CHAPTER 1

Introduction

In conceptualizing this book, I reflected on one of my earliest experiences as a child in elementary school, as well as on some recent experiences working with youth with disruptive behavior and their families. Looking back, I don't remember much about first grade, but I have a vivid memory of a hot June day at the end of the year. The teacher had said we could all go out for popsicles for recess before we went home on the bus. This was a real treat and out of the ordinary. The day seemed to crawl as we did our seatwork in a steaming hot classroom, and everyone looked forward to the special recess time. However, right before we were to go out, one of my classmates got upset at the teacher because he was asked to correct some errors on his seatwork. He got up from his chair, flipped over his desk, and started running around the room pulling papers off the wall. The teacher chased him, but the more she did, the more he ran around. Finally, a teacher from across the hall came over and the two adults marched the child down to the office. When the teacher came back, sweaty and disheveled from running around the room, she was so angry she said, "That's it! No popsicles today. We are all going to read quietly at our seats." This was one of my first experiences with disruptive behavior in the classroom, and I can state for certain that I did not enjoy the consequences of the behavior. This anecdote serves to demonstrate that the consequences of disruptive behavior go beyond the child exhibiting the behavior—the impact also reaches teachers, peers, and families, and therefore justifies intervention.

More recently, I spent some time working with a number of local districts to problem-solve behavior management. Although the districts were varied in terms of their neighborhoods, leadership, and the climate represented within the schools, it was remarkable how consistent the referring problems were to the child study teams. Teachers referred children who were not following rules, exhibiting disrespectful behavior toward adults and classmates, refusing to complete assigned work, and generally interfering with and interrupting classroom activities. The problems were frequent, ongoing, and stressful. Often the school staff lamented that the child's parents were not positively involved with the school. As the discussions on interventions progressed across the districts, it seemed like there were sig-

nificant questions about the best approaches for dealing with the problems even though it was often remarked that the referred child had been sent to the committee across multiple school years. Notably, although many of the behaviors were challenging, I remained impressed with the professionalism and dedication of the educators who truly wanted the child to be successful and meet his or her potential within the classroom setting. Typically, I would also meet with the parents of referred children, and, not surprisingly, they too were searching for viable solutions, and they had been working to remediate the problem behaviors for a long time, often since preschool or earlier. Based on these experiences it seemed like it would be helpful to have a guidebook to assist in dealing with the challenges posed by disruptive behavior in positive and proactive ways for parents, educators, and others who support youth in our communities.

My interest in managing disruptive behavior has also increased given a shift I have seen in the field since I started working with youth with attention-deficit/hyperactivity disorder (ADHD) and associated disruptive behaviors in 1997. At that time, talking about medication for children with disruptive behavior was considered a taboo subject for educators, and parents were strongly opposed to the use of medication, only rarely using it as a "last resort." Sometime since then, things changed. I have heard children labeled as "untreated" if receiving no medication or when the parents decided to avoid "medical treatment" for the behavior. I have heard educators tell parents that they really should "go see the doctor" regarding the child's behavioral challenges. The emphasis on medication as part of intervention serves to outsource the partnership parents and educators should have in working together to promote school success for the child/teen. Although medication treatments are discussed here as part of a multimethod approach to intervention (see Chapter 8), one purpose of this book is to provide multiple approaches and strategies that should be attempted first, before medication is added as an adjunctive intervention on an as-needed basis.

Finally, contemporary approaches in the field have emphasized problem-solving frameworks in which tiered intervention approaches are commonly employed. Examples of such frameworks include positive behavioral interventions and supports (PBIS; Sugai et al., 1999) and response to intervention (RTI; Fletcher, Reid Lyon, Fuchs, & Barnes, 2007). These frameworks are useful to districts because they formalize the approach to intervention, and they include clear tiers of intervention intensity. However, educators and practitioners are often left wondering what interventions should be used within each of the levels of behavioral support, and at times they may have questions about how to best work with children across the levels. One goal of this book is to provide interveners with the tools necessary to realize the promise of these frameworks for preventing problems and supporting growth.

