training process is employed more than treatment, in which counseling is essentially a learning-training process. This is one of the most important features of reality theory that distinguishes it from other approaches.[54] So far, different methods have been employed for training ODD, including the "Kazdin" training model;[45,52] the overall effectiveness rate of training for children whose parents are involved in the training was ranged from 0.80 to 1, i.e., approximately 85% better than those whose parents did not participate in the training.[52] It seems that the great effectiveness of behavioral parent training for is generalized to children's classroom behaviors and parent personal adherence. According to Kazdin, "perhaps there is no other method has been confirmed more precisely and experientially than parent management training about the treatment of ODD."[45]

Barclay's approach relates a few children's characteristics to the effectiveness of parent training programs. One of the relatively stable predictors of reducing the effectiveness of parent education is children's age.[1,7,56] Compared to schoolchildren with a lower probability of their improvement (50%–64%) and compared to adolescents (25%–35%), it seems that preschool children (under 6 years of age) have the highest positive response rates to behavioral parent training programs.[56] Adler and Dreikurs Approach[57-59] and the effectiveness of psychosocial therapy have been examined and the effectiveness rate was estimated as 0.69.[60] the effectiveness of Sanders' Positive Parenting Program; for ODD children has estimated the effectiveness of this educational method in the range from 0.35 to 0.48.[61-66]

Discussion

Reviewing the findings of other studies confirms that the research conducted on children with ODD has a high effectiveness. There are many approaches to parent training, cognitive-management and interactive approaches which are fundamentally opposed to behavioral techniques such as punishment, rewards, and incentives. On the other hand, behavioral parenting approaches, such as Kazdin and Barclay, and the parent management program that help the solution of the problems at home and school use the principles of psychology of learning and education.[7,45] Basically, behavioral parent programs have a theoretical basis for behavior and learning and employ learning techniques based on task analysis and operant conditioning. Since one of the goals of reality theory is to help parents to achieve a sense of internal control, and in this theory, the training process is more emphasized than the treatment, as well as parenting is really preventive using the theory, and if this theory is used from a younger age, educational problems requiring external control are rarely seen, what these parents really need is to look at their children's problem in a completely different way. They need a view that strengthens family relationships and leads to greater happiness and merit of their children. They should find a better choice.

Conclusion

Thus it is mandatory that some research be conducted based on reality theory with an existential psychotherapy and with the view that everyone chooses how to behave, external pressure is always an imposition, children learn from their mistakes, and everyone is responsible for his/her happiness. Finally, the type of parent communication with each other, as well as how they interact with their children, can also affect the children's characters and their behaviors; parents' behaviors with children are often done according to a particular cultural model in which the community is located. The development of a parenting model based on reality theory can be employed for designing caring programs for families of children with behavioral problems.

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Conflicts of interest

There are no conflicts of interest.

References

1. Sohrabi F, Asadzadeh H, Arabzadeh Z. Effective of Barkley's parental education program in reducing the symptoms of oppositional defiant disorder on preschool children. J Schl Psychol 2014;3;82-103.
2. Lotfi Kashani F, Vaziri SH. Child Psychiatry. 1st ed. Tehran: Arasbaran Publisher; 2017. P. 330.

