A study of social skills training and oppositional defiant disorder with a kindergarten student

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ABSTRACT

SOCIAL WORK

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A STUDY OF SOCIAL SKILLS TRAINING AND OPPOSITIONAL DEFIAN'T DISORDER WITH A KINDERGARTEN STUDENT

Advisor: Anne Fields-Ford, Ph.D.

Thesis dated: April 1996

A single system research design was used to study the use of social skills training with a child displaying symptoms of oppositional behavior in home and at school. It was found that social skills training reduced oppositional behaviors defined as on-task and off task.
A STUDY OF SOCIAL SKILLS TRAINING AND OPPOSITIONAL
DEFIANT DISORDER WITH A KINDERGARTEN STUDENT

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
MELISSA L. SMITH

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
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ACKNOWLEDGEMENTS

They that wait upon the Lord shall renew their strength; they shall mount up with wings as eagles; they shall run, and not be weary; and they shall walk, and not faint. Isaiah 40:31

I would like to thank God for giving me the strength to continue. A very special thanks, to my parents Dr. Fredrick E. Smith and Colonel Mary L. Smith for your undying love and strength. Thanks for believing in me. To the entire Smith & Davis families for your unconditional love and strong family bond. To my sister friends (Tina, Dawn, Kellye, Laura, Lisa, Lynn, and Tanna), thanks for the encouragement and much needed advice and prayers. To Jennifer, John and Joi without you I could not have made it through this program. To Dr. Ford, thank you for hanging in there with me, your advice was invaluable and I’m proud I met your challenging standards. Last but not least, to the love of my life Mr. Okyeame Gene Haley, thank you for being the true brother any sister would ever want. I Love you all! I dedicate this to the loving memories of Opral Elaine Davis Cole and Ethel M. Smith. The struggle continues, HARAMBEE!
**LIST OF FIGURES**

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Behavior During Baseline Phase</td>
<td>37</td>
</tr>
<tr>
<td>2.</td>
<td>Behavior During Follow-Up Phase</td>
<td>39</td>
</tr>
<tr>
<td>3.</td>
<td>Behavior During Intervention Phase</td>
<td>41</td>
</tr>
<tr>
<td>4.</td>
<td>Behavior Observation Phase</td>
<td>42</td>
</tr>
</tbody>
</table>
CHAPTER ONE
INTRODUCTION

Oppositional behavior is most prevalent and even expected for children between the ages of two years to three and a half years of age. Often these behaviors decline between the ages of four and six years old. From a developmental perspective, during the earlier ages (2 to 4 years) children often refuse the most reasonable requests, realizing at this point that they have a separate will and acknowledge themselves as individual persons. The child may constantly use the word "no" or other negative terms in a quest for both attention and individuality. While this behavior may be frustrating for both parents and teachers, it is appropriate behavior for this stage and should be viewed within the context of developmental theory.¹

When a child reaches preschool age and is beginning his or her educational career, conformity and structure are the goals of teachers and parents. Children are expected to participate in classroom activities, while sharing attention with other children and working within a group setting to accomplish goals. Some children are unable to meet these expectations and become a challenge for parents and teachers. When a child acts excessively, and displays

oppositional behaviors such actions may precipitate problems educationally and socially.²

Oppositional behavior is often used synonymously with Oppositional Defiant Disorder with long term behavior reflective of Conduct Disorder. These children probably do not set out to annoy people but do so because they cannot or do not sit still or comply with directions or requests in the expected manner. Generally, when the negative behavior is addressed the child may discontinue the behavior temporarily only to begin soon thereafter.³

Oppositional behavior is defiant and creates negative interaction. This type of behavior is expressed by persistent stubbornness, resistance to directions, an unwillingness to compromise, to either give in or negotiate with adults and/or peers. These children often test limits by ignoring others, arguing, and failing to accept their misbehavior. Hostility and aggression are directed at both adults and peers. Usually the behavior occurs in the child’s home and the school setting. Therefore, symptoms are most obvious with adults or peers with whom the child is most familiar. During clinical observation the symptoms may

²Ibid., 441.

not be as obvious as they were within a familiar environment.\

The Diagnostic Statistical Manual IV cites two categories of behavior disorders in children, Conduct Disorder and the other is Oppositional Defiant Disorder.

Oppositional Defiant Disorder does share some of the same criteria as Conduct Disorder and is often used as a synonym. Oppositional Defiant Disorder is a new category that is currently in search of clarity. There are contrasting views regarding its distinction. Some clinicians observe that symptoms of Oppositional Defiant Disorder are precursors to Conduct Disorder and should not be considered as a distinct disorder. Others contend Oppositional Defiant Disorder and Conduct Disorder, while sharing some of the same characteristics should not be categorized together. The thrust of Oppositional Defiant Disorder is embodied in negative and disobedient behaviors. Such behaviors must exist for at least six months and have multiple occurrences to meet requirements of the classification. While six attributes characterize Oppositional Defiant Disorder, they must meet at least four

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\textsuperscript{1}David Sue, Derald Sue, and Stanley Sue, Understanding Abnormal Behaviors, 4th ed. (Boston, MA: Houghton Mifflin), 512.

of the following criteria: losing temper, arguing with adults, actively defying or refusing to comply with requests or rules of adults, deliberately doing things that annoy people, blaming others for his or her own mistakes or misbehavior, being touchy or easily annoyed by others, expressions of anger and resentment or being spiteful or vindictive. Further consideration should be given to age as a factor prior to diagnosis.6

Studies have questioned the validity of the distinction between Oppositional Defiant Disorder and Conduct Disorder. These studies indicate that there is little difference between the two categories in both duration and intensity of the behaviors. Symptoms that are often associated with Conduct Disorder (i.e., bullying, aggression and violation of rules) also frequently occur with children diagnosed with Oppositional Defiant Disorder.

