Anger Management Difficulties of Children with Oppositional Defiant Disorder: Clinical Evaluation Protocol and Experiential Psychotherapy Guidelines

Geanina Cucu-Ciuhan*[i], Aida Marina Săraru[ii]**
*University of Pitești, Pitești, Romania
**Minnie Psychological Center, Bucharest, Romania

Abstract

Introduction: *Oppositional defiant disorder is one of the most frequent behavioral problems of children that are referred to psychological evaluation and treatment. These children present a large number of behavioral issues, like arguing, disobeying, or talking back to their parents, teachers, or other adults, but also important emotional issues, like depressive thoughts, low self-esteem and anxiety.*

Objectives: *The first part of the paper presents a model of clinical assessment protocol for the oppositional defiant disorder, with application in three case studies of children with important anger management issues. The second part of the paper presents an experiential psychotherapy model for the intervention with these children and their families, with application in a case study.*

Methods: *The evaluation protocol included a semi-structured interview with parents, unstructured interview with the child, projective techniques (Draw a person/ tree/ family), Children's Depression Inventory (CDI) (Parent, Teacher and Self-Report forms), Multidimensional Anxiety Scale for Children (MASC), CONNERS - Third Edition, (Parent, Teacher and Self-Report forms) and Raven's Standard Progressive Matrices/ Wechsler Intelligence Scale for Children (WISC).*

The therapeutic protocol is considered from the process-experiential perspective, starting with the clinical evaluation, followed by the case conceptualization.

Results: *The evaluation process revealed that all three children had a very high level of aggression and manifested oppositionist behaviors, associated with emotional difficulties. The oppositionist behaviors appear prior to the onset of the affective symptoms.*

Conclusion: *The treatment for the child's oppositional defiant disorder (ODD) should follow the pattern for emotional disorders treatment, using a child and family model of psychotherapy.*

Keywords: oppositional defiant disorder, anger management, child psychological evaluation, child psychotherapy

[i] Corresponding author: Geanina Cucu-Ciuhan, University of Pitești, Târgu din Vale no. 1, Pitești, Romania. Email: geanina.ciuhan@upit.ro.
[ii] Corresponding author: Aida Marina Săraru, Minnie Psychological Center, Panduri no. 11, Bucharest, Romania. Email: aida.sararu@psihoterapie-copil.ro

1. Introduction

Recent studies emphasize the neurocognitive impairments in oppositional defiant disorder (ODD), deficiencies in inhibitory control, abnormalities in emotional processing and social cognition, and abnormalities in reinforcement processing. The newest explanatory models describe a deficit in the executive functioning of the child, the neurocognitive processes that maintain an appropriate problem-solving set to attain a goal. The model distinguishes between "hot" executive function and "cool" executive function. The "hot" executive functions comprise the motivational and affective aspects of cognitive processing, and the brain areas responsible for these are amygdala, lateral orbital and ventromedial prefrontal cortices, superior temporal lobes, and underlying limbic structures. Children with oppositional defiant disorder and conduct disorder have abnormalities of the "hot" paralimbic system that regulates motivation and affect, comprising, most prominently the amygdala (Rubia, 2011). The "cool" executive functions comprise the goal-directed and problem-solving behaviors, and self-regulation. These involve inhibition, working memory, planning, flexibility and the ability to find creative solutions to problems. Children with attention-deficit hyperactivity disorder (ADHD) have abnormalities of the "cool" executive functions (Rubia, 2011), and the affected brain areas are the inferior frontal, striatal, parietotemporal, and cerebellar regions (Noordermeer & al., 2016). These neurological findings emphasize the idea that children diagnosed with oppositional defiant disorder (ODD) have important emotional and motivational issues underlining the behavioral symptoms.

In a 2014 study on 622 preschool children, Martin & colleagues concluded that there is an association between oppositional defiant disorder (ODD) and anxiety disorders (AD) and that this association is maintained from 3 to 5 years of age. The symptom "touchy or easily annoyed by others", part of the "Irritable" or "Negative Affect" dimension of ODD, has the highest association with anxiety, especially with social phobia, indicating that high touchiness is a maladaptive characteristic that leads to anxiety problems. The child feels insecure and is afraid of rejection, and in this context can identify the other's behavior as an attack and has the impulse to overreact (Martin & al., 2014).

The recent longitudinal studies have shown that oppositional defiant disorder (ODD) is a predictor for the development of depression in adolescence. There is no enough evidence about the process by which this pattern of symptom development occurs, but the theories published emphasize the idea that the child experiences a lot of rejection and failure because of his/her ODD behavior, and this can lead to depression over the years (Boylan, 2012).

