Oppositional Defiant Disorder, Differences, and Justice Injury

            “Don’t get me wrong. I love my son.” Marion shifted uncomfortably in her seat. “But I hate him right now.”  She looked to my face for the expected twitches of disapproval. Instead, I offered a sympathetic nod informed by over 20 years of clinical specialization in oppositional and conduct problems. “Many parents coming to this clinic share your sentiments exactly. Thank you for being open and honest about this. By the way, did you notice the soaked hallway carpet on the way in?” “One of your clinic’s patients?” she asked with interest. I nodded in the affirmative. “Sink stopped up with papers towels, and the faucet turned on. I get reminders every once in a while of what parents go through.” She smiled appreciatively, and I felt a stronger connection building between us. She added, “Sometimes I think that Oppositional Defiant Disorder is harder on parents than on the kid. He doesn’t think he has a problem. I’m the one falling apart and sitting in a therapist’s office.”

            During this first session, I chose not share my personal doubts about the usefulness of the DSM diagnosis of ODD, as it was an empowering label for Marion. Her concept of ODD described one person, her son Mathew. To her, it meant that Mathew’s problems were not her fault, that the teachers, in-laws, and others who blamed her for being a bad parent were wrong. Her only problem with the term was that it understated the button pushing and the battering that her self-esteem took each time an argument with Mathew spun out of control.

            Like Marion, I also have a refined definition of ODD that suits my needs. As a clinician, I use labels to guide me to helpful interventions and to avoid harm. DSM’s description of ODD is so broad, so very much a catch-all for a variety of unrelated problems, that I find it almost useless. As psychologist and author Mathew McKay asked in a recent blog, “If *DSM* diagnosis doesn’t inform treatment, what good is it?”

 With refinement, however, the construct of oppositional-defiant disorder can guide treatment and help to avoid doing harm. To do so, it must differentiate between those youth who respond to “normal” parenting techniques and structure and those don’t. This second group, those who don’t respond well to common parenting approaches, has been the focus of my clinical work for the last twenty years. Their caretakers are often competent and have tried techniques that have worked well with their other children. Yet their button-pushing, highly argumentative children and adolescents are on a heart-wrenching, confusing, and disruptive path at home and school. These are not kids whose parents fail to give normal structure and consequences; these are youth for whom normal structure and consequences don’t work.

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 a type of trauma that has the following qualities:

1. There is a pervasive, heart-felt sense that one is often the victim of unjust treatment at the hands of others, often but not always authority figures, and these others 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.

This case presentation demonstrates an approach to ODD that first appeared in early forms in clinical texts starting in the 1990’s (Keim, 1997, 2000a, 2000b) and that has been taught to thousands of therapists at local and international conferences over the last 20 years. The first author served as Director of Training for Jay Haley and Cloe Madanes in Washington, DC and also as a Project Director at the Mental Research Institute in Palo Alto. The approach has evolved to incorporate alliance tools developed by Duncan and Miller. The inclusion of Justice Injury represents the most recent evolution. The authors view this as an example of Evolving Structural Strategic Therapy, a diverse cloud of practices that have evolved out of the original work of those two models and that have integrated important alliance, attachment, and neuro-endocrine concepts.

 As will be demonstrated in the therapy of Marion and Mathew, there are four stages of intervention. Although the collaboration of the oppositional child is sought and usually obtained, it is not required. There is an emphasis on coaching family and teachers rather than on individual therapy. ODD-JI is not resolved by trying to convince the child that the problem is in their imagination or that they have the power to change the situation; the child’s problems with authority are quite real and therapy works best by coaching the authority figures to change the way they seek benevolent authority and emotional regulation.

*Stage One* of the intervention focuses on

* creating a therapeutic alliance with the parents and, if possible, the identified patient
* initiating a formal client feedback process such as Miller and Duncan’s ORS/SRS
* collaborative problem definition/diagnosis
* outlining the steps of therapy
* addressing the cycles of blame that characterize ODD-JI.
* A discussion and exploration of the concept of justice injury is initiated and continues through the therapy. We begin mapping how the justice-injury initiated fight or flight reactions impact perception, memory, and communication.

