Treating Disruptive Behavior Disorders with Play Therapy

Julie Nash, Ph.D., RPT-S
Riverside Psychological Associates, LLC
Julie@drjulienash.com

Agenda

• Definitions
• “Risk Factors”
• Ages and Stage Needs
• Snapshots
• Punishment Based Models
• Reward Based Models
• Play Therapy Treatment and Interventions
Attention-Deficit/Hyperactivity Disorder

- Neurodevelopmental Disorders category
- “Persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development”
- Six or more inattention symptoms (teens need 5)
- And/or six or more hyperactivity and impulsivity symptoms (teens need 5)

What is ADHD: Using the DSM-5

- Pattern of behaviors
- Multiple settings
- Performance issues
- 2 categories: inattention and hyperactivity/impulsivity
- 6 symptoms for either or both in kids; 5 for those over 17 years old
- Some must be present by age 12 instead of age 7 like previous DSMs

• **Inattention:** Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:

  - Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
  - Often has trouble holding attention on tasks or play activities.
  - Often does not seem to listen when spoken to directly.
  - Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
  - Often has trouble organizing tasks and activities.
  - Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
  - Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
  - Is often easily distracted
  - Is often forgetful in daily activities.


• **Hyperactivity and Impulsivity:** Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person’s developmental level:

  - Often fidgets with or taps hands or feet, or squirms in seat.
  - Often leaves seat in situations when remaining seated is expected.
  - Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
  - Often unable to play or take part in leisure activities quietly.
  - Is often “on the go” acting as if “driven by a motor”.
  - Often talks excessively.
  - Often blurts out an answer before a question has been completed.
  - Often has trouble waiting his/her turn.
  - Often interrupts or intrudes on others (e.g., butts into conversations or games).

• In addition, the following conditions must be met:

• Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
• Several symptoms are present in two or more setting, (e.g., at home, school or work; with friends or relatives; in other activities).
• There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
• The symptoms do not happen only during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

http://www.cdc.gov/ncbddd/adhd/diagnosis.html

• Based on the types of symptoms, three kinds (presentations) of ADHD can occur:

• Combined Presentation: if enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months
• Predominantly Inattentive Presentation: if enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past six months
• Predominantly Hyperactive-Impulsive Presentation: if enough symptoms of hyperactivity-impulsivity but not inattention were present for the past six months.
• Because symptoms can change over time, the presentation may change over time as well.

http://www.cdc.gov/ncbddd/adhd/diagnosis.html
Oppositional Defiant Disorder

- A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

Angry/Irritable Mood

- 1. Often loses temper
- 2. Is often touchy or easily annoyed
- 3. Is often angry and resentful
Argumentative/Defiant Behavior

- 4. Often argues with authority figures, or, for children and adolescents, with adults
- 5. Often actively defies or refuses to comply with requests from authority figures or with rules
- 6. Often deliberately annoys others
- 7. Often blames others for his or her mistakes or misbehavior

Vindictiveness

- Has been spiteful or vindictive at least twice within the past 6 months
Note:

- The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic. For children younger than 5 years, the behavior should occur on most days for a period of at least 6 months, unless otherwise noted (Criterion A8). For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8). While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviors are outside a range that is normative for the individual’s developmental level, gender, and culture.

Conduct Disorder

- Repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:
Aggression to People and Animals

• 1. Often bullies, threatens, or intimidates others
• 2. Often initiates physical fights
• 3. Has used a weapon that can cause serious physical harm to others
• 4. Has been physically cruel to people
• 5. Has been physically cruel to animals
• 6. Has stolen while confronting a victim
• 7. Has forced someone into sexual activity

Destruction of Property

• 8. Has deliberately engaged in fire setting with the intention of causing serious damage
• 9. Has deliberately destroyed others’ property (other than by fire setting)
Deceitfulness or Theft

- 10. Has broken into someone else’s house, building, or car
- 11. Often lies to obtain goods or favors or to avoid obligations (i.e. cons others)
- 12. Has stolen items of nontrivial value without confronting a victim