PURPOSE OF THIS BOOK

My intention in this book is to provide an overview of the identification, contextual influences, and interventions that are appropriate for youth with disruptive behaviors. Many sources exist to support these aims (e.g., DuPaul & Stoner, 2004; Lane, Menzies, Bruhn,

& Crnobori, 2010; Walker, Ramsey, & Gresham, 2003). This book serves to extend the literature by including resources, assessments, and strategies that may be useful for school practitioners across home, school, and community settings.

Within this book, when "disruptive behavior" is discussed, it serves as a catch-all for children who exhibit behaviors consistent with ADHD, oppositional defiant disorder (ODD), and conduct disorder (CD). Although children may exhibit ADHD, ODD, or CD individually, it is often the case that these disruptive behavior diagnoses are comorbid and co-occurring with one another. It also captures children classified as "other health impaired" (OHI) or "emotionally/behaviorally disturbed" (EBD) in school settings. Included under this descriptor are also children who exhibit challenging behaviors but do not meet criteria for mental health disorders or for special education classification. This is an important point to emphasize, as diagnoses in and of themselves do not result in referrals for intervention and treatment (Angold, Costello, Farmer, Burns, & Erkanli, 1999), diagnoses are unlikely to provide adequate prognostic information (e.g., Mannuzza & Klein, 1998), and diagnoses do not always describe the targeted behaviors that need to be addressed in intervention. Furthermore, the categorization itself does not represent the difficulties in daily functioning faced by the individual, or the needed areas for adaptive skills development. Indeed, simply knowing a diagnosis or categorization does not provide any information on the context within which the problem behavior occurs, something that is critical to know about if effective interventions are to be implemented. Thus, throughout the book a functional approach to assessment and intervention will be adopted (see Chapter 2).

OVERVIEW OF THE CONTEXT FOR TREATING DISRUPTIVE BEHAVIOR

When children misbehave and exhibit disruptive, oppositional, or rule-breaking behavior, the typical approach within our society is to reprimand, punish, or scold. If there is any doubt about this, one simply has to go to a local grocery store or classroom and observe how adults interact with youth. You will readily observe adults saying things like "Don't run!"; "Stop that!"; and "You're getting on my nerves!" Children who are following rules, complying with commands, and exhibiting respectful behavior rarely have similar amounts of attention directed toward them when these appropriate behaviors occur, and the already low levels recede even further as children progress from the primary grades to middle and high school. Indeed, because negative and disruptive behaviors are externalizing and therefore very easy to observe, they often become one of the main targets of adult attention.

The consequences of this approach to dealing with disruptive behavior are perhaps best illustrated via anecdote. I will describe two children. The first child is my son. By all accounts, he developed typically. Even at 2 months old his day care teachers told us he was a good baby and easy to feed and get to nap. At preschool, my wife and I were very proud of the pictures he drew, and we posted them on our refrigerator. We enjoyed talking with him about his day and learning about what he had for snack and who he played with during free

time. When he went to kindergarten, we were proud to see him get on the bus on his own, and also proud to hear positive reports from his teacher about his behavior and his progress in school. Then he went to first grade. During the first week of school, I received a panicked call from my wife that we had received a note from the teacher stating that our son was talking during quiet time. Of course, the two of us were beside ourselves with this negative news! As I drove home from work that day, I was trying to decide how to handle it. When I got home, I told my wife I was not sure what to do, and she looked at me incredulously and said, "But you're the child psychologist!" I looked back and said, "But you're his mother. You always know what to do!" Eventually, we decided we were going to make him write a note to the teacher apologizing for his behavior. As one might imagine, for a beginning first grader, a writing assignment can be very unpleasant because the ability to write is not yet fluid. It took our son almost 40 minutes to complete the note, and the process involved lots of tears. However, eventually he finished the note and we told him he needed to hand it to his teacher and apologize the next day.

