Oppositional defiant disorder strategies for changing "no" to "yes"

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OPPOSITIONAL DEFIANT DISORDER
STRATEGIES FOR CHANGING “NO” TO “YES”

by
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A RESEARCH PAPER
SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS IN EDUCATION
AT CARDINAL STRITCH COLLEGE

Milwaukee, Wisconsin
1990
For Carson James--

My motivation for pursuing this topic.
This research paper has been approved for the Graduate Committee of the Cardinal Stritch College by

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Date July 25, 1990
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CHAPTER 1

Introduction

"No."

"I won't!"

"I don't want to!"

As parents and teachers we all face a certain amount of oppositional behavior in children. We are familiar with the oppositional behavior associated with the "terrible two's" and with the defiant behavior that often occurs at the onset of adolescence. In fact, a certain amount of oppositional behavior is considered necessary for normal, autonomic development.

But what happens when defiant, noncompliant behavior becomes a chronic behavioral problem? A child that demonstrates such behavioral patterns can readily disrupt both a family and a classroom. Oppositional children may display a variety of negative behaviors in a variety of situations. These behaviors may range in severity from simple
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stubborn behavior to open defiance and aggression toward peers and adults.

Research indicated that the key behavior in diagnosis and treatment of oppositional behavior may be noncompliance. Noncompliance is the failure of a child to consistently respond to adult directives within a reasonable amount of time.

Many of the rating scales used to diagnose oppositional disorder and several of the treatment programs for oppositional behavior focus on reducing the amount of noncompliant behavior through behavior parent training. These programs generally have several key components which will be examined in greater detail. Other interventions include the use of paradoxical techniques, differential attention, family therapy, and medication.

Purpose of the Study

It is estimated that as much as 5% of the population may exhibit characteristics of behavioral disorders. As teachers we deal with a
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cross-section of the population, therefore it is inevitable that we will have these children in our classes. It is also likely that some of these children may be our own. As teachers, we need to deal effectively with these children in our classrooms—as parents we need to manage these children in our homes, in our families, and in social situations.

In looking for information on oppositional behavior, the author found that very little existed in educational journals. The information that was found tended to be in psychological or medical journals and it often focussed on a narrow aspect of the disorder. In addition, the information was written for clinicians and therapists, not educators.

The purpose of this study then was to provide a review of some of the current literature and present it in a organization that would be useful to parents and teachers of oppositional children.
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Scope and Limitations

This study was designed to provide parents and teachers of oppositional children with a source of information that would assist them in dealing with and modifying defiant behavior. To this end this study attempted to identify and describe oppositional disorder, discuss methods of assessment, review current treatment plans, and discuss possible outcomes based on current research. This study focused on oppositional behavior in children ages 18 months through twelve years. Because of overlapping diagnoses, the study also included a discussion of Attention Deficit Hyperactive Disorder and Conduct Disorder which are grouped together in the DSM III-R under the heading "Disruptive Behavior Disorders".

Definitions

For the purpose of clarity in this report, the following definitions have been used:

- Oppositional Defiant Disorder (OD) - A behavioral disorder characterized by a pattern of
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negative, hostile and defiant behavior. The DSM III-R uses the following criteria for a diagnosis of Oppositional Defiant Disorder:

A. A disturbance of at least six months during which at least five of the following are present:

1. Often loses temper
2. Often argues with adults
3. Often actively defies or refused adult requests or rules, e.g., refuses to do chores at home
4. Often deliberately does things that annoy other people, e.g., grabs other children's hats
5. Often blames others for his or her own mistakes
6. Is often touchy or easily annoyed by others
7. Is often angry or resentful
8. Is often spiteful or vindictive
9. Often swears or uses obscene language
Attention Deficit Hyperactive Disorder
(ADHD)—This paper will use the criterion set forth by the American Psychiatric Association in the DSM III-R as an operational definition. That criteria is as follows:

A. A disturbance of at least six months during which at least eight of the following as present:

1. Often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)
2. Has difficulty remaining seated when required to do so
3. Is easily distracted by extraneous stimuli
4. Has difficulty awaiting turn in games or group situations
5. Often blurts out answers to questions before they have been completed
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(6) has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension) e.g. fails to finish chores

(7) has difficulty sustaining attention in tasks or play activity

(8) often shifts from one completed task to another

(9) has difficulty playing quietly

(10) often talks excessively

(11) often interrupts or intrudes on others, e.g., butts into other children’s games

(12) often does not seem to hear what is being said to him or her

(13) often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments)

(14) often engages in physically dangerous activities without
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considering the possible consequences (not for the purpose of thrill-seeking), e.g., runs into the street without looking

B. Onset before age of seven.

C. Does not meet the criteria for a Pervasive Developmental Disorder.

It is noted that prior to 1984 this disorder was referred to by the terms Attention Deficit Disorder (ADD) and Attention Deficit Disorder with Hyperactivity (ADD-H). The current designation, ADHD, was introduced in 1984 with the publication of the D-S-M-III-R. The D-S-M-IV is scheduled for publication in 1992. At that time the ADD and ADD-H classifications will again be used. All three designations have been used in the research used in this paper.

Defiant Disorder—Former term often used for Oppositional Defiant Disorder.
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Minimal Brain Disorder/Dysfunction- Term previously used to describe the symptoms found in Attention Deficit Hyperactivity Disorder.

Conduct Disorder- A severe behavior disorder that may result in serious harm to others, vandalism, theft or running away from home. The DSM-III-R lists the following criterion for a diagnosis of Conduct Disorder:

A. A disturbance of conduct lasting as least six months, during which at least three of the following have been present:
   (1) has stolen without confrontation of a victim on more that one occasion (including forgery)
   (2) has run away from home overnight at least twice while living in parental/ or parental surrogate home (or once without returning)
   (3) often lies (other than to avoid physical or sexual abuse)
   (4) has deliberately engaged in fire-setting
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(5) is often truant from school (for older person, absent from work)
(6) has broken into someone else's house, building, or car
(7) has deliberately destroyed others' property (other than fire-setting)
(8) has been physically cruel to animals
(9) has forced someone into sexual activity with him or her
(10) has used a weapon in more than one fight
(11) often initiates physical fights
(12) has stolen with confrontations of a victim (e.g., mugging, purse-snatching, extortion, armed robbery)
(13) has been physically cruel to people

Noncompliance - Failure of the child to initiate requested behavior within 15 seconds after a command is given by an adult, or the child fails to stay on task to complete the requirements
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of a request, or the child fails to follow previously taught rules of conduct (Barkley 1987).

Summary

Oppositional behavior in children creates numerous problems for both parents and teachers. This type of disorder can manifest itself in many ways, however noncompliance seems to be a key indicator of oppositional behavior and dealing with the noncompliance may be the key to treatment.