2. A model of clinical assessment protocol for oppositional defiant disorder

2.1. Subjects

The subjects were represented by three boys aged eight and nine that were brought by their parents as a result of the manifestation of oppositionist behaviors and anger, but also because the psychological assessment was requested by teachers. The clinical assessment protocol was realized during three or four sessions. The first one contained an interview with both parents and next sessions included a discussion with the child and the administration of certain psychometric instruments in order to assess both behavior and emotional aspects.

2.2. Measures

The evaluation protocol included a semi-structured interview with parents, unstructured interview with the child, projective techniques (Draw a person/ tree/ family), Children's Depression Inventory (CDI) (Parent, Teacher and Self-Report forms), Multidimensional Anxiety Scale for Children (MASC), CONNERS - Third Edition (Parent, Teacher and Self-Report forms) and Raven's Standard Progressive Matrices/ Wechsler Intelligence Scale for Children (WISC).

2.3. Case Studies

Case 1: Daniel, age 8

Reasons for evaluation: Daniel's parents were guided by his teacher to seek psychological support, as the student tended to have a superior attitude towards his classmates and exaggerated negative emotional reactions in response to failure.

Interview with parents: During the first session of evaluation, we conducted a semi-structured interview with Daniel's parents. They declared that, besides the problems he encountered at school, their son was manifesting oppositionist behaviour in relation with them and his grandparents and difficulties in accepting his own limits and mistakes, accompanied by tantrums. He was focused on performance all the time, manifesting specific behaviour (such as crying, being glum, gritting his teeth, or even throwing things and kicking) every time he was not satisfied with a test

result or a game score. As a result of these reactions, he started to feel isolated by his classmates and other peers.

Psychometric finding: Comparing the results obtained through self-reported evaluation with those obtained from parent reports, we observed that Daniel's perfectionism tendency determined him to present himself in a socially desirable manner. Thus, the anxiety level, measured through a self-reported scale (MASC), had a total score situated under the mean. Nevertheless, the Anxiety Disorder Index, which differentiates between people with and without a diagnosis of anxiety disorder, had a Slightly Elevated T-score (62). The subscales analyse showed that "Perfectionism" and "Harm Avoidance" scales had very elevated T-scores, "Anxious coping" subscale was classified as slightly elevated and "Separation/Panic" as high average. The self-reported level of depression was classified as low (T score=36). However, the parent form completed by Daniel's father showed a depression level that is slightly above the mean (T score=58) and the functional problems scored higher than the emotional problems. The report completed by his mother indicated a similar depression level (T score=56) and the score for functional problems was again higher than the one for emotional problems. Daniel's level of intelligence was also evaluated and was classified as a superior level (I.Q.=128). The behaviour problems were assessed using self-report form and parent forms. Comparing the results of the parent forms, we observed that they are very similar. In both cases "Aggression" Scale scored very high (T score=76 - mother, T score=79 - father), and "Peer Relations" Scale had a very high score according to father's evaluation (T score=83) and a high score according to mother's evaluation (T scale=68). Analysing DSM Symptom Scales, we discover that the assessment forms completed by both parents indicate a very high score for Oppositional-Defiant Disorder Scale (T score=82). Self-reported form indicates that the boy evaluated himself as having problems connected to "Family Relations" (T score=85).

Discussion: Daniel had a very high level of aggression and manifested oppositionist tendencies in relation with both parents. He also had difficulties regarding the social interactions with peers, but also regarding the relation with his parents and other family members. All these behaviour manifestations were associated with certain emotional problems, such as tendencies toward perfectionism and harm avoidance, anxious coping mechanisms and separation anxiety.

Case 2: Philip, age 8

Reasons for evaluation: Philip's parents affirmed their son was easily distracted and agitated at home, but also at school, making many mistakes, tending to answer without being named and sometimes having an oppositionist attitude toward his parents and teachers.

Interview with parents: First session contained the interview with Philip's parents. We were informed that symptoms first appeared at the age of four, immediately after his sister was born. His parents considered this behaviour problems were triggered by his emotional difficulties of accepting the birth of his sister. At the moment of the assessment, he was described as being agitated, easily distracted, disobedient, peevish and aggressive with his sister. He didn't always respond to teacher's instructions and he was punished from time to time for his behaviour.