The next day was a long one for my wife and me. We were both anxiously waiting for our son to get off the bus so we could find out how his day went. I think we were both nervous that there would be more trouble at school, and we strongly wanted our son to return to his typical good behavior in the classroom. I got a call from my wife at 2:30 when my son came home on the bus, and I got the news. She said, "I asked him how the day went and he said good. When I asked him about the note he told me the teacher said she was surprised he wrote it because it wasn't that big of a deal." Well it was a big deal for us!

Our son is now in sixth grade, and although he is certainly not perfect, for the most part he has gone through the rest of school without much in the way of additional negative feedback. There has been an occasion or two where he has gotten in trouble or made a bad choice, but we have been able to deal with these situations and correct them. Overall, across his whole school career, we have had three instances of negative feedback about his behavior relative to multiple positive and supportive comments, report cards, and teacher notes. His school career to this point is representative of most children within school settings with regard to feedback—the majority experience no or neutral feedback with a little positive feedback sprinkled in, and negative feedback almost never happens.

So, I have told you about one child, with what I think is a fairly typical school experience—a few situations where corrective feedback is necessary are embedded within an overall positively valanced environment. Now let's consider a child with the disruptive behavior disorders I will be focusing on within this book. Furthermore, rather than focusing on a whole school career from early day care until sixth grade, let's focus on a single day for an 8-year-old-child with disruptive behavior challenges.

The day is likely to begin with a parent coming into the room to wake up the child (7:00 A.M.). Because school is often an unsuccessful place to be, there is little motivation on the part of the child to go to school, so the response to the parent's "Rise and shine" comment is to pull the covers over his head. Thus, the day begins with a parent request (admittedly a vague one) met with noncompliance. After some additional prompts that go unheeded, the parent may eventually rip the covers off and sternly tell the child to get up and get dressed

(7:05 A.M.). As the parent leaves to begin to get herself ready for the day, the child busies himself with a half-made Lego set. When the parent comes back to see the child still in his pajamas, a more irritated set of commands to get ready for school will result (7:10 A.M.). As the child begins to get dressed, he may do so in a disorganized fashion or slowly, resulting in more parental commands to get dressed appropriately (7:10–7:20 A.M.). Because the child did not put his shoes in the front hall the night before, considerable time is spent looking for the shoes, which are eventually found in an unusual place for shoes: under the couch. The search for shoes includes a long lecture from the parent regarding the need to put things back where they belong because this happens all the time (7:20–7:25 A.M.). Once dressed, the child sits down for breakfast and because he is reaching to grab a magazine his sister is reading, he spills a full glass of orange juice all over the table and gets his parent's coat on the chair soaked and sticky. His parent, now angry, yells at him to get his backpack and head outside toward the bus stop (7:30 A.M.). On the way to the bus stop at the corner, the parent scolds the child to "not bother the other kids like yesterday and just stand still!" The child, excited to see the other kids, gets upset when they do not reciprocate his excitement, and teases one in front of the other parents, resulting in a reprimand from his own parent and a number of cold stares from the other children's parents. Finally, the bus arrives and the child's exasperated parent says, "Finally, the bus is here" and briskly walks back to the home without looking back (7:35 A.M.).

This might be considered a negative morning, but it does not stop here. As the children file onto the bus, the bus driver stops the child and says, "Listen, I have had enough of your fooling around and moving from seat to seat. From now on you have an assigned seat right behind me in the front row." Because this is typically where kindergarten children sit, the other children laugh at and tease the child from the back rows (7:35–7:50 A.M.). As the child exits the bus, he gets stared down by the bus monitor, who had previously been welcoming every prior child to school by name, but who now says, "You better walk!" before he even gets off the bus and has a chance to make the choice to walk or run (7:50 A.M.).