A child with Oppositional Defiant Disorder is characterized by negativistic, argumentative, and hostile patterns of behavior. The diagnosis is most prevalent in male children who had problems during the preschool years, displaying problematic temperaments.7


7David Sue, Derald Sue, and Stanley Sue, Understanding Abnormal Behaviors, 4th ed. (Boston, MA: Houghton Mifflin), 512.
Many children go through a developmental period when expressions of rebellion are expected. It is the persistent pattern of behaviors that are embodied in oppositional behavior. One study of pre-adolescent children in a "normal" classroom setting found that 15.8 percent met the criteria for Oppositional Defiant Disorder. The distinction between normality and pathology is determined by the degree to which a child is socially or academically impaired. *

Significance of the Problem

Detecting and addressing oppositional behavior early in elementary school is very important to students overall educational development. Early detection and attention can enable a child to avoid further and more intense complications. It is suggested that the sooner behavior problems are detected, the more amenable they are to intervention. It is also suggested that early detection of negative behaviors may avoid a negative reputation with peers and teachers. *

Typically, children with behavior problems have poor school performance, poor peer relations, attention problems, excessive motor skills and demonstrate aggression or withdrawal. Inner city youth are often at greater risk to

*Ibid.

such oppositional behaviors. As a result, they face additional set backs in the classroom setting for various reasons that may contribute to and compound the behavior. Inner city youth are more likely have been exposed to low birth weight, drugs, and AIDS prenatally. These children are also more likely to have poor nutrition, been exposed to lead poisoning, aggression and a variety of physical injuries due to unsafe neighborhoods and poor housing. As a result, these children are often referred for special education classes and receive a disproportionate number of disciplinary actions in the public school system.\textsuperscript{10}

It has been suggested that school systems have not effectively engaged and responded to the unique needs of students. School achievement tends to drop below expectations in elementary school and these children may to continue fall behind as they get older. Disciplinary actions toward black students are disproportionately higher than that against white students. While African Americans account for only 16 percent of the national public school systems, they make up 28 percent of all expulsions, suspensions and corporal punishment due to behavior problems. There is no evidence to suggest that disciplinary

\textsuperscript{10}Judith J. Carta, "Education for Young Children in Inner-City Classrooms, American Behavioral Scientist 34 (March/April 1991): 440.
measures teach a child how to behave in a more appropriate manner.\textsuperscript{11}

Few school systems across the country provide proactive social skills training for students. A recent study showed that the majority of behavior interventions are reactive and ineffective.\textsuperscript{12} These systems provide no audience to develop or maintain appropriate behaviors. Their primary goal is to punish those students who do not display the desirable behavior.\textsuperscript{13}

It is clear that more attention needs to be given to teaching and improving social interaction with children. Mental health professionals are currently trying to define the childhood behavior disorders (Oppositional Defiant Disorder and Conduct Disorder) which may ultimately help to provide more positive ways to evoke desired behaviors. Until a widely accepted guideline is used, students with social maladjustments as identified with Oppositional Defiant Disorder may continue to be denied the much needed treatment. School systems and society as a whole tend more toward punitive measures in addressing inappropriate behaviors in children.


\textsuperscript{13}Ibid., 318.
**Purpose of Study**

Purpose of this study is to determine the effects of social skills training in a child with Oppositional Defiant Disorder.
CHAPTER TWO
LITERATURE REVIEW

The literature review is organized in the following manner: (1) historical perspective on childhood behavior, (2) significant studies on oppositional behavior, and (3) theoretical framework.

**Historical Perspective of Childhood Behaviors**

Behavior problems in children have been around throughout history. Over the years childhood behaviors that go against the norm have been dealt with in many ways. It is important to understand how the childhood behavior issue have come full circle and the various ways in which the problem is handled has evolved.

In the middle ages behavior disorders were seldom mentioned in regards to children. It is likely behavior disorder existed among children, but was viewed in a very different light. Abnormal behaviors were seen as demonic and treated primarily by priest or sorcerer. Near the beginning of the 1800s, the concept of demonic forces was losing its appeal, but very little treatment was given to children. *The Madness in Children* and *Childhood Mental Problems* were the first books published on childhood disorders.¹ Both books focused on the roles of parents and

teachers in preventing childhood disturbances. Prior to the twentieth century, juvenile courts were developing around the country dealing with the problems of childhood delinquency and truancy. Children were placed in orphanages in an attempt to control the new "menaces to society." The following quotation embodies the school of thought in regards to dealing with disordered children:

There are large number of children who are constantly dropping out of our schools because of insubordination and want of cooperation between the parents and the teachers and they are becoming vagrants upon the streets and a menace to good society. The welfare of the city demands that these children be put under restraint.  