This paper will focus on the symptoms and characteristics of oppositional defiant disorder and on the current methods of treatment that can be employed by both parents and teachers of defiant children.
Oppositional Disorder

CHAPTER 2
Review of Literature

Overview of Oppositional Defiant Disorder

Oppositional behavior has been discussed in psychological literature since 1955 when it was the subject of a study by Levy. In 1966 the Group for the Advancement of Psychiatry first used the term oppositional behavior patterns to express aggression. This term replaced passive-aggressive personality disorder. This refers to "those children who express aggressiveness through oppositional patterns of a generally passive nature" (Rey, Bashir, Schwarz, Richards, Plapp and Stewart, 1988, p.157). Despite this early interest in oppositional behavior, it was not until the introduction of the DSM-III in 1980 that an official classification to include Oppositional Disorder (OD) was established (Rey, et al., 1988).

In addition to the criteria listed in the definitions, the DSM-III-R, (1984) further describes children with oppositional disorder as
“argumentative with adults, frequently lose their temper, swear, and are easily annoyed by others. They frequently defy adult requests and deliberately annoy other people. They tend to blame other people for their own mistakes and difficulties” (p. 56).

This disorder is almost always present in the home setting, but it may not be present in the school setting or with other adults or children. The disorder, in some cases, is manifested in areas outside the home from its onset, or it may begin in the home and spread to other situations.

Usually, the disorder is more evident when the child is interacting with adults or other children with whom the child knows well. Because of this, these children may not show symptoms of the disorder when they are clinically examined.

Other features of this disorder may include “low self-esteem, mood lability, low frustration tolerance and temper outbursts. Often Attention-deficit Hyperactivity Disorder is also present” (APA p. 56).
The disorder may be classified as mild, moderate or severe depending upon the number and symptoms present and the severity and scope of the impairment.

Further studies have since been conducted to identify oppositional characteristics in children and to assess the effectiveness of various treatment programs.

In one of these studies, Rapp and Hutchinson (1987) used 12 subscales from the Personality Inventory for Children to investigate the personality characteristics of oppositional children. The participants in this study were the parents of 100 children between the ages of 6 and 12; forty-three of whom had been identified as oppositional children. This group included 25 males and 18 females. In this study there was no direct contact with the children; rather, the parents were asked to complete a 600 item personality inventory regarding their child. This information was used to plot personality profiles.
The resulting profile showed that oppositional children were significantly different than other children on all 12 of the subscales that were used. It was also found that there was no sex difference between oppositional and non-oppositional children. The study concluded that a personality profile of oppositional children does exist and the following characteristics may be present: psychological maladjustment, problems in school achievement, depression, delinquent tendencies, anxiety, and hyperactivity. The profile further indicated that these children may be withdrawn, lack social skills, and display features similar to children with psychosis. (p.14).

Despite the earlier literature, the DSM-III and the DSM-III-R classifications, and the subsequent studies, there are some who doubt the validity of Oppositional Disorder as a diagnosable disorder.

In a paper titled "Oppositional Disorder: Fact or Fiction?", Rey, et al. (1988), examined
this issue. The writers cited the work of other researchers, among them Rutter and Schaffer (1980) who questioned whether diagnosed oppositional behavior was much different from normal oppositional behavior. "For them", stated Rey, "OD 'sounds like the behavior of a lot of children one meets socially and not at all like a psychiatric disorder'" (p.157).

The question of OD being used as an inappropriate diagnoses for other disorders was also explored. The work of Ferguson and Rapoport (1984) was cited in which they suggest that "OD might be overdiagnosed where no other disorder exists" (p.157). These authors further suggest that a diagnosis of oppositional disorder is "likely to be used instead of ADD" (p.157). The link between Oppositional Disorder and Attention Deficit Disorder will be further examined later.

Several researchers questioned the significant differences between Oppositional Disorder and Conduct Disorder. Lavietes (1985) noticed that there is a significant overlap in the
diagnosis of the two disorders, while Weery, Reeves and Elkind, (1987a) argued that the criteria for Oppositional Disorder implies that it is a mild form of Conduct Disorder.

In his research, Rey, et al. (1988) studied 283 referrals to an adolescent treatment facility. Of this group 36 were found to meet the criteria for Oppositional Disorder. This group was compared to a group of 43 subjects who were diagnosed as meeting the criteria for Conduct Disorder. The comparison found significant differences between the two disorders and the authors stated, "the differences found between OD and CD in this study, although significant are not great and are mainly in a direction that shows that adolescents with OD function better and have fewer problems than their counterparts with CD" (p.161). The conclusion was that although this study may lend support to the assumption that OD may be a milder form of CD, the differences justified the placement of OD as a separate psychiatric classification with other disorders of
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conduct as done in the DSM-III-R is appropriate (p.161).

In this same study, Rey also notes that their research found little overlap with Attention Deficit Disorder "and these diagnoses seem unlikely to be mistaken for each other" (p.161). This conflicts with several other studies that have examined this issue of the relationship of OD and ADD.

A study by Reeves, Werry, Elkind and Zametkin, (1987) found that OD and CD did closely resemble each other and further, they rarely occurred without a diagnosis of Attention Deficit.

In their study of 108 referred children only two had a diagnosis of Oppositional Disorder alone. The findings of this study also indicated that ADD was predominantly male and "strikingly so" (p.148) for Oppositional Disorder. Data indicated a 10:1 male to female ratio.

Another study by Sharpio and Garfinkel (1986) examined the occurrence and interdependence of ADD and related conduct disorders including
Oppositional Disorder.

This study screened 315 children for symptoms of ADD and oppositional symptoms. The subjects were identified using teacher rating scales, clinical interviews and various performance measures. The findings showed that 2.3% of the children displayed attention deficit symptoms, 3.6% displayed aggressive/oppositional behavior and 3.6% showed symptoms of both problems. These students were identified on such items as "talks at school when not allowed, always on the go, problems concentrating on fun things, cutting up and/or pushing in line and problems concentrating when noisy" (p.813). The authors further found that "children with both inattention and aggressive problems had significantly more problems with conduct, inattention and unsociability than the other two symptomatic groups" (p.813).

In a study by Werry, et al., (1987) of referred children between the ages of 5 and 13, who had been identified as having a behavioral disorder, it was found that "CD and OD rarely
occurred except with ADD and were differentiable on demographic and other nondefining clinical variables from each other" (p.410). Werry also states that "ADD seems to occur with CD/OD, however CD/OD was seen rarely without ADD" (p.424). The three authors concluded that "dimensional studies seem, in the main, to have found difficulty separating these two disorders" (p.424).

In a related review article, Werry, et al. (1987) noted that some of the difficulty in diagnoses may be due to the method of measurement. "Parent/teacher ratings used in dimensional systems inevitably confuse Hyperactivity with Conduct Problems because of the social nuisance caused by overactivity" (p.134).