Then the child enters the classroom and instead of hanging up his coat and putting his backpack in his cubby like the other children, he walks back to the corner of the classroom where the class turtle is located to look at it and see how it is doing. As he is distracted by the turtle, his classmates are sitting down and beginning their bellwork (7:50–8:00 A.M.). When the teacher notices him in the back of the room, the first thing she says to him is "Why aren't you ready? I hope today is not going to be another one of your days like yesterday because I am not in the mood to deal with it!" (8:00 A.M.).

To recap, within the first hour of the day this child has had more negative interactions with parents, siblings, peers, teachers, and other adults than most typically developing kids have within their entire school careers! Until this context is acknowledged, identified, and changed, forward progress is unlikely to occur. It is no wonder that when we plan interventions for youth with disruptive behavior that they do not work right away, or even after a few weeks. Indeed, it is foolish to think a couple of stickers on a chart or a one-time reward will reasonably improve behavior when this is offered within the context of a pervasively and chronically negative environment. Within this context, punishments are also unlikely

to work because the child's whole environment is already punishing. Doling out punishments within an already negative context is like putting water on a grease fire: they are likely to only make the situation worse and more difficult to control. Notably, there are also different functional explanations for the child and adult behaviors (see Chapter 2), making a one-size-fits-all approach unlikely to be effective. This example of a prototypical child with challenging behavior underscores the need for coordinated, sustained, positively focused interventions for youth with disruptive behavior disorders.

BRIEF REVIEW OF A THEORETICAL MODEL OF CREATING AND SUSTAINING DISRUPTIVE BEHAVIOR

Gerald Patterson (1982) was an early pioneer of the study of the nature, causes, and interventions for youth with disruptive behavior disorders. One of his key contributions to the field was a theoretical framework that used social learning theory as a way to explain the development of disruptive behavior disorders within the family context. He called this pattern a "coercive family process" and defined it as a process through which negative child behaviors and parental attention administered through reprimands or correction occur reciprocally within a cycle of reinforcement, strengthening maladaptive patterns over time. Thus, the negative behaviors escalate due to an attempt to override parental consequences (e.g., punishments).

The coercive family process is best described through an example. Let's think about a young child who does not want to eat her vegetables. During dinnertime, she might initially whine when offered vegetables and avoid eating them. Her mother may command or coax her into eating her vegetables, but after some time might give up this effort. Thus, the child is negatively reinforced because the demand to eat a food she dislikes is removed. Importantly, the mother is also negatively reinforced because she no longer has to deal with irritating child behavior. However, the next time the mother attempts to place the demand of eating vegetables on the child, it happens within the context of this historical event where the child was successful in having the demand removed following the whining behavior. This next time, she may not only complain but physically push the plate away when her mother instructs her to eat her vegetables. The mother may now raise her voice and repeat the commands, but if she relents, the child has now learned that increasing her negative behavior may be a useful tool for influencing her mother's behavior. If we fast forward across many dinners and many requests to eat her vegetables, it is not necessarily hard to envision how the situation could eventually involve the mother screaming at her child and the child throwing vegetables at the mother. This very serious situation that includes harsh parenting and extremely negative child behavior is the culmination of a number of insidious, transactional parent–child interactions that over time escalate and strengthen the negative behavior exhibited by the child and the maladaptive approach to parenting this child in this situation. The framework of this theoretical model of coercive family process provides natural areas to target within effective intervention approaches, as described below.

EVIDENCE-BASED TREATMENTS FOR DISRUPTIVE BEHAVIOR DISORDERS

Fortunately for individuals who work to support youth with disruptive behavior disorders, there is a strong evidence base of interventions with which to work. The best interventions for youth with disruptive behavior in general, those with ADHD, and those with ODD/CD will be reviewed, followed by a discussion of best practice approaches to intervention.

Treatments for Disruptive Behaviors

To some degree it is "funny" to try to make an argument that evidence-based treatments should be used for disruptive behavior disorders. After all, who would take the position that one should use "non-evidence-based practices"? Yet, many of the treatments used for disruptive behavior disorders are not supported by evidence, including individual counseling, school grade retentions, suspensions, and expulsions, and "shock" interventions such as taking the child to a police station or prison to "scare the child straight."