Serious Violations of Rules

- 13. Often stays out at night despite parental prohibitions, beginning before age 13 years
- 14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period
- 15. Is often truant from school, beginning before age 13 years.
Specifier: with limited prosocial emotions

• At least 2 of the following persistently over at least 12 months and in multiple relationships and settings
• Typical pattern of interpersonal and emotional functioning
• Need multiple information sources
• Lack of remorse or guilt
• Callous—lack of empathy
• Unconcerned about performance
• Shallow or deficient affect

Prevalence Rates: ADHD

• Approximately 11% of children 4-17 years of age (6.4 million) have been diagnosed with ADHD as of 2011.
• The percentage of children with an ADHD diagnosis continues to increase, from 7.8% in 2003 to 9.5% in 2007 and to 11.0% in 2011.
• Rates of ADHD diagnosis increased an average of 3% per year from 1997 to 2006 and an average of approximately 5% per year from 2003 to 2011.
• Boys (13.2%) were more likely than girls (5.6%) to have ever been diagnosed with ADHD.
• The average age of ADHD diagnosis was 7 years of age, but children reported by their parents as having more severe ADHD were diagnosed earlier.
• Prevalence of ADHD diagnosis varied substantially by state, from a low of 5.6% in Nevada to a high of 18.7% in Kentucky.

http://www.cdc.gov/ncbddd/adhd/data.html
Prevalence of children aged 3–17 years who ever received a diagnosis of behavioral or conduct problems or with current behavioral or conduct problems

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Ever received a diagnosis of behavioral or conduct problems (parent report) (N = 78,042 persons surveyed)</th>
<th>Current behavioral or conduct problems (parent report) (N = 78,042 persons surveyed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>(95% CI)</td>
<td>(95% CI)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6.2</td>
<td>4.6</td>
</tr>
<tr>
<td></td>
<td>(5.7–6.8)</td>
<td>(4.1–5.1)</td>
</tr>
<tr>
<td>Female</td>
<td>3.0</td>
<td>2.2</td>
</tr>
<tr>
<td></td>
<td>(2.6–3.4)</td>
<td>(1.9–2.7)</td>
</tr>
<tr>
<td>Age group (yrs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3–5</td>
<td>1.5</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>(1.2–1.8)</td>
<td>(1.0–1.6)</td>
</tr>
<tr>
<td>6–11</td>
<td>5.1</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>(4.5–5.8)</td>
<td>(3.3–4.4)</td>
</tr>
<tr>
<td>12–17</td>
<td>5.7</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>(5.2–6.3)</td>
<td>(3.7–4.7)</td>
</tr>
</tbody>
</table>

Something to keep in mind...

- According to CDC data, 3 to 11% of children receive these diagnoses.
- That means that 97 to 89% DO NOT receive these diagnoses.
What is Normal Misbehavior in Preschool?

• Losing one’s temper
• Low-intensity destruction of property
• Low-intensity deceitfulness/stealing

What is Not?

• High intensity argument/defiant behavior
• Low and high intensity aggression to people/animals
• High-intensity destruction of property
• High intensity deceitfulness/stealing
• High intensity peer problems
Primary Contributors to DBDs

- Temperament of the Child
- Parenting Extremes
- Acute/Chronic Trauma
- Family Discord

Temperament of the Child

- Kids are born different
- “Unformed personality”
- Matching temperaments

- The DSM reports 3-18% are temperamentally disruptive because of who they are. 97-82% are NOT.
Parenting Extremes

• Unrealistically high expectations; no choices
• Permissive parenting

Acute/Chronic Trauma

• Situational losses
• Adult can’t keep the child safe: abuse, abandonment, enmeshment
Family Discord

- Divorce/custody fights
- Chaos at home
- Parental loss/separation from significant caretakers
- Significant alcohol and/or drug use
- Harsh discipline
- Frequent moves/social changes
- Inconsistent affection
- Depression/mental illness/sociopathy in family

Core Needs

- **Physical**
  - Food
  - Clothing
  - Shelter

- **Emotional**
  - Safety
  - Security
  - Love
Communication is Key!