This is not surprising. Russell Barkley (1987) found that children with ADD often have problems with compliance to rules, directions and commands as well as problems with social etiquette. They often exhibit behavior problems in classrooms, have poor academic performances,
have difficulty in cooperative play and other activities with peers. As a result, they tend to receive "disproportionate share of reprimands, censure, punishment, teasing and austracism from others often beginning very early in development (ages 2 to 3 years)" (p.145). This situation makes ADD children highly susceptible to acquiring aggressive, defiant, and oppositional behaviors.

There also appears in literature to be reference to two types or to at least varying degrees of oppositional behavior. One type obviously refers to oppositional behavior as defined in the DSM-III-R, while the other often uses more vague descriptors such as "expression of free will" (Haswell, 1981 p.443).

In their study of 63 preschool age children Haswell, et al. (1981) found opposition behavior, as defined by the child's refusal to comply to adult requests as universal. In the report it was stated that a period of oppositional behavior usually between 18 months and 6 years of age is a normal part of a child's struggle for autonomy and
that "the emergence of oppositional behavior is a normal expression of independence" (p.440). She further states that "whereas oppositional or negative behavior is frustrating for parents, educators and all involved, it is a normal and crucial aspect of early childhood development. Many parents can come to enjoy or appreciate some oppositional behavior" (p.443).

It is this writer's opinion that it would be the rare parent or teacher who could enjoy or appreciate the behavior described in the DSM-III-R!

Many authors are using the same terms (oppositional, noncompliant) to describe the same behaviors but to varying degrees. Perhaps one could categorize the types of oppositional behavior being written about as "clinical" and "non-clinical", with clinical oppositional behavior being treated as a diagnosed disorder using DSM-III-R criteria and non-clinical behavior as being a less pervasive problem common in most young children. Nonetheless, the authors discuss
similar interventions and treatments with common goals and therefore those writings dealing with lesser degrees of oppositional behavior have been cited here.

No matter how defined, the behavior at the root of oppositional behavior appears to be noncompliance.

Barkley (1987) cites the work of Johnson, Wahl, Martin and Johansson, (1973) and Patterson (1976, 1982) when he states that "noncompliance in various forms appears to be the most frequent complaint of families referring children to child mental health center" (p.11). Although these children received varied diagnoses of behavior disorders, the major concern of the referring parent or teacher was noncompliance. Barkley, (1987) defines noncompliance as falling into three categories:

1) The child fails to initiate requested behaviors within a reasonable time after a command given by an adult (p.9). (Reasonable time is 10 to 15 seconds.)
2) The child fails to sustain compliance until the requirements stipulated in an adult's command have been fulfilled (p.10).

3) The child fails to follow previously taught rules of conduct in a situation (p.10).

Typical noncompliant behaviors seen in children referred for behavior disorders are found in the following table (Barkley, 1987, p.11).

Table 1. Types of Noncompliant Behaviors Common in Children Referred for Behavior Disorders

<table>
<thead>
<tr>
<th>Yells</th>
<th>Steals</th>
<th>Physicallyresists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whines</td>
<td>Lies</td>
<td>Destroysproperty</td>
</tr>
<tr>
<td>Complains</td>
<td>Argues</td>
<td>Physicallyfightswithothers</td>
</tr>
<tr>
<td>Defies</td>
<td>Humiliates</td>
<td>Fails to complete school home</td>
</tr>
<tr>
<td>Screams</td>
<td>Teases</td>
<td>work</td>
</tr>
<tr>
<td>Throws tantrums</td>
<td>Ignores requests</td>
<td>Disrupts other's activities</td>
</tr>
<tr>
<td>Throws objects</td>
<td>Runs off</td>
<td>Ignoresself-help tasks</td>
</tr>
<tr>
<td>Talks back</td>
<td>Cries</td>
<td></td>
</tr>
<tr>
<td>Swears</td>
<td></td>
<td>Fails to complete chores</td>
</tr>
</tbody>
</table>
Forehand and McMahon (1981) have also identified noncompliance as the most prevalent childhood behavior problem. These authors have researched noncompliance and developed a behavioral training program based on this research. Russell Barkley has since developed a parent training program using the tenets and research of Forehand and McMahon as its basis. Both of these programs are discussed later in this paper.

Possible Causes of Oppositional Behavior

If noncompliance is at the root of oppositional behavior, it is important to look at the factors which may cause or foster this behavior.

Several factors which have been examined include the temperament of the child, familial factors, and ineffective behavior management in dealing with an oppositional child.

Several researchers have noted that a child's basic temperament may be linked to oppositional behavior.
Earls, (1981) studied the relationship of temperamental characteristics to behavioral adjustment in preschool children. This study indicated that three temperament characteristics, high distractibility, high intensity, and low adaptability are associated with poor behavioral adjustment. Earls felt that his findings fit well within the framework of the transactional behavior model of Sameroff and Chandler (1975).

In this model, a child's oppositional behavior would "represent the outcome of the transaction of earlier behavior predispositions with the environment and behavior problems would represent an index of the child's current emotional adjustment" (p.340).

Earls also notes that Sostik and Anders, (1977) found infants who received low social and motoric interactive scores on the Brazelton Neonatal Assessment Scales at 2 weeks of age were later rated low on distractibility at 8 months (p.341). He believes that these low social interaction scores represent a reduced capacity of
these children to stop ongoing activity and to respond to other environmental stimuli. This may be the foundation of oppositional behavior that manifests itself later. Earls further states that "temperamental differences can be recognized quite early postnatally and may rapidly become the cast of parental expectations" (p.341). The implication of this is that early oppositional behavior may not represent motivated behaviors by the child, but rather it may indicate the child’s emotional capacities at that point of development. Over time, of course, a pattern of oppositional behavior will adversely effect the parent-child relationship.

Earls, (1981) summarizes this position by saying:

Although this behavioral style [opposition] may have its origins in a constitutional predisposition, it carries the risk of being viewed as motivated resistance by the parent. If a pattern is established in which repeated negativisms are perceived as intentional, the
resulting tension between parent and child may increase to the point that the child is left without the supportive relationship necessary to promote healthy emotional growth. (p.341).

Barkley, (1987) in his work with children with attention deficits and oppositional disorders states that "children having certain temperament and cognitive characteristics are more prone to emit coercive-aggressive behavior and acquire noncompliance than are other children" (p.21). He notes that children who display negative temperament characteristics such as irritability, high activity levels, inattention, impulsivity and poor habit regulation are more likely to acquire noncompliance and coercion that other children. These same traits are likely to hinder a child from finishing assigned activities "and thus more likely to elicit increased commands, supervision and negative reactions form parents" (p.21).

Barkley, (1981) also notes that temperamental parents may increase the likelihood of their
children acquiring oppositional or coercive behavior. Parents who are immature, impulsive, inattentive, or inexperienced may use inconsistent behavior management techniques with their children. This results in the child successfully avoiding demands by the use of oppositional behavior. These parents may also provide a model of improper behavior for the child to follow by using coercive behaviors with other family members.