In the early 1900s, with the onset of the mental health movement children’s unacceptable behaviors were viewed as pathological. Much attention was given to the need for treatment of those individuals with behaviors outside of the norm. In 1909, William Healy founded the Juvenile Psychopathic Institutions. The institution began as an attempt to help the Chicago court system deal with juvenile delinquency. He developed the interdisciplinary team approach to treat and assist children with adjustment and compliance difficulties.

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2Ibid., 8.
3Ibid., 9-11.
4Ibid.
From the mid-1900s the focus has continued to be on pathology, for seriously emotionally disturbed children. Public Law 94-142, in 1975, provided specific definitions excluding many children with behavior problems. Professionals from several disciplines developed an organization called Council for Children with Behavior Disorders. This organization began to look at children's behavior problems from many different perspectives. The psychodynamic, ecological, humanist, behaviorist, and psychoeducationalist all began to work with, and develop, ways to address children's behavior issues. In 1965, Conflict in the Classroom was published and accepted as a guide for dealing with children's classroom behaviors. The book provided techniques on improving and specifying children's behavior challenges. Professionals began to operationalize oppositional behaviors very differently. Problems with the definition continue to plague disciplines of mental health.\(^5\)

Some suggest that definitions provided by Public Law 94-142 focused on psychiatrically defined disturbances that make up only a small percentage of classroom problems. Public Law 94-142 defines seriously, emotionally disturbed as:

\[\ldots a \text{ condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which}\]

\[^5\text{Ibid.}, 9-13.\]
adversely affects educational performance: (a) an inability to learn which cannot be explained by intellectual, sensory or health factors; (b) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (c) a general pervasive mood of unhappiness or depression; or (d) a tendency to develop physical symptoms or fears associated with personal or school problems.6

Public Law 94-142 includes children who are schizophrenic and excludes those children who are socially maladjusted, unless they are seriously emotionally disturbed. It also has been suggested that the label "seriously emotionally disturbed" is far too stigmatizing for children and parents. The fear of labeling surrounds the notion of a self-fulfilling prophecy.

Significant Studies on Oppositional Behavior

In many studies Oppositional Defiant Disorders are included with Conduct Disorder and Attention Deficit Hyperactivity Disorder. Very few studies deal exclusively with patients categorized as Oppositional Defiant Disorder. For the purpose of this section it is important to keep in mind the variables of the disorder that are noted throughout this study.

Frick and others set out to determine if there was a legitimate difference in the Conduct Disorder and Oppositional Defiant Disorder categories because they appear to be so closely related. The population included 177 boys

6Ibid., 13.
with conduct problems who were in outpatient treatment. They utilized the criteria for Oppositional Defiant Disorder and Conduct Disorder according to the DSM-III. Units of observation were gathered from parent, teacher, and psychiatric interviews. The results supported a distinction between Oppositional Defiant Disorder and Conduct Disorder, showing two dimensions to conduct problems. However, some behaviors such as bullying, fighting, and lying appeared heavily on both observed behaviors. Loeber, Lahey, and Thomas supported the distinction of Oppositional Defiant Disorder and Conduct Disorder citing that many youths with Oppositional Defiant Disorder never develop Conduct Disorder, and Conduct Disorder that develops during adolescents, appears to be independent of Oppositional Defiant Disorder.

Some family characteristics thought to contribute to Oppositional Defiant Disorder are marital disharmony, and conflicting communication patterns. Studies have shown that families with high marital disharmony have had high frequencies of behavior problems, especially in boys. Reed

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and Sollie, based on a random sampling of children ages 3 to 8 years, found strong evidence that marital disharmony played a powerful role in the development of behavior problems. It also found that students who were in families characterized by stress developed problematic behaviors within a five-year span subsequent to the study.9

Literature offers strong support for the linkage of parents and family functioning to students who have displayed oppositional behavior. Frick et al. suggest that depressed parents are more inclined to have some child behavior problems. They conducted a study on 177 clinically referred children ages 7-13, with Conduct Disorder, Oppositional Defiant Disorder and behavior problems not diagnosed. The study looked at maternal parenting styles which included discipline and supervision; and parental adjustment which included substance abuse and Antisocial Personality Disorders. Study findings showed parents of children with Oppositional Defiant Disorder had a higher rate of Antisocial Personality Disorders and substance abuse than children with no diagnosed behavior problems. It also found parents of Conduct Disorder children had higher rates of both Antisocial Personality Disorder and substance abuse than Oppositional Defiant Disorder.10

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10Paul J. Frick, Benjamin B. Lahey, Rolf Loeber, Magda
Wenning, Nathan, and King suggest that inconsistent, abusive, and/or harsh disciplinary actions by parents may also contribute to oppositional behavior. Children's behavior has been found to improve when parents are taught to become more involved in their child's activity, and avoid the use of corporal punishment.\textsuperscript{11}

Poor communication between parent and child is also an indicator of behavior problems. Studies have shown that mothers of children with behavior problems often send conflicting verbal and nonverbal messages.

