

Anger Overload in Children:

Diagnostic and Treatment Issues

By David Gottlieb, Ph.D.



Anger reactions in some children are quite frequent and troubling to parents and teachers who witness them. The child's intense anger may erupt quickly and intensely in reaction to limit setting by adults, to teasing or to seemingly minor criticism by peers or adults. This is a distinct psychological problem in children which is separate from diagnoses such as attention-deficit/hyperactivity disorder, bipolar disorder and oppositional defiant disorder. It can co-occur with AD/HD or learning disabilities, but may also occur separately from these diagnoses.

At this time, the diagnostic manual, DSM-IV, does not consider anger disorders as a separate category like depression and anxiety. However, many mental health professionals feel it is a category unto itself and are devising treatment strategies for anger problems. Daniel Goleman (in Emotional Intelligence) and John Ratey and Catherine Johnson (in Shadow Syndromes) offer cogent reviews of this literature. Goleman uses the term "anger rush" to describe anger problems in adults, while Ratey and Johnson refer to a shadow syndrome for "intermittent anger disorder" in adults. Anger disturbances in children need to be classified as a discrete psychological problem as well, and they require particular treatment strategies. This article defines the syndrome and outlines effective treatment strategies.

Diagnostic Issues

The term "anger overload" is used to refer to the intense anger response which has been the presenting problem for a number of young children and preadolescents seen in a suburban outpatient practice. There is an intense and quick reaction by the child to a perceived insult or rejection. The rejection can seem quite minor to parents or others. For example, a parent saying "no" to something the child has been looking forward to doing can trigger an intense period of screaming and sometimes hitting, kicking or biting. Another common situation which can trigger anger overload may occur in a game with peers. It can involve a disagreement on how the game should be played or its outcome. Parents often explain to the mental health professional that these reactions have been going on since early childhood in one form or another. It is frequently reported that these children become sassy and disrespectful: they will not stop talking or yelling when they are upset. At other times, when their anger has not been stimulated, these children can be well-mannered and caring.

The problem is called anger overload because it is more severe than a temporary anger reaction lasting only a few minutes. With anger overload, the child becomes totally consumed by his angry thoughts and feelings. He or she is unable to stop screaming, or in some cases, acting out physically, even when parents try to distract the child or try to enforce limits and consequences. The anger can last as long as an hour, with the child tuning out the thoughts, sounds or soothing words of others.

Another significant characteristic is that these children are sometimes risk takers. They enjoy more physical play than their peers and like taking chances in playground games or in the classroom when they feel confident about their abilities. Other children are often in awe of their daring or scared of their seemingly rough demeanor. Perhaps most interesting is that these very same risk takers can be unsure of themselves and avoid engaging in other situations where they lack confidence. A number of these children have mild learning disabilities, and feel uncomfortable about their performance in class when their learning disability is involved. They prefer to avoid assignments where their deficits can be exposed, sometimes reacting with anger even if the teacher privately pushes them to do the work with which they are uncomfortable.

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One diagnostic fallacy is to assume that these children have bipolar disorder. Dr. Dimitri and Ms. Janice Papolos recently devoted a full book to the disorder (*The Bipolar Child*, 1999). The rages of children with bipolar disorder are more intense and lengthy than for the children we are currently discussing. The Papoloses describe (page 13) that for children with bipolar, these angers can go on for several hours and occur several times a day. In children with bipolar, there is often physical destruction or harm to something or someone. In children with anger overload, the outburst is often brief, less than half an hour, and while there may be physical acting out, usually no one is hurt. In addition, children with bipolar have other symptoms such as periods of mania, grandiosity, intense silliness or hypersexuality.

Anger overload is also different from attention-deficit hyperactivity disorder. Children with AD/HD have significant distractibility, which occurs regularly in school and/or the home. By contrast, children with brief outbursts of anger often pay attention well when they are not "overheated" emotionally. In addition, children with AD/HD may have hyperactive movements throughout the day; whereas children with anger overload only seem hyperactive when they are overstimulated with feelings of anger. Finally, children with AD/HD are often impulsive in a variety of situations, many of which have nothing to do with anger.

