**Handout for ODD Workshop, draft from the upcoming book, *Justice Injury: A New Approach to Oppositional Defiant Disorder***

This chapter provides the reader with a simple map that informs clinical intervention. *Intervention in complex systems requires acknowledged oversimplifications, and advances are often are the result of identification of tools or “maps” to narrow our focus* (Gladwell, \_\_\_\_\_). We proceed with the awareness that these are constructs that will probably outdated to us in another decade.

We begin with a review of the DSM-V definition of Oppositional Defiant Disorder and the various subdomains including the Headstrong (ODD-JI) subgroup that is the focus of this book. We then begin to describe additional aspects of ODD-JI from the perspective of the clinician, parents, teachers, and the child or adolescent.

We then differentiate **Oppositional Disorder – Justice Injury** **(ODD-JI)** from ***oppositional tendencies – headstrong* (OT-H)**. Although OT-H has some oppositional characteristics, is a more common and less severe category of problem. This is an important diagnostic differentiation, because there are very different sets of interventions for ODD-JI and OT-H.

ODD as it appears in DSM-V

DSM-V is a shared means of describing problems, and it has the advantages and disadvantages of being the common denominator of description between researchers following millions and the psychotherapist dealing with one individual. Practical use requires that we use it as a starting point and then customize it to our more precise needs.

Due to soon-to-be resolved copyright issues related to this draft, the following DSM-V description of ODD is quoted from Wikipedia:

**Oppositional defiant disorder** (**ODD**) in DSM-5

ODD is defined by the [DSM-5](http://en.wikipedia.org/wiki/DSM-5) as a pattern of angry/irritable behavior, or vindictiveness lasting at least 6 months, and is exhibited during interaction with at least one individual that is not a sibling. Individuals must display four symptoms from one of the following categories: angry/irritable mood, argumentative/defiant behavior, or vindictiveness. Unlike children with [conduct disorder](http://en.wikipedia.org/wiki/Conduct_disorder) (CD), children with oppositional defiant disorder are not aggressive towards people or animals (even though this directly contradicts the "signs and symptoms"), do not destroy property, and do not show a pattern of theft or deceit.[[1]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-1) A diagnosis of ODD cannot be given if the child presents with conduct disorder.[[2]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-2)

## **Signs and symptoms[[edit](http://en.wikipedia.org/w/index.php?title=Oppositional_defiant_disorder&action=edit&section=1" \o "Edit section: Signs and symptoms)]**

Previously, [DSM-IV-TR](http://en.wikipedia.org/wiki/DSM-IV-TR) (that is now replaced by DSM-5) stated that the child must exhibit four out of the eight signs and symptoms listed below in order to meet the diagnostic threshold for oppositional defiant disorder.[[3]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-3) Furthermore, they must be perpetuated for longer than six months and must be considered beyond normal child behavior to fit the diagnosis.[[4]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-4)[[5]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-kaneshiro-5)

* Actively refuses to comply with majority's requests or consensus-supported rules.[[6]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-psychcentral-6)
* Performs actions deliberately to annoy others.[[6]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-psychcentral-6)
* Angry and resentful of others.[[5]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-kaneshiro-5)
* Argues often.[[5]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-kaneshiro-5)
* Blames others for his or her own mistakes.[[7]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-behavenet-7)
* Frequently loses temper.[[7]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-behavenet-7)
* [Spiteful](http://en.wikipedia.org/wiki/Spite_(sentiment)) or seeks revenge.[[7]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-behavenet-7)
* Touchy or easily annoyed.[[7]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-behavenet-7)

These patterns of behavior result in impairment at school and/or other social venues.[[5]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-kaneshiro-5)

Common features of oppositional defiant disorder (ODD) include excessive, often persistent anger, frequent [temper tantrums](http://en.wikipedia.org/wiki/Temper_tantrums) or angry outbursts, as well as [disrespect of authority](http://en.wikipedia.org/wiki/Insubordination). Children and adolescents with ODD often purposely annoy others, blame others for their own mistakes, and are easily disrupted. Parents often observe more rigid and irritable behaviors than in siblings.[[8]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-8) In addition, these young people may appear resentful of others, and when someone does something they don't like they prefer revenge over more sensitive solutions.[[9]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-9)

For a child or adolescent to qualify for a diagnosis of ODD, these behaviors must cause considerable distress for the family or interfere significantly with academic or social functioning. Interference might take the form of preventing the child or adolescent from learning at school or making friends, or placing him or her in harmful situations. These behaviors must also persist for at least six months. Effects of ODD can be greatly amplified by other disorders in comorbidity such as [ADHD](http://en.wikipedia.org/wiki/Attention_deficit_hyperactivity_disorder).[[10]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-chandler-10) Other common comorbid disorders include depression and [substance use](http://en.wikipedia.org/wiki/Substance_use) disorders.[[11]](http://en.wikipedia.org/wiki/Oppositional_defiant_disorder#cite_note-Dickstein-11)

The ODD-JI Subgroup from Multiple Perspectives

The refined definition of ODD used in my approach is focused on the construct of ***Justice Injury*** and thus is referred to as ODD-JI. The construct of Justice Injury describes difficulties that, in addition to meeting the DSM criteria of ODD, must meet the following three criteria and tend to meet most of the general tendencies.