Thomas and Chess, (1977) suggest that certain temperamental characteristics may be genetic. Gard and Berry, (1986) also note that there may be "an organizing characteristic within these children that predisposes them to act in such a manner" (p.148). Having stated this, Gard goes on to say that although these possibly genetic temperamental characteristics may be a factor in oppositional behavior, "it seems more likely that children learn how to be noncompliant and deviant through interacting with their environment" (p.154).
Other researchers have also examined the relationship between a child's environment and oppositional, noncompliant behavior.

Dadds, (1987) looks upon the origin of behavior problems from "an ecological perspective" (p.342). That is, the individual's behavior is considered in relation to the general behavioral and social systems in the person's environment.

It is noted that the application of these ecological principles differs from behavioral principles in that it makes several assumptions. First, it assumes that "a child's behavior is determined by a network of subsystems that form the components of other more complex systems" (p.342). Second, these components function interdependently at each level and third, "each level is affected by the dynamics of levels above and/or below it" (p.342).

As previously mentioned, there has been some success in predicting the development of oppositional disorder from measures of infant temperament. In relating this to an ecological
model, Dadds, (1981) notes that due to inherited biological factors, certain children may be predisposed to develop oppositional disorder, and that "the manifestation of this is related to the mother's attitude and behaviors to the newborn" (p. 343).

Research indicates that oppositional children tend to have poor relationships with their peers. This would be an example of another "level" or factor in this model working on the child and affecting the child's behavior.

Dadds also notes a strong environmental link to the disorder. Variables associated with the family include marital discord, maternal depression, lack of social support for the family, amount of family involvement by the father, low socioeconomic status, divorce and the presence of an ill or handicapped family member.

Dadds concludes his discussion by saying, "no single factor or theory can fully account for the development of oppositional behavior. At best, it can be said that it is multidetermined and that
a comprehensive understanding may involve analysis at the biological, interpersonal, social and political levels" (p.314).

Reeves, et al. (1987) and Barkley, (1987) have also examined factors within the family relating to the development of oppositional behavior with differing conclusions. Barkley noted that children of families experiencing greater marital stress, financial, health or personal problems may have a higher incidence of oppositional behavior, while Reeves, et al. (1987), in a previously discussed study, found that "there were no differences in race, family background, family size, working mothers and recent life stress effecting the parents" (p.151) in families producing children who display oppositional behavior. The researchers feel this raises questions about the "currently accepted views of the general etiology of psychopathology in children especially the role of working mothers and recent life stress in parents" (Reeves, et al., p.151).
One factor over which there is appears to be no disagreement is the role of ineffective behavior management techniques employed by parents in the development and/or maintenance of oppositional behaviors. Such associations have been made by Patterson (1976), Wahler (1976), Earls (1981), Forehand and McMahon (1981), Percival (1985), Gard and Berry (1986), Barkley (1986, 1987) and Reeves, et al. (1987).

Patterson and Wahler propose a hypothesis for the development and maintenance of noncompliant behavior in which most children employ coercive behaviors the first several years of life, but they develop more appropriate verbal and social skill as they grow older. However, some children, due to conditions in their environment, continue to use coercive behavior strategies. This may be due to the parents' failure to model or reinforce appropriate social skills, or they may continue responding to the child's coercive behavior.

Forehand and McMahon, (1981) use this hypothesis in explaining the relationship between
parental commands and a child's reaction that may negatively reinforce coercive behavior.

When a parent issues a command, a child can respond to it by acts of compliance or noncompliance. The coercive, negative responses by the child may result in the parent terminating the command and so, in time, the child learns to escalate the coercive behaviors in order to avoid what may be considered, by the child, to be an aversive situation. The parents may respond to the child's behavior by either withdrawing the with coercive behavior, the child may comply, which would reinforce the parental coercive behavior, or the child may intensify his or her own coercive behavior. "Consequently, parent-child interactions that are initiated by a parental command eventually are characterized by high-rate coercive parent and child behaviors including noncompliance" (Forehand and McMahon, 1981, p. 7).
The following diagrams (Forehand and McMahon, 1981, p.8), illustrate this negative reinforcement pattern.

**Examples of child’s coercive behavior negatively reinforced:**

<table>
<thead>
<tr>
<th>Application of aversive event</th>
<th>Child coercive response</th>
<th>Removal of aversive event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent gives command</td>
<td>Child noncomplies</td>
<td>Parent gives up</td>
</tr>
<tr>
<td></td>
<td>(whines, yells)</td>
<td>(withdraws command</td>
</tr>
<tr>
<td></td>
<td></td>
<td>rather than listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>to child)</td>
</tr>
</tbody>
</table>

**Example of the parent’s escalating coercive behavior reinforced by the child’s eventual compliance:**

<table>
<thead>
<tr>
<th>Application of aversive event 1</th>
<th>Child coercive response</th>
<th>Application of aversive event 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent gives command</td>
<td>Child noncomplies</td>
<td>Parent raises voice</td>
</tr>
<tr>
<td></td>
<td>(whines, yells)</td>
<td>repeats command</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child response 2</th>
<th>Application of aversive event 3</th>
<th>Removal of child coercive response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child noncomplies,</td>
<td>Parent begins to</td>
<td>Child complies</td>
</tr>
<tr>
<td>(yells louder, kicks chair)</td>
<td>yell, repeats</td>
<td></td>
</tr>
<tr>
<td></td>
<td>command again</td>
<td></td>
</tr>
</tbody>
</table>
Oppositional Disorder

Percival, (1985) notes that while oppositional behavior may be negatively reinforced by allowing the individual to escape an aversive situation, "the occurrence of such behavior might also serve to increase the amount of attention received from others. Thus, oppositional behavior may be maintained by positive reinforcement" (p.286).

Barkley, (1987) also notes that ineffective child management methods are one of the major causes of noncompliance. Because of this, "noncompliance by children becomes a very effective method for escaping or avoiding unpleasant, boring or effortful tasks and on some occasions, even getting rewards for doing so" (p.21).

Research by Patterson, (1976) and Forehand and McMahon (1981) show that oppositional or disruptive behavior is not continuous or random, "but rather appears in 'bursts' or 'chunks' " (Barkley, 1987, p.11). Parental or teacher requests are one of the most common precipitators
of oppositional behavior. A "noncompliant interaction" (Barkley, 1987, p. 35) sequence then takes place between the child and the adult. Figure 1 shows this interaction in a schematic form (Barkley, 1981, p. 100). See Figure 1.

Figure 1. Diagram of noncompliant interaction.
Using this flow chart, the sequence begins when the parent issues a command. Barkley, (1987) notes that on rare occasions the defiant child may comply to the first request if it involves little effort or if involves immediate reinforcement. It is also noted that "rarely is such compliance followed by a positive reaction from the parent, such as acknowledging appreciation for the compliance" (p.13). Because of this the frequency of compliance is likely to decline and may only occur when the request results in immediate reward for the child.

