Journal of Psychiatry and Psychiatric Disorders

Volume 1, Issue 4 Case Report

Oppositional Defiant Disorder: A Case Report

Benjamin M Blumberg*

6 Horizon Rd. Apt 1708, Fort Lee, NJ 07024, United States

***Corresponding Author:** Benjamin M Blumberg, PhD. Departments of Neurology, Microbiology & Immunology, University of Rochester Medical School, Rochester, USA, Retired. Present Address: 6 Horizon Rd. Apt 1708, Fort Lee, NJ 07024. Tel: (201) 282-4044; Res: (201) 753-8635; E-mail: bbrl@aol.com

Received: 10 June 2017; **Accepted:** 19 June 2017; **Published:** 03 July 2017

Oppositional Defiant Disorder [DSM-4, ©1994; DSM-4-TR, ©2000; DSM-5, ©2013; 313.81 (F91.3)] is a relatively new addition to the diagnostic armamentum of psychology and psychiatry. Criteria for this diagnosis include a pattern of angry/irritable mood, argumentative/defiant behavior, and vindictiveness lasting at least 6 months. In addition, the individual often blames others for his/her mistakes or misbehavior. The diagnosis was at first was considered to be mainly a behavior disorder of children interacting with parents and other adult authority figures. Here, I describe a case where the disorder persisted well into adulthood and was diagnosed by an amateur (BMB). Once pointed out to the affected individual (JL), the diagnosis was taken to heart, the ODD behavior dissipated, and the individual was able to achieve a much happier, normal life.

According to JL's mother (RL), the ODD behavior began at the age of 3 or 4, and was brought on by JL trying to emulate her mother. According to RL, JL would literally follow RL around the house as RL did housekeeping chores, and would re-arrange chairs, table settings, etc., perhaps as an attention-getting mechanism. This behavior annoyed RL, who admonished her daughter, and thus indadvertently triggered the opposition and defiance that later became a large part of JL's emotional makeup. I can only speculate on what might have transpired had RL praised JL instead, and then later re-re-arranged the household to suit her own, adult tastes.

Finding herself in an unsuitable marriage with four combative children, RL divorced and JL went to live with the father, thus cutting off JL's prospects of resolving her emotional issues in the mother's household. The ODD behavior persisted as JL's primary coping and defensive mechanism, and eventually manifested as difficulties with school courses and teachers, and inability to form friendships easily. I entered the picture when JL was in her late teens, as RL's partner, and as an academic I was struck by the degree of difficulty JL had with furthering her education, and also with attracting suitable young men, even though JL was and still is a physically very attractive woman.

Three examples will illustrate how JL's ODD behavior influenced her life. First, while I was still on the Rochester Faculty, she came to live with us as a teenager. She went to a local Community College to study Nursing, but had great difficulty with the coursework, complaining that her teachers did not pay enough attention to her. She also met several young men, including an eminently suitable one, but none of these relationships lasted. Second, when JL was about 21 years old, we sent her to Seville, Spain for a summer course to learn Spanish and get to know Europe a bit, as I had done some 30 years previously (in West Berlin, to learn German). In Seville, JL struggled to learn the language, made only one friend, did little travelling and rejected the advances of a young Spanish policeman. Third, a few years later we sponsored her to again study Nursing at a University in Virginia, but again she had great difficulty with the coursework, complaining that her teachers did not pay enough attention to her or give her sufficient guidance. In this case, she received failing grades in her coursework without telling us until it was too late to remedy her academic standing, and then made a tearful visit to us in which she blamed us for her difficulties in college.

Both in Rochester and in Virginia, JL consulted professional psychologists, and was diagnosed with Co-dependency and Depression. As an undergraduate, I had done some volunteer work with classmates at Metropolitan State Hospital, an old-fashioned "insane asylum" now abandoned, so I gained some familiarity with psychology and its terminology and with the behavior of individuals with serious mental illnesses. There was no doubt that JL was depressed about her existential condition, but she was not naturally a depressive person, and I could never understand the diagnosis of co-dependency or how it applied to her. Then one day I was watching a program on TV where the phrase Oppositional Defiant Disorder was mentioned, and I immediately recognized this as being an appropriate description of JL's behavior. So I looked up ODD in the DSM-4-TR (DSM-5 had not yet been released at that time) and printed out its definition.