1. There is a pervasive, heart-felt sense that one is often the victim of unjust treatment at the hands of others (usually authority figures) who deny the unfair treatment.
2. This sense of being treated unjustly is the source of the child’s most passionate, confrontational, and problematic behavior. There is a resulting unwillingness, for the sake of dignity, to “bend” to normal consequences.
3. The associated trauma with this unfair treatment is so severe that it regularly evokes a *fight-or-flight* neuroendocrine response during difficult conversations with authority figures. During difficult conversations with authority figures, and sometimes at the mere expectation such a discussion, this fight or flight response is evoked. Thus, when oppositional youth enter into anxiety-provoking conversations with adult authority figures, **they quickly enter into a disregulated “fight or flight” neuroendocrine state that not only changes the way they perceive and handle conflict but also alters their memory of the event**. This neuroendocrine shift can occur in any person, but the fact that it happens, sometimes invisibly, to oppositional youth during conversations with well-intended, unsuspecting authority figures has profound implications that we will explore.

GENERAL TENDENCES OF ODD-JI

1. The manner of arguing is often self-defeating, as the goals of argument often become subordinated by the dysregulation (especially fight or flight reactions) that occurs during the arguments.
2. Arguing more often occurs when the youth is anxious and unable to self-sooth, especially if then presented by an authority figure with a task or limit. Parents often describe a dysregulated mood, sometimes of unknown origin, as a precursor to very emotional arguments.
3. The greatest complaints of the authority figures is how the youth behaves during arguments rather than how that child or adolescent behaves when out of sight.
4. There is authority-focused anxiety that starts with one figure or context but may extend to difficult conversations with all family and school authority figures.
5. Many parenting techniques that work with the average child or adolescent, that may work well with the siblings of the ODD-JI youth,
6. These highly argumentative/defiant interactions *usually disrupt the discussion and enforcement of consequences.*
7. There is often but not necessarily an early history of a) emotion dysregulation, b) high levels of temperamental activity, and c) strong justice sensitivities.
8. The face-to-face interaction must so seriously stress authority figures that they feel exhausted and may become dysregulated themselves during arguments.

General Observations of ODD-JI

1. ODD-JI is often characterized by normal parents and teachers who employ standard parenting and teaching techniques that work with most children. There should be no automatic assumption of abnormal home or school environments.
2. There are three main reasons for failure in the therapy of ODD, the first generic to all psychotherapy and the second specific to ODD. The first is the failure to repair disruptions in the therapeutic alliance (Miller, Duncan, \_\_\_\_\_\_\_\_\_\_\_\_\_). The second is “burnout,” a sense of feeling overwhelmed by the demands of therapy on top of the ODD and other family stressors. The third is a sense that the therapist blames the clients for causing the ODD.[[1]](#footnote-1)
3. The treatment of ODD-JI is best viewed as a marathon, not a sprint. Experiencing ODD is chronically and profoundly stressful for parents and teachers (Anastopoulus et al, 1992), and treatment can create even more stress. Sensitivity to the optimism, self-care, and endurance of the adults is the hallmark of a good therapist of ODD.
4. ODD-JI may be further aggravated by information processing problems, Attention Deficit Disorder, or mismatches in attachment or communication styles between youth and adults.
5. Aggravation of ODD can occur when authority figures are unaware of these Attention Deficit or other differences and, consequently, treat the youths as if they are misbehaving or have ill intent. The presence of strong justice sensitivities in these youth make them much more vulnerable to being traumatized by chronic experiences of feeling shamed for behaviors that they are unaware of or are unable to control.
6. ODD-JI are often unsure of the benevolence of adult authority. Therapy is not just about changing behavior; it seeks a more global shift in the youth’s relationship and comfort with authority in general.
7. Ideally, children and adolescents respond to the experience of their own anxiety by self-regulation efforts and by inviting soothing from adults. What characterizes ODD-JI from an early period is not only poor self-regulation (Stringaris\_\_\_) but a failure to effectively seek soothing from caretakers. They react to their own anxiety by externalizing and getting angry at or very controlling with caretakers.