It is more likely that a behavior disordered child will not comply to a parental request. This begins the chain of events on the left side of the flow chart. As is seen, the usual response by the parent is to repeat the command "perhaps as many as 3 to 7 times (or more!) in various forms, without the child complying with any of the commands" (p.13). This leads to increasing frustration for the parent and may result in the parent threatening the child with some unpleasant
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consequence for continued noncompliance. Often the child will still not comply, perhaps because the threat, like the command, is again repeated over and over. "Over time, both parent and child escalate in their emotional behavior towards each other, with voices rising in volume as well as intensity and with collateral behavior as displays of anger, defiance or destructiveness" (p.13).

The sequence could end with the parent disciplining the child, the child finally complying, or most often, with the parent acquiescing to the child’s behavior. Even if the child does eventually comply, the child has succeeded in delaying the task or request and continuing current activities, which was the child’s initial goal. Thus, the child’s behavior is doubly reinforced, positively by continuing the desired activity and negatively by escaping from the initial request of the parent. It is cited by Patterson (1976) that this double reinforcement of oppositional behavior rapidly accelerates the development and maintenance of such behavior.
Clinical Interventions

If these are the problems, what are the solutions? A number of interventions including family therapy, medication, psychotherapy, differential reinforcement, parent training and others have been used in an attempt to modify oppositional behavior.

Percival (1985) notes that "behavior does not occur in a vacuum; if one response is eliminated or reduced...something else will take its place" (p.302). Because of this, it is necessary to provide the child with opportunities of success through appropriate behavior. It is noted that often children who engage in oppositional behavior are perceived by others in a negative way and therefore they are treated negatively. "This only serves to worsen the problem as the very behavior considered inappropriate by the child is modelled...in the child's environment" (p.302).

There needs to be a positive component to any successful intervention program. In their work with preschool children, Haswell, et al., (1981),
Oppositional Disorder

devised several techniques which can be employed in dealing with nonclinical oppositional behaviors. This study found a relationship between the amount of oppositional behavior of a child and the mother's flexibility. It was found that flexible mothers seemed more sensitive to their children's "rhythms" (p.444).

Techniques used by these mothers included the timing of requests so as not to interfere abruptly with current activities. These mothers also used warnings of impending requests. Haswell felt that warnings both allow the child to adjust to an upcoming change and to bring closure to the current, ongoing activity. In a related study, Schaffer and Crook (1980) found that "greater compliance to maternal requests occurred when mothers did not interrupt an ongoing activity, but rather waited for a change in the child's attention or gently attracted attention to the area of request before stating it directly" (p.444).
Haswell also cites the work of Lylton (1977) and Lylton, Lylton and Zwirner (1975) in noting the role of verbal suggestions and increased child compliance. It was noted that these researchers found that verbal suggestions from parents are "more successful in achieving compliance from a child than are commands or prohibitions" (p.444).

It was further stated that the actions of a parent that accompany verbal requests can influence the amount of compliance. For example, "positive actions...by a parent increased the likelihood of the child complying with the request, whereas, negative action...or physical control increased the likelihood of the child refusing to comply with the request" (p.444).

The timing of parental requests is another factor that may influence oppositional behavior. Forehand (1981) found that parents who repeated requests at brief intervals when child compliance was not immediate, tended to exacerbate oppositional behavior, rather than to eliminate
it. An interval of ten seconds or longer was found to be effective by Haswell.

Giving children options, even if the choices are limited, may lessen oppositional behavior by eliminating the child's motivation to resist. Haswell found the technique of giving children choices effective with oppositional children in her clinical practice (p.445). Such choices can include giving the child alternatives between activities such as watching television for an additional amount of time in lieu of a bedtime story or exchanging extra playtime for a shower instead of a bath.

While these general strategies may be effective with some oppositional behavior, more serious deviations of behavior require a more intensive, comprehensive approach. One approach that has been used in the treatment of oppositional disorder is family therapy. One type of family therapy, systems family therapy, (SFT) has been studied for its effectiveness.
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The family systems therapy model is "based on the assumption that an individual's behavior can be understood only in the context of the family group as a whole" (Wells and Egan, 1988, p.139). In this model, the symptoms of a behavior disorder are viewed as "homostatic mechanisms which serve to reestablish or maintain ongoing equilibrium within the family" (p.139).

The goals of family therapy are to alter the nonadaptive aspects of the family structure and to modify the family interaction patterns that maintain oppositional behavior.

In a study of comparative treatment outcomes by Wells and Egan, (1988) SFT did not emerge as the most effective treatment for oppositional defiant disorder. However, they note that this does not rule out the use of family therapy for childhood disorders. They note that it has been shown to be effective with anxiety disorders and psychosomatic disorders in particular.

At least one study has been conducted on the use of medication to treat oppositional disorder.
In this study by Speltz, Varley, Peterson, and Beilke (1987), dextroamphetamine (10 mg and 5 mg per day) was administered to a four-year-old boy who was diagnosed as having met the criteria for Attention Deficit Disorder and Oppositional Defiant Disorder. This child exhibited "extremely high levels of impulsivity, overactivity, noncompliance and aggressiveness" (p.175). His aggressiveness included "hitting, kicking, and biting of his mother, teachers and peers" (p.175). Such episodes were occurring four to five times a day at school and one to two times daily at home. These outbursts would last 15 to 20 minutes each. His behavior resulted in removal from two preschools and placement in a day treatment program.

The initial treatment plan for this child included parent training sessions, a classroom behavior management program, and a social skills training program for the child. Initial gains leveled off quickly. After obtaining baseline data on the child's behavior, the treatment with
dextroamphetamine was begun. Results indicated a 50% increase in on task behavior and a dramatic decrease in the number and intensity of tantrums. Side effects included a slight increase in solitary play, reduced appetite, listlessness, whining and stomachaches.

On two occasions when the medication was stopped "his behavior again returned quite abruptly to the previous pattern of aggressive oppositionalism" (p.177).

The authors of this study concluded that dextroamphetamine can be used successfully to treat a child with ADHD and Oppositional Defiant Disorder.

Other interventions cited in the literature include differential reinforcement and the use of children's autogenic stories.

Differential reinforcement is a "procedure in which the occurrence of a particular class of behavior postpones the delivery of reinforcement" (Sulzer-Azaroff, 1977, p.515). Using this approach, the child would receive a scheduled
reinforcement except when engaging in oppositional behavior, therefore a child is rewarded for not engaging in inappropriate behavior. Percival (1985) notes that initially the reinforcement should be scheduled at very short intervals so that the child will be able to be reinforced and to "eliminate the possibility that the target behavior may also occur and also be reinforced" (p.296). No data was found to support the effectiveness of this technique.

The use of children's autogenic stories was cited in the work of Brandell (1986). The hypothesis is that "as children are able to expand their repertoire of adaptive solutions to conflict," (p.285) their projective stories will reflect behavior improvements. This strategy is not well documented and, as it requires the use of a trained psychotherapist, is beyond the realm of use for parents and teachers.

Gard and Berry (1986) note that "there have been two major types of interventions for
oppositional children: traditional psychotherapy and behavior management” (p.151).