3. Mash E, Wolfe D. Abnormal Child Psychology. 4th ed. Belmont, CA: Wadsworth Cengage Learning publisher; 2010. p. 600.
4. Steiner H, Remsing L. Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. J Am Acad Child Adolesc Psychiatry 2012;46:41-126.
5. Costin J, Lichte C, Hill-Smith A, Vance A, Luk E. Parent group treatments for children with oppositional defiant disorder. Australian Network for Promotion. Clin Psychol Rev 2011;23:121-34.
6. Sadock B, Sadock V, Pedro R. Kaplan and Sadock synopsis of psychiatry. In: Translation by Mehdi Gangi. 11th ed. Tehran: Savalan; 2015. p. 855.
7. Barkely RA. Defiant Children: A Clinician's Manual for Assessment and Parent Training. 3rd ed. New York: The Guilford press; 2013.
8. Psychology association publishing. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. DSM. American: Psychology association publishing; 2015. p. 1416.
9. Schroeder CS, Gordon BN. Assessment and Treatment Childhood Problem: A Clinician's Guide. 5th ed. NY, London: Guilford press; 2011. p. 615.
10. Kratochwill Thomas R. Morris Richard J. The Practice of Child Therapy. 4th ed. New York and London: Routledge Taylor & Francis Group; 2012. p. 583.
11. Kim HW, Cho SC, Kim BN, Kim JW, Shin MS, Yeo JY. Does oppositional defiant disorder have temperament and psychopathological profiles independent of attention deficit/hyperactivity disorder. Comp Psychiatry 2010;51:412-8.
12. Whelan Y, Stringaris A, Maughan B, Edward D, Barker E. Developmental continuity of oppositional defiant disorder sub dimensions at ages 8, 10, and 13 years and their distinct psychiatric outcomes at age 16 years. J Am Academy Child Adolescent Psychiaty 2013;52:961-9.
13. Lawton MP. Emotion in later life. Curr Direct Psychol Sci 2001;10:120-3.
14. Boylan K, Vaillancourt T, Boyle M, Szatmari P. Comorbidity of internalizing disorders in children with oppositional defiant disorder. Eur Child Adolesc Psychiatry 2007;16:484-94.
15. Canino G, Polanczyk G, Bauermeister JJ, Rhode La, Frick P. Dose the prevalence of CD and ODD vary across Cultures? Soc Psychiatry Epidemiol 2010;45;695-707.
16. Behan J, Carr A. Oppositional defiant disorder. In: Carr A, editor. What Works for Children and Adolescents? A Critical Review of Psychological, Interventions with Children, Adolescents and Their Families. London: Routledge; 2000.
17. Dick DM, Viken RJ, Kaprio J, Pulkkinen L, Rose RJ. Understanding the covariation among childhood externalizing symptoms: Genetic and environmental influences on conduct disorder, attention deficit hyperactivity disorder, and oppositional defiant disorder symptoms. J Abnorm Child Psychol 2005;33:219-29.
18. Ohan JL, Johnston C. Gender appropriateness of symptom criteria for attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder. Child psychiatry Hum Dev 2005;35:359-81.
19. Hommersen P, Murray C, Ohan J, Johnston C. Oppositional defiant disorder rating scale: Preliminary evidence of reliability and validity. J Emot Behav Disord 2006;14:118-25.
20. Sanders MR, Markie-Dadds C, Turner KM. Theoretical, scientific and clinical foundations of the triple p-positive parenting program: A population approach to the promotion of parenting competence. Parenting Res Practice Monograph 2003;1:1-21.
21. Burt SA, Krueger RF, McGue M, Iacono WG. Sources of covariation among attention-deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder: The importance of shared environment. J Abnorm Psychol 2001;110:516-25.
22. Greene RW, Biederman J, Zerwas S, Monteaux MC, Goring JC, Faraone SV. Psychiatric comorbidity, family dysfunction, and social impairment in referred youth with oppositional defiant disorder. Am J Psychiatry 2002;15:1214-24.
23. Loeber R, Burke JD, Lahey BB, Winters A, Zera M. Oppositional defiant and conduct disorder: A review of the past 10 years, part 1. J Am Acad Child Adolesc Psychiatry 2000;39:1468-84.
24. Gadow KD, Nolan EE. Differences between preschool children with ODD, ADHD, and ODD+ADHD symptoms. J Child Psychol Psychiatry 2002;43:191-201.
25. Sutton Hamilton S, Armando J. Oppositional defiant disorder. Am Acad Fam Phys 2008;78:861-8.
26. Tiggs PL. Play Therapy Techniques for African American Elementary School-Aged Children Diagnosed with Oppositional Defiant Disorders; 2010.
27. Bradley MC, Mandell D. Oppositional defiant disorder: A systematic review of evidence of intervention effectiveness. J Exp Crim 2005;2:343-65.
28. Sharifi-Daramady P, Bagean-Kulemarez MJ, Padervand H, Gravand F. The effect of impulse control training on impulsiveness and reduce the symptoms of students with oppositional deficit disorder. J Clin Psychol 2014;5;29-41.
29. Marmurstein NR. Relationship between anxiety and externalizing disorder in youth: The influences of age and gender. J Anxiety Dis 2007;21:420-32.
30. Loeber R, Burke J, Parini AD. Perspective son oppositional defiant disorder, conduct disorder and psychopathic features. J Child Psychol Psychiatry 2009;50:133-42.
31. Macklem GL. Practitioner's Guide to Emotion Regulation in School-Age Children. Manchester, Massachusetts, USA: Springer press; 2012. p. 221.
32. Garnefski N, Koopman H, Kraaij V, ten Cate R. Brief report: Cognitive emotion regulation strategies and psychological adjustment in adolescents with a chronic disease. J Adolesc 2009;32:449-54.
33. Garnefski N, Rieffe C, Jellesma F, Terwogt MM, Kraaij V. Cognitive emotion regulation strategies and emotional problems in 9-11 years old children. Euro Child Adolesc Psychiatry 2007;16:1-9.
34. Garnefski N, Kraaij V, van Etten M. Specificity of relations between adolescents' cognitive emotion regulation strategies and Internalizing and Externalizing psychopathology. J Adolesc 2005;28:619-31.
35. Gross J. Handbook of Emotion Regulation. 1st ed. American, New York: The Guilford Press; 2007. p. 42-3.
36. Garnefski N, Kraaij V. Cognitive emotion regulation questionnaire – Development of a short 18-item version (CERQ-short). Pers Individ Dif 2006;41:1045-53.
37. Spencer T, Faraone SV, Surman C, Petty C, Clarke A, Batchelder H, *et al*. Towards defining deficient emotional self-regulation in youth with attention deficit hyperactivity disorder using the child behavior check list: A controlled study. Postgrad Med 2011;123:50-9.
38. Ghasempour A, Ramzani V, Kalhori A. The comparison of emotion regulation strategies in adolescents with oppositional defiant disorder and normal. Alborz Univ Med J 2014;3:153-60.
39. Barkley RA, Fischer M. The unique contribution of emotional impulsiveness to impairment in major life activities in hyperactive children as adults. J Am Acad Child Adolesc Psychiatry 2010;49:503-13.
40. Supplee H, Skuban H, Shaw S, Prout J. Emotion regulation strategies and later externalizing behavior among European American and African American children. Dev Psychol 2009;21:393-415.
41. Fainsilber K, Windecker-Nelson B. Parental meta-emotion philosophy families with conduct-problem children. J Abnormal Child Psychol 2004;32:385-98.
42. Katz LF, Windecker-Nelson B. Parental meta emotion philosophy in families with conduct-problem children. J Abnormal Child Psychol 2004;32:385-98.