*Stage Two* begins a coached, carefully documented experimentation by caretakers with new ways to handle confrontations, an approach that disavows all that works with other children and adolescents and focuses instead of what works with this single youth. *Stage Two* focuses more on the self-care, happiness, and endurance of the parents than it does on changing the child. The parents begin keeping an individualized parent guide, a record of what does and does not work with their particular child and with their own self-care. The individualized parent guide is a binder typically containing the following sections:

* How I want to look and feel during difficult conversations with my child
* What does and doesn’t work in parental self-care
* How are we doing with Blame?
* Which of the child’s three behaviors are we focusing on at this time?
* Escape Strategies – dignified ways to leave a conversation
* What Doesn’t Work with Our Child
* Current experiments in not doing what doesn’t work
* Things that work some of the time

*Stage Three* focuses on one of the defining qualities of ODD-JI, the unwillingness, for the sake of dignity, to “bend” to normal consequences. The normal relationship between rules and consequences enforced by authority figures does not exist, and this requires nothing less than a complete revision of discipline and reinforcements. What worked for the parents when they were children, what worked for the siblings of the ODD youth, and the advice in most parenting books will not work. In Stage Three of this therapy, we embark on more a highly individualized experiments to discover what rules, positive and negative reinforcements work. The delivery of these is just as important as their substance. We try to map and bypass the fight-or-flight reactions that wipe or corrupt intended lessons from a child’s memory or that explode the conversation with the authority figure. The right consequence is not one that “fits the crime” but rather one that fits the energy and resources of the caretakers as well as the understanding of the child.

*Stage Three* emphasizes:

* Moving towards a healthy ratio of positive to negative interactions and reinforcements
* Moving towards a greater emphasis on positive reinforcement than punishment
* Moving away from consequences that require the direct cooperation of the child
* Deconstructing myths such as the idea that it is best to give a consequence at the time of bad behavior
* Emphasizing parental modeling of self-regulation, especially during the delivery of consequences
* Giving rewards and consequences in a way that is informed by influence of trauma arousal on perception and memory.

 *Stage Four* addresses one of the most critical issues in parental authority, the ability of parents to soothe children over their justice injuries and other significant pains[[1]](#footnote-1). ODD-JI has an unfortunate tendency to over-focus parents on the rules and consequences, a process which leads to the neglect the *soft side of hierarchy*, the ways in which nurturing (especially the provision of soothing, fun, and rewards) empowers caretakers’ benevolent authority. Soothing, especially over the painful issues in the life of the child or the family system, is the most significant issue in the treatment of ODD-JI[[2]](#footnote-2)*.* Because ODD-JI children test parents with provocative behavior when the parents try to discuss these injuries, these conversations often are held at the therapist’s office. Before initiating the therapist coaches the parents on how to stay true to their sense of how they want to be during difficult conversations, always a combination of empathy, patience, and self-assurance. During coaching sessions with parents alone, there is frequently role play of the child’s testing and the parents intended responses.

There are several overarching themes in the way these four stages of therapy are addressed. These are:

* There is a strong focus on and sensitivity to caretaker endurance and optimism. Outside of safety concerns, these determine the pacing of therapy.
* We work towards client appreciation of how tendencies towards emotional dysregulation (which may be unrelated to justice injury) and trauma reactions (often related to justice injury) perpetuate problems. Some levels of dysregulation change the way we perceive and communicate during confrontations[[3]](#footnote-3) and change how we remember these events. Such changes seem to only perpetuate social misinterpretation and oppositional sequences between people.
* The ability to soothe a child is viewed as one of the defining qualities of healthy family functioning. Who soothes whom is one of defining issues in family hierarchy in the constructs of some clinicians (Keim).
* Caretaker modeling of self-regulation during difficult conversations is one of the primary therapeutic interventions. The therapy of ODD-JI must therefore address not only the self-regulation differences and justice injuries of the child but also those of the family, school, and other significant social networks. Caretaker modeling of self-regulation is emphasized over caretaker efforts to “teach” self-regulation. The importance of relationships and activities outside the home in the development of self-regulation is also explored (team sports, horseback riding, etc).
* This approach avoids blaming children, parents, and teachers. A diagnostic requirement of ODD-JI is that normal rules and consequences, ones that work with the average child and that commonly work with siblings, don’t work with this particular child. Parents and teachers are not viewed as having done things incorrectly; the challenge is that the child needs an approach other than what works for most kids.