Psychotherapy is based on the assumption that the "child's insights into the origin of the behavior problem is needed for the change to occur and that "the child can change their own behavior patterns without major changes in the environment" (Card and Berry, p.151).

Although psychotherapy has a long tradition, there is no research to support it's effectiveness with oppositional children. In fact, Card and Berry state that several researchers have noted that this treatment was less effective than parent training and that the parents were less satisfied with the results.

As stated earlier, the key to diagnosis and treatment of Oppositional Defiant Disorder is noncompliance. The interventions that most effectively deal with noncompliance are parent training programs that can improve parental management skills and competence in dealing with behavior problems; increase parental knowledge of
the causes of misbehavior; and "improve child compliance to commands and rules given by adults" (Barkley, 1987, p.4).

The model behavior management program based on parent-child interaction was developed by Constance Hauf (1968). The model was revised and formulated by Forehand and McMahon (1981). A similar parent training program has also been developed by Russell Barkley (1987).

The basis of the treatment strategy used by Forehand and McMahon follows their hypothesis that noncompliant behavior is developed and maintained through maladaptive family interactions. Therefore, their treatment plan focuses on parental behavior change toward the child and more appropriate family interaction.

Forehand cites the work of Berkowitz and Graziano (1972) for developing a rationale for this type of treatment. First, assuming that the noncompliant behavior developed and is being maintained within the family structure, "it is unlikely that clinically significant changes can
be obtained by treating the child 'out of context.'" (p. 47).

This program employs two therapists who work with one family at a time at twice weekly training sessions. The program has two components or phases. The first phase, called Child's Game, trains parents in effective ways to reinforce and reward the child and in ways to more positively interact with the child; thereby increasing the amount of compliant behavior. "Phase I is considered to be the most important part of the program since it is critical for a positive parent-child relationship" (Forehand and McMahon, 1981, p. 58).

The second phase or Parent's Game, trains the parent in giving commands appropriately and in the use of time out procedures. These focus on the elimination of noncompliant behavior. Together the intent is to achieve a "situation in which the child engages in compliant or appropriate behavior most of the time" (p. 56). Another benefit of decreasing noncompliance is that punishment can be
used less frequently but more effectively. Overall, "a focus on increasing child compliance makes for a much more pleasant family life, since the parents' positive influence on the child is increased and a positive parent-child relationship is facilitated" (p.57).

In Phase II the parent is taught to deal directly with noncompliant behavior. The skills taught are: giving specific, direct commands, and the use of the time out procedure. It is essential that the positive skills from Phase I be used in conjunction with these Phase II skills.

The sequence of skills taught in Phase II, in relation to the child's response, is as diagramed in Figure 2 (Forehand and McMahon, 1981, p.78).

Figure 2.
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The entire training program usually lasts approximately 9 sessions, 60 to 90 minutes in length.

In addition to the basic training program, Forehand and McMahon have two adjuncts which enhance the effectiveness of the basic program.

The first is a parental self-control program that allows the parent to provide for reinforcement of good parenting skills after the treatment program ends. In this program the parents reward themselves from a list of reinforcers every day that they meet predetermined criteria for attending and rewarding appropriate behavior and using time out correctly for noncompliance. A follow up study showed that "children in the parent training plus self-control group were significantly more compliant and less deviant than the children in the parent training alone group" (p. 161).

The second adjunct was parental training in social learning principles. McMahon, Forehand, and Griest (1981) studied the effectiveness of
incorporating this training into the basic parent training program. This study included twenty mother-child pairs who were assigned to one of two groups: one group received behavioral skill training techniques only, while the second group received didactic instruction and reading assignments in social learning principles that related to the parent training program. Topics included positive and negative reinforcement, behavior shaping, extinction and punishment. The results of multiple outcome measures suggested "that the integration of formal training in social learning principles into the parenting program enhanced treatment outcome, setting generality and temporal generality" (p.164).

Barkley, building on the original work of Constance Hauf and the research of Forehand and McMahon, has developed a detailed ten-step parent training program for parents of children between the ages of 2 and 11 who exhibit deviant behaviors. The parents work with a qualified therapist and are taught behavioral principles and
techniques in management through direct instruction, modeling, role playing, practice and home assignments. The ten steps are generally taught in weekly group training sessions, but they may be integrated into an on-going family therapy or counselling program.

Briefly, the ten steps incorporate the following skills:

Step 1: The parents are taught the typical causes of child misbehavior and what they can do to identify such causes within their family. The parents are asked to complete a profile of parent-child characteristics to help identify problems within the family that may be contributing to child noncompliance.

Step 2: Parents are taught the importance of effectively attending to the child's play behavior. Parents are trained in ways of eliminating ineffective or detrimental attending skills. A "special playtime" is established during which the parent practices attending appropriately.
Step 3: Parents are taught to respond to the child's compliance to commands and requests with acknowledgement, appreciation and praise. Such parental attending by itself may improve child compliance. Parents are also taught techniques in giving effective commands which also increases compliance.

Step 4: This step is an extension of step 3, which provides parents instruction in "how to attend to children when they are not interrupting or bothering their parents" (p.54). This includes times such as when the parent is talking on the telephone, working within the home, or speaking to a visitor.

Step 5: Realizing that praise alone is often not enough reinforcement for many children, a reward system is established at this step. Poker chips are used with young children (ages 4 to 8), while 9-to 11-year-olds use a point system. The program "enlists a variety of rewards and incentives readily available within the home to increase child compliance to commands, rules,
Step 6: In this step, the parents are taught the appropriate use of effective punishment. The punishments used are fines utilizing the token system established in step 5, and the use of time out. Parents are instructed to use time out procedures for one or two misbehaviors and to punish other inappropriate behaviors with token fines.

Step 7: This step is an extension of step 6. The time out procedure is expanded to include one or two additional behaviors and parents discuss problems encountered during the first week of implementation of time out.

Step 8: This step deals with managing noncompliance in public places. Parents are trained to use modified versions of previously taught techniques involving commands, tokens, and time out to manage children in stores, churches, restaurants, and in other people's homes.
Oppositional Disorder

Step 9: At this point parents are instructed in ways of using the previously taught skills to handle future behavior problems that their children may develop. Techniques for "self-correction" of ineffective behavioral management are discussed to insure that parents will continue to use appropriate methods.

Step 10: This is a "booster session" held one month after the completion of the instruction to assess the parent's adherence to the treatment program and to discuss any problems that the parent may be experiencing.

These parent training programs are successful because, by focusing on noncompliance, they do not allow the child to escape aversive situations (parental commands) and they break the cycle of parental acquiescence which reinforces a child's coercive behavior.

Expected Outcomes

Barkley (1987) states that the goals of his program are three-fold: to improve parental management skills; to increase parental knowledge
of behavior principles; and to increase child compliance.