It is possible, however, for children to have symptoms of AD/HD and anger overload. This combination is especially difficult for parents to manage. Behavioral strategies for AD/HD are not as effective because the child becomes excessively angry despite efforts by others to focus his attention elsewhere. Sometimes, professionals then tell the parents or teachers that they are not applying behavior modification techniques properly. What may work for a child who has AD/HD may not be as effective for a child who also has the problem of anger overload.

Another diagnostic category which can be differentiated from anger overload is oppositional defiant disorder. Oppositional children have a continuing pattern of disobedience to adult demands, whereas children with anger overload are only defiant when their anger is stimulated. The situations which trigger their anger are more restricted. There are certain areas which have special importance to them, such as winning a game, buying a toy or being seen as successful in school. In most other situations, they are described by their parents as sweet and cooperative. Few, if any, oppositional defiant children are described by their parents in this manner.

Treatment Techniques: Behavioral Strategies

When these children first come to a professional's attention, there may be a tendency to think that the parents must learn to ignore their children's tantrums. But this will not work reliably for children with anger overload. Their angry outbursts will not be extinguished this way. Behavior therapy for these children involves working with the parents as much as, or more than, the children themselves. Parents and teachers can learn strategies to teach their child self-control in a shorter period of time than the therapist can teach the child alone. By coaching the parents, the therapist has an impact on the child throughout the week. In addition, children cannot apply therapeutic strategies themselves at home when the anger is building. They need someone to cue them on what to do — usually a parent or teacher.

The first strategy is for the adult to recognize when the child is about to experience anger. This is sometimes difficult for anyone to predict. However, over time, parents and teachers begin to recognize signs that an angry outburst is impending. The look in the child's eyes, the tone of his voice or the tightness in his body tell the adult that the child is beginning to get upset. The time from when the child gets upset to when he shows full-blown anger may only be a few seconds. If it is caught in time, the child is much more likely to achieve self-control than if the adult tries to intervene once the child is overflowing with emotion. It is as if the child's brain has reached overload then, and it takes some time to cool off.

One technique to use before reaching this point, is distraction. The parent should try to turn the child's attention to something else that is interesting to him/her. It is important that the distraction be interesting to the child — something he/she likes and that involves some action. The child is unlikely to immediately choose a quiet, sedentary activity like reading. A more effective distraction technique is going outside to ride a bike or playing catch. For example, if the family is at a park and the child does not want to leave the swings, then suggest he try the slide — which is an activity with a more natural ending point. Once he comes down the slide, the activity is at a possible stopping point. That is a good time to direct him to the car.

To help motivate the child, some behavior modification mechanism should be in place. Choose incentives and consequences that are brief and preferably immediate. A colorful chart or poster can be used to track two or three behaviors which the child needs to demonstrate during the day in order to earn a reward. Select one or two behaviors and review a behavior plan for these situations with your child.

The basic principle is to offer an alternative behavior that is more socially acceptable than an angry reaction. If the child does not use the alternative behavior, and moves into a rage, a negative consequence may be imposed. The principle for negative consequences is similar to rewards: brief and immediate, where possible. A brief consequence such as being grounded from going outside and/or playing computer games for a few hours (or up to a day long, depending on the severity of the offense) is helpful in getting the child to recognize the importance of using self-control. If, instead of using a strong verbal response, the child hits back when teased, a consequence will send a message better than trying to talk to the child. Children take consequences more seriously than "lectures." They are more likely to remember a consequence later and to choose a more appropriate response the next time. Parents need to be firm about applying negative consequences because they send an important signal to the child. While such enforcers do not help shorten the immediate anger, they can help lower the frequency of angry outbursts in the future.

Another key principle when applying negative consequences is to eliminate discussion at the moment the child is raging. Giving the child attention, even talking, is a reward for negative

behavior. Plus, the child who is raging is not rational at the moment, and the rage is likely to escalate further if consequences are mentioned while he is having a meltdown.

Therapy for AD/HD and Anger Overload

If the child also has AD/HD, problems like distractibility in the classroom or failure to complete assignments cannot be effectively dealt with until the child learns how to control his angry reactions. Otherwise, the child will likely react with extraordinary anger when teachers or caregivers give consequences or time outs for not working on or not completing class work. The child may feel criticized or embarrassed and not know how to control these feelings. Once anger control is learned, behavior modification aimed at goals like completing assignments is much more effective.

