Clinical Case Study of Psychological Picture of Patient with Oppositional Defiant Disorder

Alfeyni Ainun Nadlifatul Arifah[1], Nanda Audia Vrisaba[2]
Department of Psychology, Faculty of Psychology, State University of Surabaya, Surabaya, Indonesia
[2]Department of Psychology, Faculty of Psychology, State University of Surabaya, Surabaya, Indonesia
alfeyni.22158@mhs.unesa.ac.id; nandavrisaba@unesa.ac.id

Abstract: Conduct disorders are often characterized by aggression and violation of other people's rights. Behavioral disorders are behaviors that involve problems in controlling emotions and behavior. This article presents a clinical case study of a 15-year-old patient with a primary diagnosis of behavioral disorder, which was later clarified as oppositional defiant disorder. The study aims to understand the patient's psychological profile by examining the patient's lifestyle through their social background, conducting a direct self-interview with the patient, obtaining information from the patient's close relatives, conducting structured interviews, observations, and reviewing psychological records over a one-month period. The findings were analyzed using Sigmund Freud's psychoanalysis of defense mechanisms, focusing on the suppression of emotions known as repression.

Keywords: Conduct Disorders, Oppotional Defiant Disorder, Case Study

1 INTRODUCTION

Conduct disorders are a set of behaviors that persist and repeat over time, these disorders refers to severe behavior problems including repetitive and persistent manifestations of serious aggressive or non-aggressive actions and behaviors in which the basic rights of others and major age-appropriate social norms or rules are violated (Pisano et al., 2017).These conduct disorders consist of intermittent explosive disorder, impulse disorders and oppositional defiant disorder. Most symptoms in conduct disorders are caused by poor emotional control such as being unable to feel anger. Anger is often out of sync with the provocation of stressor, resulting in sudden/explosive anger. Symptoms are also usually self-destructive and impulsive. The majority of the symptoms that define conduct disorder itself can be present to some degree in individuals during development (American Psychiatric Association (APA), 2013)This disorder seriously disturb a child's social and academic functioning (Campbell et al., 2000)

One type of conduct disorder is oppositional defiant disorder (ODD) which characterized by an ongoing pattern of angry and irritable mood, argumentative and defiant behaviour, and vindictiveness. This disorder can be diagnosed at any age between early childhood and adulthood, although onset is typically before 8 years of age (Lavigne et al., 2009)moreover childhood with ODD is one of the most common precursors of other mental health problems throughout the lifespan. Accordingly, ODD should be a key priority for research, practice and policy concerning early intervention and prevention in mental health (Comer et al., 2013)

This writing is focused on a psychological case study of 15-year-old female patient initials DRI with conduct disorders which then became focused on oppositional defiant disorder at Bhakti Dharma Husada Surabaya Hospital, the focus on patient is carried out as an effort to understand the mental problems experienced by patients in depth, the efforts made are to approach, observe, collect information data related to patients both through written data and statements from people closest to the patient in order to later get objective results.

2 MATERIALS AND METHODS

The subject of this case study is a 15-year-old female patient with the initials DRI from Bhakti Dharma Husada Hospital in Surabaya, who, based on her medical records, was diagnosed with a conduct disorder. After obtaining permission to approach the patient, the approach and data collection were carried out from April to June 2025.

The research method used during this study was a qualitative method with a case study technique. The qualitative method with a case study technique is a method used to explore phenomena or cases in depth. In addition, this method is used for cases or issues that need to be explored thoroughly. There were two stages in this research. First, the author selected the case, and second, the author collected data through observation, documentation, and interviews conducted between April and June 2025 during approximately four meetings.

The author in this writing conducts both written and unwritten methods, first the author conducts in-depth interviews, namely semi-structured interviews both to the patient directly named autoanamnesis and to those closest to the patient named alloanamnesis, which allows the author to get an clear data. In addition the author conducted direct observation which is observing situations or things related to the case to get data that is not revealed through interviews. The author also conducted documentation by collecting data about individuals through interview notes, observation notes, and medical records, as well as observations from the patient's family. Furthermore, the author tringualated data by using various sources interview data, observations, and patient medical record data.
The author conducts qualitative data analysis approach, as an effort to analyze the data by making an description of the case of conduct disorders including symptoms and causes. Then, the author draws conclusions about the phenomenon of oppositional defiant disorder by connecting relevant theories and literature.

3 RESULTS

Based on the results the interviews obtained by the author in this study include the patient's family situation, the patient's educational background, the patient's hobbies, the patient's social activities, and the patient's use of free time. In an interview with the patient, the author obtained data that the patient is a 15-year-old girl who is the 2nd of 2 siblings. The patient's relationship with her family is quite good but between the patiien's father and mother have different parenting patterns which result in an imbalance in patient's care.