Although it may seem obvious, the emphasis on using evidence-supported treatments that have been vetted within controlled research has only been present in the field for a relatively short period of time. In the late 1980s and the early 1990s the medical field began to identify and recommend that doctors use approaches supported by research evidence. This movement served as a model for psychology and education, where child treatments for disruptive behavior disorders have been formally evaluated and the approaches with supporting evidence have been identified (e.g., Brestan & Eyberg, 1998; Pelham, Wheeler, & Chronis, 1998; also see the website *http://ies.ed.gov/ncee/wwc*). Currently, there are professional treatment guidelines for pediatricians and psychiatrists, teachers, and consumers that provide reviews of the state of the evidence for treatments used to support youth with disruptive behavior disorders.

Thus it is important to explicitly state that the position of this book is that the treatments employed for youth with disruptive behavior disorders should be based on research evidence that indicates effectiveness for the approach. Although it is difficult to state equivocally that a particular intervention is evidence-based as new evidence can be continually accruing, in a situation where there is evidence in support of a particular intervention, this will be the chosen emphasis in treatment planning relative to an intervention without supportive evidence.

Resources are available for managing disruptive behaviors using evidence-based practices in homes and schools. A nice guide for educators was disseminated by the U.S. Department of Education that describes best-practice foundational strategies for use in schools (Epstein, Atkins, Cullinan, Kutash, & Weaver, 2008). This practice guide suggests a clear, stepwise approach to behavior management grounded in a large literature. The first step includes conducting a good functional analysis of the targeted behavior. Next, the educator should modify the classroom environment to promote positive behaviors (i.e., antecedent control; see Chapter 5). Next, the teacher teaches and reinforces new skills and appropriate

behaviors (see Chapter 6). Following this, educators adopt schoolwide strategies, as needed (see Chapter 10).

Similar findings have been recommended for young children. Hemmeter, Fox, Jack, and Broyles (2007) describe a positive behavioral support model appropriate for early childhood settings. In this approach, foundational strategies that include building strong relationships with children and families are emphasized for the whole class. This includes simply ensuring there are more positive than negative interactions with children and parents. Furthermore, as in the Epstein and colleagues (2008) practice guide for elementary schools, environmental modifications are made to ensure appropriate behavior is maximized in the classroom. In addition, educators are supported in their teaching of social and emotional skills, something that may be particularly relevant for young children who are becoming socialized to a structured school setting. Finally, any children that still require support and intervention receive individualized positive behavioral support strategies on an ongoing basis.

Treatments for ADHD

An additional line of research has identified effective interventions for youth with ADHD. ADHD is a disruptive behavior disorder characterized by developmentally inappropriate levels of inattention, hyperactivity, and impulsivity. These behaviors are pervasive, meaning they occur across settings. Furthermore, they are long-standing, meaning that they occur over long periods of time, across development; current conceptualizations of ADHD consider it to be a life-course-persistent disorder that begins in childhood and continues through adolescence into adulthood (American Academy of Pediatrics, 2011). Finally, and perhaps most importantly, ADHD results in considerable impairment in daily life functioning across major life domains including peer relationships, adult interactions and relationships, academic progress and functioning, family functioning, and work situations (American Psychiatric Association, 2013; Fabiano et al., 2006).

Multiple treatments have been tried to reduce ADHD behaviors and problems. Among the most common interventions are the stimulant medications (e.g., Ritalin, Adderall, Dexedrine, Concerta, Focalin). A discussion of this intervention is elaborated in Chapter 8. A broader category of potential intervention includes psychological or psychosocial treatment. This might include one-to-one counseling, family therapy, parent training programs, token economies or other behavior management programs, social skills training, cognitive-behavioral therapy, exercise programs, neurofeedback, cognitive training programs (i.e., working memory training), and other treatments such as withholding potential allergens, food dyes, and sugars, or by providing supplements such as vitamins or natural extracts.