Psychometric finding: Results of psychometric measurements administered during next three sessions revealed the fact that, although the child didn't have a high level of general anxiety, he confronted with some certain anxiety issues such as a slightly high level of "Perfectionism" (T score=62) and "Harm Avoidance" (T score=61), which scored above the mean and "Anxious coping", which scored only slightly above the mean (T score=58). The self-reported level of depression was classified as average, although "Anhedonia" Scale scored above the mean (T score=63) and "Negative Self Esteem" Scale (T score=58) scored slightly above the mean. The same level of depression resulted from mother's report was classified as high above the mean (T score=66), the one resulting from father's report was classified as being above the mean (T score=64) and the teacher perceived his student's level of depression as being an average one (T score=50). The only similarity between these results was represented by the fact that all the adults described his emotional problems as being more severe than his functional problems. Philip's level of intelligence was measured with Wechsler Intelligence Scale for Children and he obtained an I.Q. score of 141, which emphasize that he is a gifted child. Assessing his behaviour problems, we observed that "Aggression" Scale obtained the highest score in almost all respondent's reports (T score=67 – mother; T score=64 – father; T score>=90 – self-report). He also seems to manifest some specific symptoms of "Hyperactivity/Impulsivity" and "Inattention". The DSM Symptom Scale that scored high in all reports was Oppositional-Defiant Disorder Scale (T score>=90 – mother, T score=68 – father, symptom score=4 – teacher).

Discussion: Philip had a very high level of aggression manifested especially at home toward his sister, but also some specific oppositionist behaviours expressed exaggerated in relation with his mother, but also toward his father and in relation with his teachers at school. All these behaviour problems were associated with emotional difficulties, such as perfectionism, harm avoidance, anxious coping, anhedonia and a negative self-esteem.

Case 3: Lucas, age 9

Reasons for evaluation: The psychological assessment was required by Lucas's teacher, who felt overwhelmed by dealing with his behaviour problems, such as violence toward his classmates, inattention, speaking during classes, destroying school supplies and many others.

Interview with parents: During our first session of assessment, his parents expressed their worries regarding their son's aggressive behaviour manifested at school, lack of interest and motivation in studying, inappropriate language, oppositionist behaviour and video game addiction. Lucas refused to study and write his homework and responded only to his father indications as a result of his fear of his father's reactions. They admitted that the lack of efficiency of any other disciplinary measures determined them to use physical punishment repeatedly.

Psychometric finding: Second and third sessions of the evaluation contained a discussion with Lucas followed by the administration of several psychometric instruments that were mentioned above. Contrary to parents' declarations, he was cooperating, honest and positive. The results of the assessment indicated that his self-reported level of anxiety was slightly under the mean (T score=44) and none of the scales exceed the average scores. Nevertheless, self-reported level of depression scored above the mean. "Ineffectiveness" Scale scored very high above the mean (T score=72), "Anhedonia" Scale was classified above the mean (T score=63) and the scales "Interpersonal problems" (T score=59), "Negative Self Esteem" (T score=58) and "Negative Mood" (T score=58) scored slightly above the mean. The Parent Report completed by his father indicated a value of the depression level above the mean (T score=64), the one completed by his mother revealed a score classified as high above the mean (T score=78) and the Teacher Report indicated a score that is very high above the mean (T score=75). All respondents described the child's functional problems as being more severe than emotional problems. Lucas level of intelligence was characterized by an I.Q.=110 which is classified as being above the medium level. The behaviour problems were reported by his parents and his teacher. The Parent Report completed by his mother was not considered, as the "Negative Impression" Scale suggested an overly negative response style. The results of the Parent Report completed by the father indicated very high scores for "Peer Relation" Scale (T score=78), "Hyperactivity/Impulsivity" (T score=78) and "Inattention" (T score=75) and high scores for "Learning Problems" (T score=65) and "Executive Functioning" (T score=65). The results of the Teacher Report reveal very high scores for "Aggression Scale" (T score=81), "Peer Relation" Scale (T score=81) and "Inattention" (T score=74) and high scores for "Hyperactivity/Impulsivity" (T score=68), "Executive Functioning" (T score=66) and "Learning Problems" (T score=60). The Self-Reported Form's results indicated very high scores for "Inattention" Scale (T score>=90) and "Learning Problems" (T score=72) and high scores for "Hyperactivity/Impulsivity" (T score=67), "Family Relations" (T score=64) and "Aggression" (T score=63). Analysing DSM Symptom Scales, we discover that the assessment form completed by the teacher indicates a very high score for Oppositional-Defiant Disorder Scale (T score=86).

Discussion: Philip had a very high level of aggression manifested at home, but also at school toward his classmates, difficulties regarding peer relationships, learning problems, severe oppositionist behaviours, inattention and hyperactivity. All these symptoms were associated with emotional problems expressed through a high level of depression, ineffectiveness and lack of motivation, anhedonia, but also problems in interacting with peers as a result of his behaviour problems, a negative self-esteem and negative mood.

3. An experiential psychotherapy model for oppositional defiant disorder

3.1. Subject

The case study that is going to be described in this section is represented by Daniel, whose assessment was discussed in the first part of the paper. This eight years old child was manifesting oppositionist behaviors toward his parents, teachers and even classmates, perfectionism tendencies and tantrums as a result to failure behaviors that significantly altered his relationship with peers.