The Case of Mathew and Marion

 At the start of therapy, Mathew, was thirteen-years old and living with his mother in Oakland, California. His father had died in a motorcycle accident when Mathew was six months old, and his parents had never married or lived together. His mother had raised him as a single parent with an admirable network of friends who formed an extended family to this household of two. She was a nutritionist and worked for a hospital.

Mathew was described as having been on the temperamental side since he was a toddler. By his mother’s and school’s account, he had evolved from temperamental to “problematic” in the last two years. His school psychologist had diagnosed him with Oppositional Defiant Disorder (ODD) and Attention Deficit Disorder ADHD. He had been prescribed Ritalin last year and, though Mathew thought it helped his school work “and my ability to endure boring teachers,” it did nothing to stop the increasingly angry, prolonged arguments he was having at school and at home. Mathew blamed others for his misbehavior, was often angry and resentful, and sometimes even sought to embarrass his teachers “to get even.” Marion was referred to me by a friend who had had a similar experience with her daughter.

The First Session

            When Marion first called to set up an appointment, I left it up to her to decide whether or not to bring her son. She came alone, and after some initial introductions to myself and our clinic, I requested that Marion fill out an Outcome Rating Scale (ORS). I also showed her the Session Rating Scale (SRS) and noted that I would give it to her at the end of the session so that she could give me extremely helpful feedback on how I did. “Your director keeps track of things with this?” she asked. “Uh, I’m actually the director of this particular clinic. But you are the boss of this therapy, so in a way that’s true.” As will be noted later, these sorts of feedback tools and, more importantly, the collaboration they engender, are the single most important tool in the therapy.

 Marion was offered coffee or tea, popcorn, and other snacks as soon as she entered the office. I make a great effort to create an atmosphere that suggests that this office is a warm, soothing, comfortable refuge from the challenges of parenting. Soothing is one of the major themes of this intervention, and there is a trickle-down effect that needs to start as soon as the client walks into the office.

Marion had initially told me that she had planned to bring her son but showed up alone. They had had a loud argument before the session, and he refused to come. “If you hadn’t left it up to me to come with or without him,” she let me know, “I might have just canceled the session, holed up in my bedroom, and cried, ice-creamed, or TV’d away my afternoon.” A tear made its way down her cheek.

 “What would you have watched on TV?” I asked as I passed her a Kleenex box.

 “This probably would have been a Six Feet Under marathon.”

 “I take that as a sign of a parent in need of some significant relief.” She laughed and continued to dab at tears.

 “Most of my adolescents,” I shared with her, “at times refuse to come to my office. The therapy is designed to work without any cooperation and, if necessary, even without their attendance. Most of the time, we can greatly improve their behavior even if they never come to therapy. The parents are the true therapists, and I function more as a coach. This is how this type of therapy works. If you son is willing to come in, wonderful. If not, no problem.” Marion was visibly relieved. “As we’ll discuss later, your energy levels are one of your most important decision making tools. You did the right thing in not continuing to stress yourself and by instead coming in alone.” “Thank you,” she responded. With Marion’s permission, I then provided an overview to the four stage process we us to address these types of problems.

We started on the issue of finding an empowering description, a customized diagnosis if one prefers that term. “Our diagnostic manual’s definition of ODD is too broad,” I began. “This therapy only gets on track when parents narrow things down, provide a more customized description of what is going on. By the way, what term are you more comfortable with when it comes to problem description? Some people just like that term problem description, others like the term diagnosis, and others still another way of defining things.”