Reed and Sollie compared the use of parent instructions to children's compliance levels.\textsuperscript{12} There were two types of instruction used: one called an alpha command, the other a beta command. The alpha command was a clear, direct, specific command of which the child was expected to respond without further coaxing by the parent. The beta commands were vague, interruptive chain of commands. Children responded better to alpha commands which ultimately pleased the parents because of compliance. The beta

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commands were not followed as often and resulted in the noncompliance. Thus, noncompliant behavior is thought to be connected with the lack of giving specific instructions.\textsuperscript{13}

Many studies on children's compliance have been conducted, testing the use of beta and alpha commands resulting in similar conclusions. Powers and Roberts suggesting the focus of toy clean up and children's response concentrates too heavily on the task completion and not parent directions. In such training programs parents are taught to engage the child in activities, whereby the parent, gives specific instruction (which is normally cleaning up the room or picking up toys). These activities, even though they have proven successful via the training is said to be insufficient in evoking skillful parenting.\textsuperscript{14}

White, Taylor, and Moss suggested early interventions which include parents have a high success rate in producing compliant behavior. The lack of success found in many studies is believed to be due to the way in which the research studies were conducted. Intervention including parents should focus on teaching parents positive forms of discipline, providing them with information, skills and techniques to help improve their child's performance. These

\textsuperscript{13}Ibid.

types of goals can be achieved through workshops, and school programs aimed at strengthening the relationship with child, family and school. The concept of empowerment should be stressed because it is primarily the parent's responsibility to look out for their child's best interest.\textsuperscript{15}

Prescription drug treatments are also considered a method of intervention. Studies of school aged children with disruptive behavior disorders investigated the effects of psycho stimulant medication on preschool aged children found few positive effects. Additional studies also discouraged the use of such medication noting many side effects and encouraged the use of behavioral interventions such as social skills training and parent training. However, the following studies tested the use of antidepressants and amphetamines and found positive results. Two out of the four reported some kind of side effects shortly after the beginning of treatment. The literature is awaiting results on current longitudinal studies.\textsuperscript{16}

Speltz et al. conducted a study on a 4-year old student diagnosed as Attention Deficit Hyperactivity


Disorder (ADHD) and Oppositional Defiant Disorder was done using the drug Dextroamphetamine. The child displayed aggressive behaviors striking out at peers, parents and teachers. Such outbursts would occur 4 to 5 times daily in the classroom setting and once or twice at home. After failure to reduce such symptoms with behavior training within two months, he was prescribed 5 mg of Dextroamphetamine daily. His off task behaviors declined from a mean of 50% during the baseline period to 21% during the intervention. He was placed on placebos for a week during the intervention at which time the behaviors returned to those reflective of the baseline period with a mean of 62.5%.[17]

Ghaziuddin and Alessi conducted a study on three children who displayed large amounts of oppositional behavior shown that the use of drug treatments reduced aggressive behavior. The children were described as highly aggressive, argumentative, and difficult to control. Patient "A" often tried to hit his parents and siblings, had a poor attention span and was very impulsive. The duration of the problem prior to referral was three years. Play therapy was tried for two years with little positive results. However, Pemoline 37.5 mg twice daily was tried and reduced aggressive behaviors though, the child had difficulty sleeping. Amitriptyline 50 mg daily was

[17]Ibid.
unsuccessful in reducing aggression. Lithium Carbonate 600 mg daily had no significant change. Patient B is an eight year old boy who was court referred to inpatient treatment due to physical and verbal aggression. Past treatment included individual and family counseling with no significant improvement. Patient C is a 9 year old also, with a history of high levels of aggression since age 4. Past treatment of counseling and Methylphenidate 10 mg daily showed no decrease in aggression. Trazodone helped all three clients in the reduction of aggressive behaviors within two weeks of prescription. Patient C had the only reported side effect (two penile erections at which time the dosage was decreased). After the decrease in aggression, all three patients were taken off Trazodone at their parents' request and the behaviors reoccurred. Once the medicine had been reinstated, the symptoms decreased.

The antidepressants used in the above study have multiple side effects in adults. Amitriptyline is the most sedating antidepressant while Trazodone has the least reported side effects. Both have been successful in the

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19 Ibid., 293.
treatment of depression (which is not a criterion for Oppositional Defiant Disorder). 20

Amphetamines such as Dextroamphetamine have proven effective with treating ADHD in children. Parents should be advised that the medication may decrease hyperactivity, which is the major component of ADHD, however it is unrealistic to expect major changes in social behaviors. Non-drug treatment is highly recommended for social skills training behavior issues. 21

Social Skills Training is routed in cognitive social learning. The fundamental belief of this theory is that children can learn and utilize new behaviors through observing, listening and modeling. Once taught children will be able to put such behaviors within their learning context and use them as guides for performance. The use of various reinforcement will increase the desired behaviors and can be adjusted according to performance. The three major principles of the theory are enhancing skills concepts, promoting performance and utilizing of skills taught, and recalling skills acquired. 22

Theoretically, social skills deficits that results from faulty learning can be remedied


21 Ibid.

through instruction in specific components of social interaction; the effectiveness of this approach has been demonstrated in adults and aggressive children.23

In teaching skill concepts the instructor is attempting to enhance or develop positive behaviors. Skill selection should be developed based on appropriate goals in relation to developmental age and peer group. It is equally important to utilize information obtained from observation keeping in mind cultural and environmental factors.24 Task mastery is the goal and each task should be clear and specific. For example, if the goal is to become more liked by peers, the student’s task may include how to introduce himself, how to give compliments, and how to interact with peers.