On her next visit, at breakfast on the day of JL's departure, I showed her the printout, and attempted to explain how I thought it applied to her. She was upset, but kept the printout, and must have taken the diagnosis to heart, because over the next several months her life improved dramatically. Her mood lifted, and instead of having to reject abusive men who added to her depression, she finally met one who was just right for her; they are still happily together.

There is no specific treatment for ODD offered in DSM-5. However, it is remarkable that simply placing a printout of the characteristics of the disorder in the hands of JL, a person to whom it clearly applied, was able to bring about the self-cure of her disorder of over 40 years' standing. I think the very name of Oppositional Defiant Disorder had curative power in this case because, unlike Depression which leads to feelings of powerlessness and passivity, and unlike Co-dependency which does not make sense where the individual has no one to depend upon, the definition of ODD is based on anger, and on sour and irritable mood, with defiance as a primary response tool, all of which are easily recognizable in one's own behavior and which can all be self-controlled once recognized. In particular, the criterion "often blames others for his/her mistakes or misbehavior" is so easily recognizable that it tends to confirm the anger and mood issues, and gives the affected person more reason and power to self-control the anger/mood issues.

The Editors and Staff of DSM-4 and DSM-5 deserve much praise for including the diagnostic category of ODD, which at first was considered controversial. Unlike autism, which is at base an infectious disease (1-3), or schizophrenia which may represent a nutritional disorder, miswired brain circuitry or an infectious disease (4 - 6), or

Parkinson's which is caused by death of dopaminergic neurons, or Alzheimer's disease, for which infectious and physical causes are still being sought (7 - 9), ODD appears to be a pure psychiatric condition, which has now been shown to be curable simply by the affected individual gaining sufficient insight into his/her emotional makeup.

References

1. Blumberg BM, Mock DJ, Powers JM, et al. The HHV-6 Paradox: ubiquitous commensal or insidious pathogen? A two-step PCR approach. J. Clin. Virol 16 (2000): 159-178.
2. Nicholson GL. Evidence for Mycoplasma spp, Chlamydia pneumoniae, and human herpesvirus-6 co-infections in the blood of patients with autistic spectrum disorders. J. Neurosci. Res 85 (2007): 1143-1148
3. Henderson TA. Is valacyclovir a mood stabilizer? Autism Open Access 3 (2014): 118.
4. Brown AS, Susser ES. Prenatal nutritional deficiency and risk of adult schizophrenia. Schizophr. Bull 34 (2008): 1054-1063.
5. Fellerhoff B. High risk of schizophrenia and other mental disorders associated with chlamydial infections: hypothesis to combine drug treatment and adoptive immunotherapy. Med. Hypotheses 65 (2005): 243-252.
6. Dalman C et al. Infections in the CNS during childhood and the risk of subsequent psychotic illness: a cohort study of more than one million Swedish subjects. Am. J. Psychiatry 165 (2008): 59-65.
7. Itzhaki RF, Wozniak MS. Herpes simplex virus type 1, apolipoprotein E, and cholesterol: a dangerous liason in Alzheimer's disease and other disorders. Prog. Lipid Res 45 (2006): 73-90.
8. Wozniak MA, Mee AP, Itzhake RF. Herpes simplex virus type 1 DNA is located within Alzheimer's disease amyloid plaques. J. Pathol 217 (2009): 131-138.
9. Carter CJ. Alzheimer's disease plaques and tangles: cemeteries of a pyrrhic victory of the immune defense network against herpes simplex infection at the expense of complement and inflammation-mediated neuronal destruction. Neurochem. Int 58 (2011): 301-320.