“I like the term diagnosis.”

“Very good, diagnosis it is. The second part of Stage One is dealing with blame. Parents, especially good parents, seem to reflexively blame themselves for their children’s problems. We will discuss how ODD-JI is not the result of bad parenting. Anyone who thinks that is, whether they be parents, teachers, in-laws, or your friends, is draining valuable energy from the crux of the matter, what to do about it.”

“You know,” Marion began, “I know that intellectually. I mean, I really do. But how can you help but think about that from time to time?”

“Exactly. We know one thing, but our feelings tell us another story, and sometimes speak with a louder voice. We are going to be spending time talking about this almost every session, and especially later in today’s session.” I continued with the overview of the Four Stages.

“Once we have started to wrestle with self-blame and other blame, and once we are sure we have the diagnosis right, we can add Stage Two. These stages stack on top of each other, as each is added on without stopping the efforts of the previous steps. In Stage Two, you step back from trying to fix your child, take a breather, and begin experimenting with doing things in an easier way for you. The goals for stage two are for you and the school to rest up for a moment while beginning to experiment in ways to make things easier on you without your son’s behavior having changed yet. His change comes later.”

Marion chuckled at this. “Are you going to send me to a spa?”

“Actually, we are organizing a Parent Spa[[4]](#footnote-4) for parents in your situation, but it is just getting off the ground and won’t be up and running for a few more months.”

“I don’t know why it seems so strange that I’m supposed to take care of myself during this process.”

“Actually, one of the best predictors of success in this intervention is the degree to which you can manage to place self-care first in any situation other than an emergency when dealing with your son.”

“This is going to take some getting used to,” Marion said with a slightly unsure smile. “Could I have some more of those nuts?” She allowed herself to relax a bit more deeply into the sofa. Marion has started the crucial process of viewing my office as a place of occasional refuge and renewal.

I went on to describe how our version of ODD is characterized by the failure of normal rules and consequences that work well with other children in the same family and classroom. We thus begin a process of gentle experimentation with new and atypical ways of handling these issues. And, critically, we write down these experiments in what is called an Individualized Parent Guide, essentially a collection of detailed records of what works and what doesn’t work with a particular child. The Parent Guide is also a place where we record the experiments in self-care of the parents.

A strong focus by the therapist on the self-care of the caretakers is important for various reasons. First, it helps to maintain the alliance between the therapist and the primary drivers of the therapy, caretakers and teachers. Second, one of the central interventions is having adults only begin complex discussions on problem behavior when the adults are in a grounded, preferred state. Third, good self-care increases the authority of adults in the eyes of their children and adolescents, just as poor self-care decreases adult influence.

 I requested that Marion return home and observe her son’s behavior in light of our discussion. I asked that she be the ultimate diagnostician and that I would be convinced by her observations. In this approach, the proactivity of the clients is crucial. The diagnosis is something that the client convinces the therapist of, not the other way around.

“If I’m convinced right now, is that good enough?” she asked.

“If you are convinced, I’m convinced, but it’s actually really helpful if you can observe and write down specific examples in the coming week or two. And I’ve never had a parent do a bad job of this. Is it fair to say that you are the world’s top expert on your son’s behavior?”

“Yes, I am,” she laughed.

“As the expert, then, allow me to ask you some crucial questions that represent forks in the road of treatment. Answering yes or no to these results in some very different approaches to what we will do in therapy.”

“OK, shoot.” Marion was sitting on the edge of the couch, engaged and competent in her bearing.

“Here is the first question. What is the bigger problem, the way Mathew argues and blows up with authority figures, or the way he behaves when no authority figure is around?

“It’s much more about how he argues with me than it is about how he behaves when I’m not around. Actually, some of his friend’s parents love him and tell me what a pleasure he is to have over. And I smile and say thank you, but I’m thinking, are they talking about my kid?”

“Very helpful answer Marion, thank you. May I ask the second question?”