A few studies have found no significant change in students behaviors after receiving social skills training. The belief is that many of these studies do not select specific and relevant goals. Many programs select goals that may be important to changing adult behavior but not children. One study evaluated this concept and selected more child appropriate goals and had more positive outcomes. They also found that success and failure of programs


24Ibid.
directed toward enhancing social skills vary from teacher, parent and peer context.
CHAPTER THREE

METHODOLOGY

The "A-B" single system research design was used in this study. The use of the design indicates changes in the subjects behavior at multiple data collection points during the "baseline" and intervention phases. The baseline phase is the non-intervention period when the observation is conducted on the target problem. At this point the clinician is attempting to make an accurate assessment of areas in which to focus the intervention. The intervention phase was based on information observed during the baseline phase. The Behavior Observation Form was used to measure changes in the target problem in phase "A" and "B" of the design.¹

The research was conducted in a local public school in Atlanta. The clinician observed Norman within the classroom setting and recorded his oppositional behavior, referred to as off task behaviors. The setting in which observation occurred consisted of 24 kindergarten students, a teacher, and a paraprofessional. The students sit at assigned tables. Norman and one other student sat at individual desks, due to their constant need for

supervision. Norman’s desk is directly adjacent to the teacher.

The most frequently observed behaviors were called oppositional behaviors. The targeted oppositional behaviors were operationally defined as behaviors that interfered with instructions and were off task; hitting, arguing, bullying, talking back to the teacher, encouraging others to misbehave, leaving the instructed area, and not following classroom rules. When Norman displayed oppositional behaviors, it was defined as off task. The Behavior Observation Form was developed to collect data for the baseline phase (A), as well as to confirm teacher observation. Items used were partially determined by a three-day observation period of the child in the classroom by the clinician. Each time the student was off task was recorded. Literature suggests that baseline period be conducted for seven to ten days in order to establish a pattern. The baseline period was reduced because the oppositional behavior (off task) had been previously supported by teacher observation and parent information, and the student’s file. The baseline information observed by the clinician supported previous reports by teacher and parent. Specific instruction not followed by Norman were recorded and tallied on an Individual Behavior Observation Form used by the clinician. The observation was done at three different times throughout the baseline phase. The
first collection period was in the morning, the second after lunch and the final collection was taken before school dismissal. The multiple collection showed the off task behaviors that occurred most often. Prior to the intervention, the teacher was given the Behavior Observation Form with instructions on how to observe and complete Norman's behavior. He was to receive a "0" for poor behavior, "1" for average behavior and "2" for good behavior. For example he would receive a "0" if he hit a classmate, "1" if he did not hit a classmate, and "2" if he avoided confrontation which by using skills taught in the intervention.

Treatment Intervention

The intervention phase (B) was based on a cognitive training package developed from techniques used in "Good Behavior," Skills Training, and Families and Schools Together Program. The literature suggested that there be a 10-day waiting period between the baseline phase and the intervention. However, it was determined by the clinician and parent that the intervention should begin as soon as possible with hopes of reducing the behavior before the problem got worse. The rationale for the intervention was based on improving behaviors in the following areas:

interpersonal communication skills (appropriate ways to identify and express feelings), conflict resolution (ways in which to avoid problematic situations) and compliance skills (meeting teacher request and following directions). The intervention took place in a separate classroom.

Norman's intervention consisted of 30 minutes of training for 10 days conducted by the clinician. During the morning session, the clinician reminded him of his goals for the day and the quest for tokens (stars), as reinforcers for positive behavior. During the 30 minutes the clinician and Norman participated in some planned activity that focused on "on task" behaviors. Activities included items on social skills training and reinforcement of items in the Families and Schools Together program (i.e., games focusing on intercommunication skills). On the first day of training, Norman was given instruction and was to write out a goal sheet (contract). He and the clinician decided on the rewards to be given to him based on the number of stars earned. Unsatisfactory behavior will receive no rewards. Good (6-10 stars), very good (11-15 stars), and excellent behavior (16-20) he received the certificate for that respective category with the amount of stars earned. After the 15 minute playtime the clinician and the student

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discussed the itemized chart of techniques and skills. After the second session at the end of the day the clinician, teacher and student discussed his accomplishments or problems that took place throughout the day. Norman received the rewards if he was able to transfer on task behavior in the classroom as determined by the Behavior Observation Form.

**Case Information**

Norman, the subject in the research study, is a six year old African American male enrolled in an inner city school. He resides with both of his parents and an older sibling. He was enrolled in a Head Start program at age 4½. Norman is described by both his teacher and his mother, as aggressive, easily upset and openly defiant of rules and instructions. When confronted about his behavior Norman did not accept responsibility and projected blame on others. He is mean to others, and the behavior escalates if he has an audience. His mother is very concerned about his behavior, and is often called to the school. He has been suspended for fighting and is often sent out of the classroom or to a time out station. At home Norman, often start arguments with his brother and continues to agitate him until the brother gives up or gives him what he wants. The mother has tried time out at home, punishments and spankings in an effort to change his behavior, without success. She also
reports that he does not have any friends and is disliked by his brother's friends.