The issue of medication for AD/HD has also been problematic at times for children who simultaneously have anger overload problems. Sometimes, stimulant medication will work for both problems, but it can also make it harder for a child to control his anger. In that case, medications other than stimulants should be considered. In some cases, a combination of a low dose of SSRI medication along with a low dose of stimulant medication can be helpful. However, the issue of medication for the dual problems of AD/HD and anger overload needs further study.

Cognitive Treatment Strategies

One important point which affects how a child responds to a provocation is the way he or she perceives the problem situation: does he feel embarrassed, humiliated or rejected? If the child feels an insult to his sense of pride, or feels as if he was treated "unfairly," he is more likely to exhibit rage. Teaching the child to respond assertively but in a controlled manner helps him not to feel humiliated or put down.

This approach is similar to cognitive therapy approaches, which aim to change the way a person experiences a situation. Sometimes the parent or therapist can suggest to an older child another way to look at the intentions of the other by whom the child feels put down. This is not always effective, as many children will insist on their interpretation of the situation. Instead, the adult helps the child to respond differently so that the child then "feels" differently about herself. By being assertive or learning new social skills, the child is less likely to feel embarrassed and upset.

Teaching the child one catch phrase is an effective cognitive strategy that can be used. For many children, one such phrase is, "everyone makes mistakes." Children with anger overload often have high standards for themselves without even realizing it. They generally are not obsessive-compulsive by nature, but they also lack the social sense about what normal expectations are for children their age.

For example, one child frequently got upset when he made a written mistake in school. Another child raged when he could not find a puzzle piece, and another when his team lost a baseball game. Teaching these children that "everyone makes mistakes" really helps. They learn to say this phrase to themselves at the time of a mistake. Often we role play this scenario ahead of time in the therapist's office. This strategy, like the others we've discussed, takes time to work. The child may not remember to use it when he or she is upset, and once it is finally used, may forget it altogether. But over time, it will become more automatic.

Another useful phrase to use is, "Is this a good risk?" Since children with anger overload are often risk takers, they like to try new challenges, including those that are dangerous or likely to provoke a negative response from adults. One child liked to make jokes in class when someone made a "funny" mistake. His classmates would laugh louder, and the teacher would get angry and give him a consequence. The child felt this was unfair and reacted with anger. The therapist helped the child to see the cause and effect of his actions, and taught the child to evaluate the risk before making his remark. The child also learned to let others take chances and make funny remarks, rather than always taking the lead and getting punished.

Nonverbal cues can also be effective in some situations. A nonverbal cue, such as the adult putting up his hand like a policeman does to stop traffic, is more likely to work when the child is becoming upset rather than moving toward a full-blown rage. Also, the signal needs to be prearranged with the child when he is calm in order to increase the chances that the child will see the signal as benign, not as a punishment.

Future Research Ideas

For parents, a key factor in working with angry children is patience and practice. The techniques described above take time for parents and children to learn. The child's problems are probably related to developmental lags or to subtle neurological deficits. In *Emotional Intelligence* (1995), Daniel Goleman summarizes research with adults which suggests that the limbic system of the person's brain goes into overdrive when anger occurs, causing catecholamines to release. One neurological hypothesis which needs further testing for children with anger overload is whether there is a lag or deficit in their limbic systems, so that catecholamines are released more quickly or in higher concentrations than for other children. Building new behavior patterns is possible, but again takes time. Parents should notice gradual improvements towards the goal of self-control rather than feeling defeated if there is not an immediate change. It is not the parent's fault if the child has problems with anger. Often if the parents review their family trees, they will notice some other relative, if not themselves, who had difficulty with anger as a child. In many cases, there most likely is a genetic component. This is not to say that anger overload cannot be changed. Internal mechanisms for self-control can be learned by the child. But the approach must be methodical and requires extreme patience. Parents will feel relieved once they begin using strategies that work and realize that their children are not destined to a lifetime of anger overload. A

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