“Go for it.”

“If you had to place him in one of the two following groups, 1) over-passionate and over-sensitive, and when not arguing can be quite empathic or as 2) cold, callous, and lacking in empathy when not arguing?

“He is totally high-drama when something goes wrong. He has the constant feeling that people are unfair to him,” Marion replied. “I have no idea where it comes from. His teachers actually like him a lot, but he still feels mistreated by them. He could get caught with his hand in the cookie jar, but I swear there is a part of him that wants to cry and say “how dare you suggest I would steal a cookie?”

“Thank you again, Marion.”

Although the DSM definition of ODD does not differentiate between the two categories above (one passionate and empathic and the other cold, callous, and lacking in empathy), I would suggest that they are vastly different kids, need very different interventions, and thus shouldn’t be described by the same diagnosis.

We thus agreed that I would describe the crucial diagnostic pieces, and she would return home and observe him for two weeks with these criteria in mind. Marion, pleased with her shift to a co-therapist role, sat up higher in her chair. To this day, I am amazed at the power of this now-generic reframing of the client relationship to that of co-therapist, something that seemed such an innovation when demonstrated by Sal Minuchin and other early family therapy pioneers. But there is a special importance in Marion’s taking the co-therapist role; my approach to ODD emphasizes proactive experimentation by parents, and having the therapy begin with the parent convincing me of the diagnosis (rather than the other way around) is a way of defining the parent’s proactive role from the start. The use of feedback tools such as Miller and Duncan’s ORS/SRS further empowers this proactive parental involvement.

 I described to Marion the general approach to therapy if we later agreed that her son’s ODD was the main issue. The four step intervention that involves accepting first that “normal” approaches have not worked, throwing out the “book of normal,” and then experimenting with new ways of working their relationship. With my help, she would be carefully documented what works and what doesn’t work in an Individualized Parent Guide (“the Guide”) that we would co-write.

The next part of my interview with Marion was perhaps the most critical in a first interview. Parents of ODD adolescents usually come to therapy so very locked in painful battles with their child that they neglect themselves, their marriages, and their friendships. I described how one of the most important variables in success with ODD was the self-care and endurance of the caretakers. “Outside of safety concerns, the right action at any moment is defined NOT by what you are “supposed” to do with a difficult teenager but instead by what you need to be at your best. We’ll go into more detail about this later. But you’ll find self-care at the top of the list of what leads to success, and it’s also an important part of what we document in the Individualized Parent Guide.”

“Wait, he misbehaves and I’m supposed to do what makes me happy rather than deal with him?”

“Your happiness is actually the guide to what and when is best for him, exactly.”

“This is a weird approach. But I like it. And you are going to explain how this is supposed to happen, right?”

“Totally. Mind you, this is not how parenting usually works. You have an unusual child. You’ve tried the things that work with the average kid. And it doesn’t work, right?”

“Right, exactly.”

“Welcome to ODD. You can’t do what most parents do and have success. And the crucial starting point, as crazy as this sounds, is putting yourself first in ways that we’ll talk about.”

“I think I’m going to like this therapy,” Marion noted.

 And that’s not an easy thing for parents who have been sacrificing so much of their personal happiness wrestling with these issues.”

“I know,” Marion said. “This is not me. I’m a happy person. I love life! And I don’t ask a lot of Mathew. But he’s got to learn to be a reasonably responsible person.”

I spent some time at this juncture in the therapy affirming that I understood how much she was willing to sacrifice for her son, that she was this good of a parent. And when Marion felt that I understood her sacrifice and challenge, she was ready and eager to move forward.

**Section One of Individualized Parent Guide: Who Do You Want To Be When Things Get Tough?**

With Marion’s being assured of my understanding of her challenges and desires to be a good parent, we were ready to move forward. I gave Marion a binder which we would use to start the individualized parent guide, and I asked her to start on the first page, a sheet of paper with only the heading “How I Want to Be/Who I Want To Be During Difficult Conversations.”