Based on the patient's medical records, she has been diagnosed with a conduct disorder characterized by behavior that often does not conform to existing social norms. Furthermore, a qualitative approach narrows down the patient's diagnosis to a oppositional defiant disorder (ODD) that defies this because, based on observations and interviews with people close to the patient, she often disobeys her parents, has frequent mood swings, is easily irritated, and often argues with others.

During the interview, the patient's father stated, *"She wasn't like this before. Then after being bullied at school, she often likes to be alone, likes to tear up paper and books, and has become a temperamental and explosive child."* This was conveyed by the patient's father during her first interview with the psychologist.

Based on interview, the patient is currently still in high school and has not yet started her career journey. The patient's hobbies are watching videos and playing games on her cellphone, the patient also like to spend time on these things which often gets angry from the patient's mother because she is considered never spending time socializing. From the results of interviews that have been conducted, the patient said she did not like socialize with and tried to withdraw from her social life, after tracing it turns out that the patient was a victim of bullying at her school and t was experienced for approximately 2 years, therefore the patient tends to have a fears of socializing with others and prefers to play alone with her cellphone or play with children around her house. In addition, it was reported by the teacher at her school that the patient often tore up papers and books while in class and in a dreamy position, also the teacher reported that the patients only made friends with children with special needs at her school, therefore the teacher reported to the patient's parents because they were worried that this unusual thing could have an adverse impact on the patient.

Meanwhile, in the observations during several meetings, the client was initially someone who was closed and tented to close herself, until after the few approach patient's seemed more relaxed and became open, when explaining about the situations the patient seemed nervous and confused to start telling stories until finally the client could be more flexible on telling stories.

4 DISCUSSIONS

Conduct disorders are a group of behaviors that are persistent and repetitive over time, most often characterized by aggression and violation of the rights of others. Behavioral disorders also involve problems with controlling emotions and behavior (American Psychiatric Association (APA), 2013).Therefore, it is important to assess the frequency, the extent to which the symptom to determine whether it is normal for individuals of a particular age, gender and culture. This conduct disorder is often associated with a spectrum of personality dimensions called disinhibitation and restriction that can be comorbid, along with substance abuse disorders and antisocial behavior disorders. However, specific explanations for this comorbidity have yet to be found.

Furthermore, the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5, explains that there is a subcategory of personality disorders called oppositional defiant disorder, which is the diagnosis of the patient and the main focus of this paper. Oppositional defiant disorder (ODD) is similar to conduct disorder, however is also commonly associated with significant social and economic burdens (Hawes et al., 2023)The development of this disorder arise from the interaction of genetic and environmental factors, and mechanisms embedded in social relationships are understood to contribute to its maintenance.

Based on the data collected on the patient, the patient meets several criteria for oppositional defiant disorder in the DSM-V, including :

Angry/Irritable Mood

1. Often loses temper. Based on data collection and observation, patients are often found to lose patience during interviews nor counseling. Examples include frequently moving her feet as a sign of boredom or impatience, tapping her hand finger on the table, and complaining when faced with many interview questions.
2. Is often touchy or easily annoyed,These symptoms can be observed during the observation process patients repeatedly displayed unpleasant facial expressions whenever the psychologist asked questions during counseling about the homework she had done at home. In addition, the patient also appeared gloomy whenever the counseling topic turned to the bullying she had experienced.

Argumentative/Defiant Behavior

1. Often argues with authority figures or, for children and adolescents, with adults. According to the patient's parents during the interview, the patient often argued with her parents.
2. Often actively defies or refuses to comply with requests from authority figures or with rules. In interviews with the patient's parents, it was also stated that the patient rarely obeyed her parents' orders. *"Even for small things like cleaning himself, she does not obey"*, said the patient's mother, echoing what was conveyed by the patient's teacher at school, who also stated that the patient often tore up paper and books, even when reprimanded and forbidden from doing so again by the teacher the patient did not pay attention.

A. The disturbance in behavior is associated with distress in the individual or others in her immediate social context (e.g., family, peer group, work colleagues) or it impacts negatively on social, educational, occupational, or other important areas of functioning.
B. The behavior does not occur exclusively during the course of a psychotic, substance use, depressive, or bipolar disorder. Also the criteria are not met for disruptive mood dysregulation disorder (American Psychiatric Association (APA), 2013)
C. A pattern of angry/iiritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms of the following categories, and exhibited during interaction with at least one individual who is not a sibling:

In the case of the DRI patient described in this paper, it is explained that the patient experienced bullying by her school friends, which caused trauma to the patient as verified by the patient's medical records. Bullying itself includes physical bullying, verbal abuse, and neglect. The DRI patient experienced every forms of bullying, in terms of verbal abuse, the patient was ridiculed by her school friends without knowing the reason. The patient also experienced physical bullying, such as a school friend trying to pull off her skirt uniform in front of other friends, and the patient was also ostracized by her school friends. The effects of bullying itself include impaired physical health, difficulty adjusting to the environment, loss of self-confidence, excessive anxiety, fear, suicidal thoughts, and symptoms of post-traumatic stress disorder. (Thomas et al., 2015)