3.2. Procedure

In this section we will present the therapeutic objectives that were guided by an experiential psychotherapy model of intervention. The case is considered from the process-experiential perspective, starting with the clinical evaluation, followed by the case conceptualization (presented in *Case 1*) and then the treatment plan (Elliott et al., 2004).

The therapeutic process involved the following steps:

a) Facilitation of a safe and productive therapeutic relationship by emphatic attunement and therapeutic bond

Children with perfectionism tendencies and anxious coping live a permanent tension of trying cu succeed in every task and be on the first place in every competition, but they also have feelings of self-endangerment and a sense of helplessness, adopting maladaptive responses to avoid situations perceived as dangerous. The first step in our psychotherapeutic intervention process was to construct a safe and trusted therapeutic relationship, emphasizing the emphatic attunement, being present, resonating with client's experience and building the therapeutic bond.

b) Facilitation of task collaboration

Task collaboration represents an essential step in working with children with oppositional deviant disorder and it can't be obtained in one or two sessions, but by small steps accomplished during a longer period of time through constructing a therapeutic relationship based on equality and constantly adapting therapeutic objectives according to child's preferences.

c) Exploring client's authentic emotions and learning alternative ways to express them

Children frequently tend to be confused regarding their own emotions, have difficulties in understanding and differentiating them and, consequently, react in inappropriate manners. Learning to identify and differentiate them can help children manage the furious and maladaptive reactions. Daniel understood that he has the right of feeling sad right after losing a game or gaining a lower grade, but he should not argue, talk back to his parents or teachers, hit objects around him or cry loudly for a long period of time.

The most efficient technique in reaching this objective was represented by therapeutic stories.

d) Improvement of relationship with parents and peers

Firstly, we separately explored every relationship with significant people of his life, analyzing their strengths and weaknesses, as well as Daniel's strengths and weaknesses and discovering alternative methods of solving conflict situations in relation with each of them, using role playing strategies.

e) Identifying and implementing alternative parenting strategies within parent sessions

The psychotherapeutic intervention process also included separate sessions with Daniel's parents during which we discussed their parenting strategies in order to improve them through adapting them to Daniel's authentic needs and we explored together new ways of expressing their unconditional love for their child.

f) Raising his self-esteem

Considering that Daniel's superior attitude and perfectionism tendencies were a result of his insecurities, feelings of self-endangerment, sense of helplessness and negative self-esteem, we allocated a large part of the therapeutic process to becoming aware of their existence and raise this self-esteem through collage, modeling and drama therapeutic strategies.

g) Learning relaxation techniques and alternative responses to be applied in triggering situations

For reaching this objective, we implemented repeatedly techniques of creative meditation, but also adapted a few cognitive behavior techniques which consisted of break taking, thoughts reorientation, changing negative thoughts with positive thinking and practicing physical exercises.

h) Dealing with frustrating situations in a secure therapeutic setting and practicing learned techniques

During our psychotherapy sessions characterized by a secure and emphatic setting, we reproduced difficult situations experienced in the past, offering them a more adaptive solving alternative using role playing strategies, but we also confronted new frustrating situations during our activities (losing while playing boarding games).

i) Reprocessing of problematic experiences by retelling of the traumatic and difficult experiences

The psychotherapeutic process spontaneously revealed the presence of some negative experiences from the past which were explored and understood from a different perspective facilitated by Daniel's emotional development.

j) Self-empowerment

At the end of the psychotherapeutic process, Daniel expressed a more integrated view of self and

others and a better understanding of his own feelings, considering more adaptive ways of reacting to frustrating situations.

3.3. Results

After the psychotherapeutic treatment, Daniel's oppositionist tendencies decreased significantly, as well as his perfectionism tendencies and anxious coping, managing in the same time to present himself in a more authentic manner during the reevaluation.

4. Conclusions

The evaluation process revealed that all three children had a very high level of aggression and manifested oppositionist behaviours in relation with parent, teachers and classmates. All these behaviour problems were associated with emotional difficulties, such as perfectionism, harm avoidance, anxious coping, anhedonia, anxious coping mechanisms, separation anxiety and a negative self-esteem. The implications for practice are that the clinical evaluation protocol for children with oppositional defiant disorders should imperatively comprise tests for emotional difficulties, such as attention and depression.

Implications for psychotherapy. These findings that the oppositionist behaviors appear prior to the onset of the affective symptoms, depression and anxiety, suggest that the treatment for the child's oppositional defiant disorder (ODD) should follow the pattern for emotional disorders treatment, using a child and family model of psychotherapy that combine enhancing the parent's behavior management skills and improving the parent-child emotional relationship with enforcing the child's self-esteem and ability to recognize and manage his/her own negative emotions.

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