He notes that the likelihood of achieving these goals is affected by several factors, particularly "the extent, nature, and severity of the child's psychopathology, and that of the family" (p.4). Barkley states that this program has the greatest chance of success with children whose "major problem is noncompliance or oppositional behavior and whose families are not seriously dysfunctional..." (p.4). The program can also be expected to improve the compliance of children with other psychopathology such as ADHD or pervasive development disorder, however, their behavior may still be rated as more deviant than other children.

Further, the age of the child involved in treatment also effects the success of the program. As previously noted, this program was designed for parents of children between the ages of 2 and 11 years old. Success with children younger than 2 years is affected by language development and
children over 11 years with severe behavior problems are unlikely to have their behavior positively changed and "in fact, they may react to its procedures with intolerable rates or intensities of physically aggressive behavior that cannot be handled by the family" (p.4). Barkley feels that these children are best dealt with as inpatients in child psychiatric units or in residential treatment facilities.

The success of parent training programs is well documented. Barkley notes that much of the scientific underpinning of these techniques comes from the research of Forehand and McMahon and their students and colleagues.

This research, which included laboratory investigations, as well as field research on the various components of the parent training program, not only confirmed the success of these programs, but also yielded additional insights regarding their effective implementation. This included the finding that labeling verbal reinforcement given to children significantly increased rewarded
behaviors. It was also found that "as the number of parental commands increased, the amount of child compliance decreases" (Forehand and McMahon, 1981, p.145). This supports the first component of the parent training program in which the parents are taught to reduce the number of commands given to children. A second finding in this area "suggests that the failure to initiate compliance, rather than the failure to continue or complete the compliant act is a major factor in the occurrence of noncompliance" (p.145).

A number of studies have been conducted on the use of time out procedures. The results of these studies indicate that time out is most effective when the parent removes the child from all reinforcement. The duration of the time out should be between one and five minutes and the child should be required to be quiet to be released from isolation.

Studies have been conducted on the generalization of improved child behavior. This includes generalizations of behavior from the
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clinic setting to home and school, the length of time improved behavior is maintained after the end of treatment, the effects on untreated behaviors, the effects on the behavior of siblings and the social validity of the effects.

A study by Peed, Roberts, and Forehand (1977) of home observations of mother-child pairs after clinic treatment indicated “significant increases...for child compliance and for maternal rewards, attends, and contingent attention to compliance” (p.152).

It has been suggested in a study by Johnson, Bolstad and Lobitz (1976) that “children may increase deviant behavior in school when deviant home behavior is treated by parent training programs. However, in two subsequent studies; Forehand, Sturgis, McMahon, Aguar, Green, Wells, and Breiner (1979) and Breiner and Forehand (1981), compliance and deviant behaviors were studied in both home and school settings. Both studies “revealed no systematic changes in school behavior” (Forehand and McMahon, 1981, p.153).
Forehand and McMahon also cite several studies on the maintenance of improved child behavior after the parent training program ended. Studies by Forehand, Sturgis, et al. (1979) and Peed, et al. (1977) indicated that changes in parental and child behaviors were maintained six and twelve months after the training program. Another study by Baum and Forehand (in press at the time of their writing) indicated that improvements in child behavior and parental perceptions of the child appear to be maintained...up to 4 1/2 years after their involvement in the program" (p.153).

Another study by Humphreys, Forehand, McMahon, and Roberts (1978) examined the effects on the behavior of a sibling of a clinically referred child. The results indicated that the mothers of these children "generalized their skills for dealing with noncompliance to other children in the family" (p.156), and "the untreated children increased their compliance" (p.156).
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In a 1980 study by Wells, Forehand, and Griest, it was suggested that successful treatment of noncompliance will, in many cases, reduce other non-treated behaviors, such as tantrums, aggression and crying.

Although the success of parent training programs is well documented, not all parents and children who participate in them are successful. Card and Berry (1986) note that "predictors of success of this type of program are a stable family structure, frequency of interpersonal conflicts, maternal distress, and the amount of involvement of the father with the children" (p.153).

Dumas, (1984) also notes specific factors commonly associated with poor outcomes of behavioral parent training. These factors include maternal depression, low socioeconomic status, family discord within the home, and aversive relationships outside the home.

In her study of fifty-two mother-child dyads that participated in behavioral parent training to
modify oppositional child behavior, Dumas found that those who were unsuccessful were more aversive than mothers who were successful and their children were more aversive than successful children (p.952).

She also found these unsuccessful mothers were either socioeconomically disadvantaged, insular or both. She further found that mothers with little or no socioeconomics disadvantage or insularity were not only more successful, but "reliably maintained their treatment gains at a 1-year follow-up" (p.947).

It should be noted that these factors that indicate a lack of success for parent training programs do not directly relate to the child or the child's behavior. Dadds (1987) summarizes this when he states that "when treatment of young oppositional children fails, it appears to be due to parents and/or teachers not implementing the treatment program, rather than some characteristic of the child" (p.344).
School Interventions

As stated in the DSM-III-R criteria noted earlier, oppositional disorder is almost always present in the home and may spread to other areas outside the home including school. Teachers, therefore, need some strategies to anticipate and extinguish potentially disruptive situations.

Many times the inappropriate behaviors seen by teachers are vaguely defined or the descriptors do not mean the same thing to all individuals involved with a child's behavior. The first step then to insure that behavioral procedures will be effective is to define the behavior operationally and to define the situations in which the behaviors occur (Percival, 1987).

To accurately define the problem, a system of data collection that takes into account the dimensions of the problem (topography, intensity, frequency, and duration) must be used. Behavior checklists are frequently used to identify the behavior and its dimensions. Several examples of
such checklists are shown in figures 2-5 (Percival, 1987, p. 289-292).

As seen by the examples, such checklists may be very simple and chart only one dimension of a behavior or rather complex, being used for several children or behaviors at one time. (See table 4). These may require the use of an observer/recorder and may be beyond the use of the classroom teacher.

To use one of these checklists in a classroom, a teacher could select a 30 minute period in both the morning and the afternoon during which the teacher could monitor the targeted behavior. Whatever the assessment tool, "it is important to remember that the record device utilized must be relevant to the identified problem" (p. 288). It is equally important that any instrument used by a classroom teacher during the course of the teaching day be very efficient and unobtrusive. Experience has shown that such checklists can be very difficult to maintain, distracting to both the teacher and students, and
tend to interfere with the momentum of the classroom.

Table 4: Behavior checklist. Frequency count of several behaviors.

INSTRUCTIONS: Place a hash mark in the appropriate box each time the responses occur.

<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>DAYS</th>
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<tbody>
<tr>
<td></td>
<td>1</td>
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<tr>
<td>1. Crying</td>
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<tr>
<td>2. Talking Out</td>
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<tr>
<td>3. Hitting, Biting, Kicking</td>
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<tr>
<td>4. Out of seat without permission</td>
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COMMENTS:
Table 5. Multidimensional behavioral checklist.