Marion paused to think while staring at the *How I want to Be* page. “May I share a personal story?” I asked. “Of course” she answered. “One of my daughters was leaving the house one evening for a Middle School dance. I was watching TV, and she yelled “bye” from a distance and seemed very eager to leave the house without my seeing her, so I followed her out. And, low and behold, she had cut the back of her jeans so low that the crack of her but was showing. I had a fit to say the least. I’m no prude, but when it’s your own child...”

“I know, tell me about it,” Marion added.

“And as I’m having a fit, I caught sight of my reflection in the window of our home, and I looked like a crazy guy. And I thought, ‘I don’t want to be that guy.’”

Marion laughed and closed her eyes, perhaps imagining a similar parenting moment.

“So I understand, as a therapist and as a parent, that part of what we want is dignity. We don’t enjoy losing it, but it’s our dedication to being good parents that pushes us to the edge.”

“And beyond sometimes,” Marion added.

“Well, the first rule of endurance in this therapy is that we decide how we want to be during the difficult moments, and the therapy is designed around maintaining this dignified, true self. Outside of rare safety issues, we organize everything around maintaining your dignity, composure, and sense of self. Not only because it’s vital to your endurance, but also because it is incredibly more effective when parents can be their true selves. So let’s start by asking who you want to be during difficult conversations with your son. I want you to imagine that you are going to talk to your son about something that he has done wrong, something not too uncommon. Afterwards, when you look back on the conversation, how do you want to have appeared to him, and to yourself?

“Oh… not the way I usually feel, that’s for sure. I want to feel calm, grounded. Self-assured. Serious, confident, but I want to have empathy and some warmth. Not like I’m tripping over myself to show him I’m a nice person. I want to feel secure not matter what he says.”

“Perfect, let’s begin to write this down on the first page. This is the most important page of the whole Guide, believe it or not.

She wrote down “Calm, open to hearing, but secure in myself as an authority figure, empathic, patient, well grounded.”

“Beautiful,” I noted. “This is the most important page because, outside of safety issues, this is the single most important guideline for what to do at any time. You’ve described a basic, dignified way of being. The most important rule in this therapy is that you never feel pressured to act unless you feel *exactly* like this dignified self that you’ve just described. Outside of safety issues, nothing is as important. The dignity and grace you’ve just described on this page sums it all up, and I want to tell you how much I respect this. You’ve described the kind of parent that I want to be as well.”

Marion was quite complimented by this basic truth, that she was describing what all parents of ODD kids want, a way to be loving and grounded. She wanted a return of dignity whose loss is one of the defining characteristics of ODD interactions.

In twenty years of asking this question of parents of ODD youth, I’ve always received the same answer, and this is an amazingly invariant response. Parents want to be dignified, self-assured, calm, and empathic.

**The Individualized Parent Guide**

**Section Two of Individualized Parent Guide – What Doesn’t Work When We Try To Discuss/Address Problem Behavior**

* Some clinicians prefer to pick just a few problem behaviors to focus upon, other’s don’t and leave it to the client
* We are especially interested in what doesn’t work in terms of Timing, Content and Direction, and Mood of these discussions

**Section Three of the Individualized Parent Guide – Experiments to Try in Place of What Doesn’t Work**

**Section Four of the Individualized Parent Guide – Self-Care Required to Stay Grounded and to Maintain Self (as described in Section One)**

1. Write something here about the similarity with some other models that would refer to this as dealing with attachment injury [↑](#footnote-ref-1)
2. This coaching of parents to handle difficult conversations with dignity was a hallmark of the work of Don Jackson – say more about this. [↑](#footnote-ref-2)
3. Although adrenalin is the most commonly identified hormone in “fight or flight” reactions, it is actually only one of many whose ratios and degree of utilization mark these states. [↑](#footnote-ref-3)
4. The Alameda County Parent Spa is being organized in one of the more underserved and dangerous neighborhoods in Oakland, CA to better integrate self-care of parents struggling with their children’s behavior challenges. [↑](#footnote-ref-4)