Incidents like this often trigger conflicts and various situations where conflicting motivations arise. Victims may experience frustration, anxiety, and low self-esteem, prompting them to develop specific responses to cope with these difficulties and situations. Therefore, victims of bullying use defense mechanisms to hide unacceptable realities or tendencies in an effort to protect themselves. Returning to its historical roots, Sigmund Freud first articulated the comprehensive conceptualization of defense mechanisms, in order to harmonizing between consciousness and

unconsciousness, Freud explains the process of self-defense mechanisms, in which a human's self-defense mechanism performs a form of self-defense from id urges in order to conform to existing norms (S. Freud, 1923). Self-defense mechanisms aim to protect the mind, self, ego from anxiety and/or social sanctions and or to provide protection from situations that one cannot cope with, the conclusion is the role defense mechanisms play in the overall functioning of the psyche and their role in its major function, which is adapting to the outside world, forming relationships to satisfy needs, and reducing tension.

There are various kinds of self-defense mechanisms such as regression, repression and many more (A. Freud, 1938).Repression itself is an ego-defense mechanism, an action that the subject performs in order to protect herself from threats that conflict with the subject's beliefs and desires and/or her self-image. The existence of repression has remained controversial for more than a century, in part because of its strong coupling with trauma (Anderson & Green, 2001). In the case of DRI patients, we can relate this to Freud's theory of self-defense repression. This is because, in the process of collecting complete qualitative data, it was found that the patient had no one to talk to and was even afraid to tell her parents about her unpleasant experiences, so that the patient's parents only found out about the incidents or events experienced by the patient when the patient's teacher informed them. The lack of a place to vent their feelings is what causes patients to suppress all their emotions and repress all bad memories in order to protect their self-image.

However, this is not justified because Freud argued in his work *"The Neuro-Psychoses of Defense"* (1894) that Disorders such as phobias, hysteria, anxiety, and neurosis often arise due to unconscious emotional conflicts, especially impulses from the id (instinct) that are rejected by the ego. Freud also believed that *"What we are not aware of will resurface in the form of symptoms."*. This means that repression causes emotions to be suppressed, and eventually they find an outlet through psychological or physical symptoms, such as tremors or seizures without medical cause (hysteria), obsessive-compulsive behavior or even psychosomatic symptoms and we can relate this to the patient's problem, which is oppositional defiant disorder (ODD) (S. Freud, 1894)

This is seen when the individual is in a certain situation or problem and it is out of control. The individual chooses to forget about it and tries to suppress the bad memories or problems they are facing into the subconscious. Bad memories or problems that are continuously suppressed will result in the emergence of negative behaviors caused by too many emotions and feelings that are suppressed into the subconscious that are not handled properly, in this approach, the patient represses unpleasant events that have been experienced, such as bullying actions to the patient which causes the patient to vent or project her suppressed emotions into ODD.

5 CONCLUSIONS

The case of DRI, a 15-year-old female patient diagnosed with Oppositional Defiant Disorder (ODD), highlights the intricate relationship between unresolved emotional trauma and the manifestation of behavioral disorders in adolescence. Her history of persistent bullying, lack of emotional support, and inconsistent parenting styles contributed significantly to the emergence of her defiant, irritable, and emotionally volatile behavior. Through a qualitative case study approach, this paper reveals that DRI's behavioral symptoms are not merely signs of disobedience, but rather reflect deeper emotional wounds and unprocessed psychological pain.

By applying Freud's psychoanalytic theory particularly the concept of repression, we can understand DRI's symptoms as defense mechanisms against the internal conflict between her traumatic experiences and her inability to express or process those emotions healthily. The repression of distressing memories and the absence of a safe space for emotional expression likely resulted in displaced anger and impulsivity, central features of ODD. This aligns with Freud's argument that repressed emotions, if not confronted, will inevitably surface as psychological symptoms or maladaptive behaviors.

Thus, this case study not only provides a clinical understanding of ODD but also emphasizes the broader psychological mechanisms, such as repression, that may underlie and sustain such disorders. It underscores the importance of integrating both behavioral and psychodynamic perspectives when assessing and intervening in conduct-related disorders in adolescents.

The author's suggestion is schools and families must be proactive in identifying signs of emotional distress, especially in children exposed to bullying. Timely intervention through counseling or supportive dialogue can prevent the development of deeper psychological issues, so do the parents must be guided to adopt consistent and empathetic parenting approaches. Family therapy is recommended to address parenting style differences and to strengthen communication and emotional bonds within the family.

ACKNOWLEDGEMENTS

The author would like to thank the institutions that support and in the process of preparing this case study, especially the supervisors on campus and psychologists who are always present and provide all their knowledge to be shared.

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