<table>
<thead>
<tr>
<th>NAME_______________________</th>
<th>TEACHER____________________</th>
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</table>

NOTE: This checklist may be used to chart behavior for a week by drawing lines and labeling them with a day/date. It may also be used for several children as well. It can be used to indicate the degree of difficulty by keying "0" for not present, to "4" for excessive behaviors.

<table>
<thead>
<tr>
<th>BEHAVIOR IN CLASSROOM</th>
<th>M</th>
<th>T</th>
<th>W</th>
<th>Th</th>
<th>F</th>
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<tbody>
<tr>
<td>1. Frustration reactions:</td>
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<tr>
<td>a. Tantrum</td>
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<tr>
<td>b. Crying</td>
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<tr>
<td>c. Using profane language</td>
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<tr>
<td>d. Pouting</td>
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<tr>
<td>e. Destructive</td>
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<td>f. Explosive</td>
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<td>2. Poor adjustment of environmental change...</td>
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<td>3. Poor adjustment to change in routine...</td>
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<td>4. Response to authority</td>
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<tr>
<td>a. Disobedient</td>
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<tr>
<td>b. Difficulty accepting criticism...</td>
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<td>c. Resentful</td>
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<td>d. Defiant</td>
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<td>e. Stubborn</td>
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<td>f. Has little regard for rules, limits, punishments...</td>
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<tr>
<td>5. Behaviors related to class assignments</td>
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<tr>
<td>a. Appears to be bored...</td>
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<td>b. Does not finish work...</td>
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<td>c. Attention wanders...</td>
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<td>d. Constant need for teacher attention...</td>
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<td>e. Lacks self-sufficiency...</td>
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<td>6. Annoying behaviors</td>
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<td></td>
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<tr>
<td>a. Talks out loud...</td>
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<tr>
<td>b. Out of seat...</td>
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<tr>
<td>c. Does not raise hand...</td>
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<tr>
<td>d. Chews paper, erasers, etc...</td>
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<tr>
<td>e. Making guttural, crowing, etc. noises in classroom...</td>
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</tbody>
</table>
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Table 6. Behavior checklist with frequency count and time analysis of single response.

Place a hash mark in the appropriate time slot each time you observe a temper tantrum. (Crying, kicking, screaming, flailing arms and/or legs.

<table>
<thead>
<tr>
<th>Time</th>
<th>Mon.</th>
<th>Tue.</th>
<th>Wed.</th>
<th>Thur.</th>
<th>Fri.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
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<tr>
<td>8:30</td>
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<td>9:00</td>
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<td>9:30</td>
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COMMENTS:
Table 7. Behavioral checklist for recording duration of targeted behavior.

STUDENT: ________________ DATE: ________________

Temper Tantrums: Crying and kicking/stamping feet. Observe and record for 30 minutes twice a day.

Record the time that the tantrum starts (Time-in) and the time that it stops (Time-out).

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COMMENTS:
Once a behavior problem has been identified, strategies are needed to modify the unwanted behavior.

In a study to see how teachers successfully dealt with behavior problems, including oppositional behavior, Rohkemper and Brophy (1980) asked 98 teachers of grades K through 6, who had been nominated by their principals as being either average or outstanding in their ability to deal with difficult children to respond to vignettes of 12 problem behaviors, including defiant behaviors, found in the classroom.

Overall, the results showed that teachers used more punishments than support when dealing with problem behavior, "however teachers with greater ability to handle difficult students used more total rewards, more total support behavior, and more unique supportive methods. "In addition, high ability teachers used punishment less than other teachers" (p.18). The methods used included symbolic rewards and contracts and the supportive behaviors included comforting and reassuring.
Less effective teachers were more likely to use punishment that involved loss of privileges and the involvement of other adults in the punishment process. "Not only did less effective teachers invoke punishment more, they also failed to provide support and encouragement as teachers rated higher" (p.18). In general, less effective teachers were found to be distanced from their students. They were also less verbal and more action oriented, although the action was often reactive. In addition to the other traits cited, teachers judged as outstanding also involved the student in his or her behavior change. It was also found in a follow up study involving eight of the teachers judged as outstanding that these successful teachers also tended to view their strategies as part of a total treatment package, rather than to respond to the misbehaviors as isolated incidents (Rohrkemper, 1982).

The use of time out in a classroom is somewhat controversial. While time out has been shown to be a key component in behavioral
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management programs, (Forehand and McMahon, 1981) it has several potential disadvantages in the classroom. Some of these include potential legal barriers, and the likelihood of eliciting strong emotional reactions which may be more disruptive than the original behavior. It is also possible that a student may be too large or too aggressive for a teacher to place in time out and "the isolation may act as a reinforcer rather than as a punishment" (Percival, 1987, p.295).

It is a professional obligation of teachers to accept the responsibility of educating all of their students, including those with behavioral disorders. Therefore, it is important that teachers understand and use behavior management techniques which have been proven effective.
CHAPTER 3
Summary and Conclusions

It is estimated that as much as 5% of the population may exhibit some characteristics of behavioral disorders including Oppositional Defiant Disorder.

Children with this disorder may display a wide range of negative, hostile, defiant behaviors including tantrums, aggression, and disruptive behavior at school.

While this disorder is said to be multidetermined, research has shown that the cause may lie in a combination of basic temperament of the child, environmental factors, and ineffective behavior management.

Further research has shown that the key behavior in the diagnosis and treatment of oppositional behavior is noncompliance. Noncompliance, the failure of a child to respond appropriately to an adult command within a reasonable amount of time, has been shown to be central to a number of behavioral disorders.
Oppositional Disorder

including Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. A strong connection has been shown between OD and ADHD. It has been noted by Barkley that by age 7, 60% of ADHD children acquire defiant behaviors.

Treatments and interventions for this disorder have included family therapy, psychotherapy, medication, parent training and others.

The most effective treatment has been shown to be parent training programs that are based on parent-child interaction. Such successful programs have been developed by Forehand and McMahon, and Barkley. Both programs teach the specific skills of attending to children, rewarding appropriate behavior, giving effective commands, and the use of time out as a punishment. These programs are successful because they break the cycle of coercive behavior by the child followed by parental acquiescence. They provide the parent with improved management skills,
increased knowledge of the causes of misbehavior, and result in improved child compliance.

Such a program may not be practical for classroom intervention due to legal barriers and the potential of eliciting strong emotional reactions which may be more disruptive than the original behavior. However, there are strategies that teachers can employ to avert behavior problems in the classroom.

While a particular, specific technique may be effective in only certain situations, it has been found that teachers who are consistently successful at dealing with behavior problems tend to employ similar strategies that anticipate and extinguish disruptive behavior. These teachers use rewards, contracts, and supportive behaviors. They are also more verbal and less reactive to behaviors. They include the student in behavioral changes and they view their strategies as part of the overall treatment package.

After this examination of Oppositional Defiant Disorder and the current interventions
being used to treat it, is it deemed possible to elicit a positive change in a defiant child's behavior?

"Yes."
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References


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