43. Jones S, Eisenberg N, Fabes RA, MacKinnon DP. Parents' reactions to elementary school children's negative emotions: Relations to social and emotional functioning at school. Merrill-Palmer Quarterly 2002;48:133-59.
44. Kazdin AE. Conduct Disorders in Childhood and Adolescence. New Bury Park, CA: Sage Publications; 1997.
45. Kazdin AE. Parent management training and problem-solving skills training for child and adolescent conduct problems. In: Weisz JR, Kazdin AE, editors. Evidence-Based Psychotherapies for Children and Adolescents. 3rd ed. New York: Guilford Press. 2017. p. 142-58.
46. Kazdin AE, Whitley MK. Comorbidity, case complexity, and effects of evidence-based treatment for children referred for disruptive behavior. J Consulting Clin Psychol 2006;74:455-67.
47. Costin J, Chambers SM. Parent management training as a treatment for children with oppositional defiant disorder referred to a mental health clinic. Clin Child Psychol Psychiatry 2007;12:511-24.
48. Johnston C, Scoular DJ, Ohan JL. Mothers' report of parenting in families of children with symptoms of attention-deficit/hyperactivity disorder: Relations to impression management. Child Fam Behav Ther 2004;26:45-61.
49. Ogden T, Hagen KA. Treatment effectiveness of parent management training in Norway: A randomized controlled trial of children with conduct problems. J Consult Clin Psychol 2008;76:607-21.
50. Steele R, Elkin T, Roberts M. Handbook of Evidence-Based Therapies for Children and Adolescents. USA: Springer Press; 2008.
51. Rutter M, Bishop D, Pine D, Thapar A. Rutter's Child and Adolescent Psychiatry. 5th ed. London: Blackwell Press; 2008.
52. Kazdin AE. Parent Management Training: Treatment for Oppositional, Aggressive, and antisocial behavior in children and adolescents. New York: Oxford University Press; 2005.
53. Glasser W. Choice Theory: A New Psychology of Personal Freedom. New York: Harper Perennial; 1999.
54. Sahebi A. Choice theory and reality therapy. Quarterly of growth of education and school consular 2013;27(7):4-11.
55. Khalili SH, Barzegar Kahnamouei S, Sahebi A, Farahani H. Explore the impact of choice theory and reality therapy interventions on couples' marital satisfaction. Appl Psychol Res Quarterly 2016;7:1-23.
56. Barkley RA. Defiant Children: A Clinician's Manual for Assessment and Training. New York: Guilford Press; 2013. p. 224.
57. Hashemi Malekshah SH, Alizadeh H, Pezeshk SH, Soheili F. The effectiveness of parental education with Adleri's approach on executive functions of children with attention deficit/hyperactivity disorder. Adv Cognitive Sci 2017;18:88-99.
58. Moradi Z. The Effectiveness of Maternal Education Using the Adler-Dreikurs's Approach on the Reduction of Contraceptive Disorder Symptoms. M.A Thesis; Alameh Tabataei University; 2013.
59. Alizadeh H, Sajadi H. Democratic Relations and Mutual Respect. Tehran: Danzheh Publisher; 2011. p. 300.
60. Prochaska JO, Norcross JC. Systems of Psychotherapy (A trans theoretical Analysis). 6th ed. United Kingdom: Oxford University Press; 2007. p. 734.
61. Manshadi S, Gholamrezay S, Ghaznanfari F. The effectiveness of positive parenting skills training on parental self-efficacy and children's behavioral problems in female-headed households in city of Yazd. Quarterly J Soc Work 2016;5:20-7.
62. Abedi S. Positive Parenting Program (Triple-p). Quarterly Excep Educ 2012;1:1-8.
63. Sanders MR, Prinze RJ. The Triple *P* system, A multi-level evidence-based, population approach to the prevention and treatment of behavioral and emotional problems in children. J Reg Rep 2005;31:42-6.
64. Sanders MR, Woolley ML. The relationship between maternal self-efficacy and parenting practices: Implications for parent training. Child Care Health Dev 2005;31:65-73.
65. Matthys W, Lochman JE. Oppositional defiant disorder and conduct disorder in children. In: Translation by Akram Parand, Abbas Ali Hossein Khanzadeh. Tehran: Arjmand; 2012. p. 288.
66. Nowak C, Herinrichs N. A comprehensive meta-analysis of Triple p-positive parenting program using hierarchical liner modeling: Effectiveness and moderating variables. Clin Child Fam Psychol Rev 2008;11:114-44.