• What is the NEED at each stage? How do we speak their language?

• Birth to Five Years: Mechanical
  • Need is to be heard. Communicate through behavior

• Six to Twelve Years: Verbal
  • Need is for YOU to be in control. More verbal communication

• Twelve to Eighteen Years: Emotional
  • Need is for a relationship. Task here is emotional regulation

Snapshot: ADHD

• Want friends desperately: can function socially but has poor skills
• If impulsive, trouble seen more in elementary school
• If inattentive, trouble seen more in middle/high school
• Academic potential/performance fluctuates
• Acting out/misbehavior is much more unintentional
  • Reacts out of frustration or failure at task
• Needs to feel competent
• Intervene with reward based approaches
• For pure ADHD, individual therapy is not the best approach
Snapshot: ODD

• Trust issues
• Wants to like you and have you like them
• Passive/aggressive
• Socially functional
• Does have academic potential
• Usually apologetic then blames others (disguise the behavior)
• Strong need for autonomy; reacts out of frustration
• Intervene with awareness and choices

Snapshot: CD

• “Juvie kids”
• Socially dysfunctional
• Behavior much more blatant
• Academic potential is not high
• Needs power and reacts out of desperation
• Intervene with empowerment and decision making
What is the Common Need?

• Stubborn kids:
• Anxious/nervous:
• Negative/pessimistic:

Typical Treatment Approach: Punishment Based

• Expectation: Child and adult both high

• Thinking about the 3-18%...
  • If high expectation, and medium to low child performance:
    • Adult feelings:
    • Adult behaviors:

    • Child feelings:
    • Child behaviors:
Why? What is the Primary Need?

• Approval.

• If can’t get approval, will settle for attention.
  • Child gets attention in the punishment based model—but for which behaviors?

• If ignored, will escalate.

• If escalating, who is in control??

Reward Based Treatment Approach

• Expectation: Child and adult both low

• Thinking about the 3-18%...
  • If low expectation, and low to medium child performance:
    • Adult feelings:
    • Adult behaviors:

  • Child feelings:
  • Child behaviors:
What does the reward based model lead to for the 3-18%?

- If low expectation, and low to medium child performance:
  - Adult feelings:
  - Adult behaviors:
  - Child feelings:
  - Child behaviors:

What are we trying to improve for these kids?

Self-confidence.
Using Play Therapy: Axline’s Eight Basic Principles

- Warm rapport
- Acceptance of the child
- Permissive attitude
- Reflect feelings
- Respect child’s choices
- Follow child’s lead
- Do not push the pace
- Minimum limits

Landreth’s Basic Principles

- Children are not miniature adults.
- Children are people.
- Children are unique and worthy of respect.
- Children are resilient.
- Children have an inherent tendency toward growth and maturity.
- Children are capable of positive self-direction.
- Children’s natural language is play.
- Children have a right to remain silent.
- Children will take therapy where it needs to go.
- Children’s growth cannot be fast-forwarded.
Making Contact

- Non-directive foundation
- Introductions?
- Office space?
- Family Play Genogram
- Color Your Life
- Feelings for the Week

Engagement

- Rules of Sessions
- Hula Hoops
- Squiggle Game
- Bubble Contest
- Cotton Ball Hockey
- Mirroring
- Hokey Pokey
Build Trust, Security, and Vocabulary

• Name that Feeling
• Feelings Faces cards
• Trash Can Basketball

• Flip Me the Bird
• No Rules Games/Change the Rules Games
• Red Light, Green Light/Simon Says

Competency

• What I Like About Me
• Three Wishes
• Balloon Tennis
• Timed Cotton Ball Races

• Jenga
• Uno (with colors as ________)
• Shields
• Bibliotherapy: Oh the Places You’ll Go
Taking it Outside

• Punch Cards
• Connect the Dots
• Behavior Charting
• Paper Links/Chains
• Bracelets

Other Treatment Approaches

• Multimodal treatment
• Parent-child interaction therapy
• Multiple family groups