"Norman" and his family were referred to a special school program, Families and Schools Together, to improve his classroom behavior. However, by the sixth week of the program, the teacher reported no change in his behavior, and in fact an increase in problem behaviors.

Baseline information was collected from observation in the classroom setting three times daily for three days. By the second day of the baseline phase, a pattern was determined, using the Individualized Behavior Observation Form. Behaviors observed were the focus of the intervention. He displayed more off task behavior during the morning observation period and less off-task behaviors in the afternoon.

Treatment Hypothesis

Cognitive techniques will decrease oppositional behaviors (off task behaviors) in a six year old Kindergarten child.

Intervention Strategy and Plans

Several off task behaviors were observed and recorded on the Individual Observation Form. The most frequent behaviors were the focus of the intervention. Each behavior was worked on and reinforced throughout the ten-day span.
Interpersonal communication focused on the elements of verbal and nonverbal communication as well as the appropriate ways to express and identify feelings. Conflict resolution focused on techniques, ways to find alternative solutions, reaching goals, examining consequences, problem solving and identification and strategies to avoid confrontations. Compliance training focused on teaching the child how to respond to adult direction in the appropriate manner.

**Day 1**

**Objective:** To establish a contract with the student and discuss goals, expectations, and rewards of the intervention.

Norman was told about the individual sessions with the clinician. Twice a day they met to work on issues around behavior. In the morning we reviewed daily goals and techniques to utilize throughout the day. The goal was to earn stars. The more stars received throughout the day the better the reward. Norman was asked to pick his three favorite colors out of a pile. He was to place them in chronological order according to his personal preference. Number 1 was the color he liked most. That color was selected for his highest reward certificate. After the third day of intervention it was necessary to add additional reinforcers. Each day Norman received the highest certificate indicating excellent behavior he would get a
picture taken of himself, his favorite color certificate (blue) and a prize. Color number 2 (yellow) was used for very good behavior. He would receive the certificate for that level with no picture or prize. Color number 3 (orange) was used for good behavior. He received a smaller certificate with no picture or prize. The second meeting with the clinician included the classroom teacher. The teacher, clinician and Norman went over each item on which he was going to be scored and the highest possible scores. There he wrote and signed a contract that read "I Norman will do my best."

**Day 2**

**Objective:** To work on interpersonal communication skills focusing on verbal skills.

Norman was asked to draw a happy, sad, and mad face. After he drew the pictures, he was asked what made him happy, sad and mad. He drew a picture of each situation that reflected that feeling and was asked to explain the picture. After it was clear what the feelings was he was asked what are some of the things he does to make his teacher happy, sad and mad. It was obvious that he understood many of his positive and negative behaviors. After the session he was asked if he wanted to do his best. He was asked how he was to go about doing his best. He was given a notebook called "Norman’s Best Book." Inside the notebook he was to keep his activities done in training on
his observational form. At the end of the session he recited his contract. His mother reviewed the rating scale each day.

Day 3

Objective: To work on interpersonal communication focusing on nonverbal communication.

Norman was asked to draw other faces and explain their meanings. He drew surprised, bored, tired, and proud faces. He discussed a few situations when he had those feelings. He was also asked to show how to express those feelings nonverbally using body language and facial expressions. He was asked to identify the clinician expressions and gestures. At the end of the session he recited his contract.

Day 4

Objective: To work on interpersonal communication; the focusing was on being kind to others and to add additional rewards.

Norman was asked to retrieve his happy, sad and mad faces. He was again asked to explain each feeling. He was then asked if he had friends. He responded yes. He was asked what he liked and did not like about his friends. He was also asked how they hurt his feelings, and how he hurt feelings of others. After discussing each we discussed ways to interact with friends and classmates. He was shown how
to introduce himself, how to initiate and maintain positive interaction and give and receive compliments. Each task was role played. The clinician provided additional rewards to increase responses. Various prizes were shown to Norman. He was asked which toy he did not like. He said he liked them all. He was then told that he would receive the prize of his choice on the days he displayed very good and excellent behavior. Thus, he needed to receive 11 or more stars each day. At the end of the session he recited his contract.

**Day 5**

**Objective:** Review interpersonal skills and begin working on ways to avoid problem situations, and ways to resolve conflict.

Norman was asked to introduce himself and start a conversation. He was also asked to give a compliment. He drew a picture of how each activity made him feel and how it made others feel. He was asked what made him mad. He was then asked how he dealt with each situation. He was asked to come up with other ways to deal with each problem. Often he alluded to the fact that other students bothered him and evoked negative responses. He was asked the best thing to do in each situation. He was taught the stop sign. When something made him mad or someone was trying to get him to misbehave he was to put his hand up giving them the stop sign. At the end of the day he recited his contract.
Day 6

Objective: To work on problem solving skills and conflict resolution.