Differential Diagnosis

1. In contrast to the most common presentation of conduct disorders, in *early* ODD, the strongest annoyance of parents and teachers comes not from the initial misbehavior but rather from the arguing and acting out that accompanies normal efforts to talk about transgressions and enforce consequences.
2. ODD-JI behaviors are not constant with authority figures. They flare when youth become anxious and dysregulated.

Some Specific Interactional Criteria:

1. Zero-Sum (Win-Lose) Expectations

These youth enter anxiety-provoking (especially boundary setting) conversations with adult authority figures a) with a zero-sum or win-lose perspective, and b) they feel a great need to win and 3) attempt to do so in a forceful, anxious manner.[[2]](#footnote-2) The adult may enter into a conversation with a collaborative, win-win expectation, but such conversations quickly degrade into win-lose frameworks. To the degree that the adult is converted to this win-lose perspective and also tries to “win” the conversation, the argument tends to escalate. [[3]](#footnote-3)

Our observations suggest that the resolution of ODD-JI in our out of the context of therapy is characterized by a youth’s no longer reflexively approaching anxiety provoking discussions in a win-lose manner. The youth is sometimes able initiate collaborative, win-win initial stance in conversations with adult authority figures.

1. An oppositional youth’s concept of “winning” an anxiety provoking conversation is quite different from an adult’s. Adults tends to view “winning” as getting their way in the end, as **determining the outcome of the interaction**. Oppositional children and adolescents have a different definition; they view winning as getting their way during the conversation, as **determining the process of the interaction**. These two styles of getting needs met are described as ***outcome oriented*** or ***process oriented***.

Parents and teachers often describe ODD youth as “being willing to cut off their noses to spite their faces.” In other words, they take a stubborn stance during an argument that only results in big, long term problems for them.

Communication works best if parties are either both outcome oriented or both process oriented. Neither style is healthy or unhealthy; what is important is that there is a match of style. When one party tries to get needs met through process while simultaneously the other tries to get needs met through outcome, the results can be disastrous. **This mismatch of outcome and process styles of conflict resolution are characteristic of oppositional arguments between youth and parents or teachers.**

Resolution of ODD-JI is characterized by a youth’s engaging in conversation in a more balanced manner. The youth no longer sacrifices long term needs for momentary victory (“cuts off his nose to spite his face”) but rather balances immediate needs not only conversation was handled (process) but also by the outcome.

1. When one party in a human interaction tries to resolve a problem by focusing on process while the other focuses

The process oriented ODD youth feels like they are “winning” to the degree to which they control three important aspects of process.

1. The timing of conversations
2. The content (topic) and direction (who initiates and who responds) of conversations
3. The mood of the conversation

This myth of winning is perpetuated by the degree to which these children and adolescents determine ***in unhealthy ways*** the above issues.

The resolution of ODD-JI is characterized by the **youth’s being much less controlling during difficult conversations with authority figures**. The youth is able to collaboratively and positively determine issues of timing, content and direction, and mood.

The resolution of ODD-JI is characterized by the youth’s having gained the ability to remain regulated when posed with or involved in difficult conversations with authority figures.

If ODD does not involve highly argumentative stances that disrupt discussion of behavior and neutralizes efforts to give consequences, we don’t recommend the intervention described in this book. Chapter 13 describes variations of the intervention with other populations including non-ODD problems. The creation of the construct the ODD-JI subtype thus serves merely to direct clinicians to the most helpful set of interventions and to avoid misapplication to those situations don’t require the careful management described in this book.

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1. Burnout and blame could be considered alliance disruption issues, but their importance with this treatment population leads us to name and monitor them separately. [↑](#footnote-ref-1)
2. This is diagnostically significant. There are children who enter difficult discussions with a win-lose perspective, but not only don’t try to win but rather seem to accept the position of “loser.” We call these *low hierarchy children and adolescents,* and they need very different interventions than our ODD-JI group. Clinical experience suggests that low-hierarchy kids are much more likely to be seriously depressed, are much more likely to be suicidal, and are much less likely to be identified at home and school as being in distress. [↑](#footnote-ref-2)
3. It is work noting that, although such conversations may be approached from a win-lose perspective, this does not mean that such outcomes are possible. One might be able to win a soccer match or court case, but relationship conversations lack the structure and rules required successful zero-sum games. The misapplication of zero-sum debating styles to relationship discussions is not only a part of the oppositional sequence but has also been identified as characteristic of marital and other discord (\_\_\_\_\_\_\_\_\_\_\_) [↑](#footnote-ref-3)