Norman was given several scenarios and asked to explain the problem. After which he was asked what is the best and worst way to deal with each situation described. He then drew a picture of the best way to deal with each case. He was also taught the appropriate way to respond to teacher instructions. Instructions were centered around following directions. He was asked the correct and incorrect way to respond to each instruction. At the end of the day he recited his contract.

Day 7

Objective: To work on following instructions and giving responses.

Norman was asked to respond to instructions given. He was asked the correct and the incorrect way to respond. He was asked what he thought would happen if he chose the incorrect response. He was asked to demonstrate the correct ways to receive punishment for choosing incorrect behavior. He was asked about the consequence for positive behavior. At the end of the session he recited his contract.

Day 8

Objective: To work on reviewing interpersonal skills and complying with teacher request.
Norman was asked to identify things that make others happy. He was asked what he could do to make his teachers and parents happy. He was to draw a picture of himself doing those things. He was asked to identify what he had done in the past few days that made both his parents and teacher happy. He was also asked to identify times when he made them mad or sad. He was asked how to avoid those behaviors. At the end of the day he recited his contract.

**Day 9**

**Objective:** To review skills taught and prepare to decrease sessions.

Norman was told that he and the clinician would meet twice a week instead of daily. He was asked how he would treat others and ways to accomplish being kind to others. He was given several cards with feelings on them and asked to act them out and to explain what they meant. The feelings included: happy, sad, mad, tired, surprised, and bored. He was also given scenarios and asked the best way of handling them. At the end of the day he recited his contract.

**Day 10**

**Objective:** To review skills taught.

Norman was asked the best way to deal with various feelings and situations. He drew positive responses and expressions. He was shown a chart of how to deal with
anger. The chart included the stop sign and other techniques to deal with being mad. He was asked to pick which he thought was best to use in the school setting. He described times in which he would utilize his techniques. At the end of the tenth session his mother was given the remainder of the rewards to continue evaluating his behavior.
CHAPTER FOUR
PRESENTATION OF FINDINGS

In this study on oppositional behavior, (the targeted behavior) was defined as hostile and negative behavior. Children with these behaviors often defy rules, become aggressive toward both adults and peers. Often these children blame others for their mistake and express difficulties complying with the most reasonable request. The oppositional behaviors in the classroom, referred to as "off task," interfered with the child's performance. These behaviors were observed as arguing, bullying, leaving the instructed area and not doing the instructed class work. Other behaviors observed, though not as frequent, were hitting, encouraging others to misbehave, and talking back to the teacher. These behaviors were reported in interviews with teacher and parent. They were also directly observed by the clinician and recorded on an Individual Behavior Observation Scale. The items most frequently observed were placed on The Behavior Observation Form which used by the teacher and included following classroom rules and overall expectations and behaviors. The highest possible score in each category on the Behavior Observation Form was "2" equaling above average behavior. Scores of "1" or "0" represented average and poor behavior respectively.

During the baseline period, as shown on Figure 1, Norman had an overall score of "0" on "on task" behavior on
FIGURE 1

BEHAVIOR DURING BASELINE PHASE
ON TASK BEHAVIOR SCORES

DATA COLLECTION POINTS

| BASELINE PHASE SCORES | 0 | 2 | 2 |

BEHAVIORAL LEVELS:
0-5= UNSATISFACTORY 6-10=GOOD
11-15= VERY GOOD 16-20= EXCELLENT
the Behavior Observation Form, representing unsatisfactory behavior. He had a fight with a classmate and was sent to the office for the remainder of the day. He was also out of his area and bullied the same classmate which resulted in the fight. On day 2 Norman scored a total of 2 stars (representing unsatisfactory behavior). He did average on classroom work and bullying other classmates. Day 3 Norman received a total of 2 stars scoring above average on classroom work. At the end of day 3 Norman was introduced to the clinician by the teacher.

Figure 2, is a display of the first three days of the intervention showing few changes in Norman’s behavior scores. He received a total of seven stars on the Behavior Observation Form. On day 1 he received two stars, on day 2 he received 5 and on day 3 he did not receive any stars all of which represented unsatisfactory behavior. It was at this point the clinician decided to add additional reinforces. He would receive a prize above average and excellent behavior (11 or more stars). Excellent behavior would also include a picture of himself with an instant camera. Each prize and the cameras was visible during the intervention. Prizes included his favorite items as identified by his mother. He was allowed to choose from the prizes on days he received 11 or more stars. On the fourth

FIGURE 2

BEHAVIOR DURING INTERVENTION PHASE
ON TASK BEHAVIOR SCORES

DATA COLLECTION POINTS

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

INTERVENTION PHASE SCORES

2 5 0 11 10 14 11 8 15 12

BEHAVIORAL LEVELS:
0-5 = UNSATISFACTORY 6-10 = GOOD
11-15 = VERY GOOD 16-20 = EXCELLENT
day he received a total of 11 stars and was able to receive a prize. He received 10 stars on day 5 and 14 on day 6. On day 7 he received 11 stars and 8 stars on day 8. His ninth day he received 15 stars and was allowed to take a picture. On the tenth and final day he received 12 stars.

During the follow-up phase, Norman’s mother reported a score of 11 or more 2 out of five days. He received 9, 11, 6, 8 and 12 stars respectively as shown on Figure 3. Termination of the intervention included the parent, teacher, clinician and Norman. He was praised for his progress. He was told that the teacher would give him the certificates in the designated categories on a daily basis. On those days he received 11 or more stars his mother would allow him to chose from the prizes.

The results on Figure 4, show strong improvement in Norman’s behavior. He actively participated throughout the intervention by responding to clinician’s request and engaging in each day’s activities. However, he did not transfer those skills in the classroom setting until after the use of additional reinforcers. The use of social skills training improved his classroom behaviors after the use of reinforcers.

**Limitation of Study**

It is important to keep in mind that the success of the intervention was determined using only one subject. As with all single systems studies the goal is to test the
### FIGURE 3

**BEHAVIOR DURING FOLLOW-UP PHASE ON TASK BEHAVIOR SCORES**

<table>
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<td>FOLLOW UP PHASE SCORES</td>
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<td>11</td>
<td>6</td>
<td>8</td>
<td>12</td>
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</table>

**BEHAVIORAL LEVELS:**
- 0-5 = UNSATISFACTORY
- 6-10 = GOOD
- 11-15 = VERY GOOD
- 16-20 = EXCELLENT
FIGURE 4

BEHAVIOR OBSERVATION FORM
ON TASK BEHAVIOR SCORES

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<th>DATA COLLECTION POINTS</th>
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<th>15</th>
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<td></td>
<td></td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>11</td>
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<td>11</td>
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<tr>
<td>FOLLOW-UP PHASE</td>
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<td>9</td>
<td>11</td>
<td>6</td>
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</tbody>
</table>

BEHAVIORAL LEVELS:
0-5= UNSATISFACTORY  6-10= GOOD
11-15= VERY GOOD  16-20= EXCELLENT
intervention’s effectiveness with a single unit of analysis. Although a clear pattern of improvement was shown, the use of one subject limits its generalizability.
Recommendations for Future Studies

The results of this study demonstrate that the use of social skills training improved a child's oppositional (off task) behavior within the classroom setting. Based on the results the clinician concluded that it was important to include the teacher in the observation and evaluation of the subject (Norman). The teacher in this study welcomed the intervention and was willing to assist in making improvements. For future studies on the use of social skills training within the classroom setting, it is recommended that the teacher be involved in the observation and planning of the intervention for reinforcement purposes. In addition, the teacher was able to constantly observe Norman throughout the study because of the large amount of time they were in contact with each other (seven hours). Since the goal was to improve the off task behavior within the classroom setting the teacher should be trained on what to observe and how to respond to, and record significant activities. Most studies utilize high technical equipment such as constant videotaping, trained recorders and two way observational mirrors that are not readily available in most urban classrooms.

The parent also played a key role. She continued the use of reinforcers after termination. She also identified
the reinforcers that ultimately played a key role in the success of the intervention. Studies focused on improving oppositional behavior in the home environment, may benefit from working with the parent in the same manner as described for the teacher in the classroom setting.

It is also recommended that parent and child social skills training be done simultaneously. Parents can learn ways in which to evoke desired behaviors while learning new techniques. The parent could also be used as instructor in those cases where the negative behavior happens primarily at school.

**Implications for Social Work**

The use of a behavioral intervention as shown in this study, has proven to be effective. Social skills should be the intervention of choice with parent, child and teacher before using drug treatment. Behavioral interventions are much less intrusive and can provide the desired outcomes without negative side effects in adolescents and adulthood as identified in drug treatments.

School social workers should teach social skills as a proactive measure. Many children display oppositional behavior in some form and could benefit from positive curriculums to deal with confrontations, problems, and feelings. Reactive measures such as suspensions, expulsions, and drug therapy may temporarily solve the
problem but does little to eliminate undesirable behavior and teach positive behaviors.
APPENDICES
APPENDIX A

INDIVIDUAL BEHAVIOR OBSERVATION FORM

Student________________________
Observer________________________

Collection Number_________________
Time Observed (Hours/Minutes)__________

<table>
<thead>
<tr>
<th>Date</th>
<th>Behavior Observed</th>
<th>Frequency</th>
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APPENDIX B

BEHAVIOR OBSERVATION FORM

Student’s Name__________________________________________

Date__________________ Score__________________________

Ratings
0 = Poor Behavior
1 = Average Behavior
2 = Good Behavior

<table>
<thead>
<tr>
<th>Did not hit classmates</th>
<th>Did not argue with classmates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not bully classmates</td>
<td>Did not talk back to teachers</td>
</tr>
<tr>
<td>Did not encourage others to misbehave</td>
<td></td>
</tr>
<tr>
<td>Stayed in the instructed area</td>
<td></td>
</tr>
<tr>
<td>Did the instructed class work</td>
<td></td>
</tr>
<tr>
<td>Followed classroom rules</td>
<td></td>
</tr>
<tr>
<td>Met classroom expectations</td>
<td></td>
</tr>
<tr>
<td>Overall behavior</td>
<td></td>
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</tbody>
</table>
BIBLIOGRAPHY


Vitaro, Frank, Richard E. Tremblay, Claude Gagon and Daniel Pelletier. "Predictive Accuracy of Behavioral and