Out of all of these interventions, the number without an evidence base dwarfs the number with an evidence base. There is no evidence that one-on-one counseling provides an effective remediation of ADHD symptoms or impairment. This makes sense if one really thinks about it—youth with ADHD often do not have challenges within one-on-one situations. Problems are much more likely to occur in group settings such as families, classrooms, or sports teams when the child experiences behavioral demands. Furthermore, youth with

ADHD often have poor insight into their own problems, overestimating their contributions to success in their functioning and underestimating their role in failures in functioning (Owens et al., 2007). This attributional style does not align well with insight-oriented therapies or counseling approaches that require the individual to account for his or her own role in his or her current difficulties. Coupled with the young age of many children with ADHD, this approach, although commonly recommended and employed, is not an effective way to help. There are also numerous other treatments that have been debunked or not critically evaluated for ADHD. These include biofeedback, play therapy, cognitive training, and individual social skills training. These treatments are limited because they also occur outside the typical situations where youth with ADHD have difficulties. There is little evidence within the field that children with ADHD can effectively generalize any strategies presented within a one-to-one treatment to a novel situation. Furthermore, although many parents are adamant that food dyes, sugars, or other foods *cause* ADHD behavior, controlled trials have repeatedly illustrated that these substances do not have an appreciable effect on the behavior of youth with ADHD (Wolraich, Wilson, & White, 1995), except perhaps in individuals with known food sensitivities.

So, what does work in the treatment of ADHD? There is consensus that three approaches meet predetermined criteria for calling an intervention "evidence-based." Multiple reviews (Fabiano, Schatz, Aloe, Chacko, & Chronis-Tuscano, 2015; Pelham et al., 1998; Pelham & Fabiano, 2008) including different review teams (Evans, Owens, & Bunford, 2013) have concluded that three interventions have acceptable empirical support from well-designed research studies as treatments that work for ADHD. These three interventions are behavioral parent training (see Chapter 4), contingency management procedures employed by teachers in schools (see Chapter 5), and training interventions that teach the child or teen specific, adaptive skills (see Chapter 6). Because they are evidence-based interventions and therefore the best approach for an effective treatment plan for individuals with ADHD, there is a specific chapter dedicated to each.

Treatments for ODD and CD

There are also evidence-based approaches for ODD and CD. Notably, the comorbidity between youth with ADHD and ODD/CD is high, so in many cases treatment providers, parents, and educators are likely to be dealing with behaviors representative of multiple categorical disorders. Reviews of best-practice interventions for children with ODD and CD yield similar conclusions to the reviews for ADHD treatment, at least with respect to psychosocial treatments. Systematic reviews clearly support behavioral parent training as an evidence-based intervention for youth with ODD/CD (Eyberg, Nelson, & Boggs, 2008). Eyberg and colleagues (2008) review over a dozen parent training interventions for ODD/CD and conclude that most meet criteria as probably efficacious treatments for these disruptive behavior disorders. The main reason for most of the parent training programs failing to be classified in the strongest evidence category (well established) is that there were not multiple clinical trials conducted by independent investigatory teams for each specific parent training "package." However, if the literature is viewed through a different lens, and

the treatment is conceptualized as simply "parent training," there are now dozens of studies that document positive results for youth with disruptive behavior following parent training. Thus, like treatment studies for ADHD, there is clear evidence supporting behavioral parent training for youth with ODD/CD.

SUMMARY AND OVERVIEW OF THE BOOK

Following this chapter is a description of the approach to conceptualizing disruptive behaviors that uses a functional rather than a psychiatric diagnostic approach (Chapter 2). Chapter 3 reviews assessment strategies that are appropriate for different purposes that might be clinical goals when working with youth with disruptive behaviors and their families. There are a number of foundational strategies that are effective for youth with challenging behaviors. Chapter 4 outlines these strategies that may be used by parents, and Chapter 5 outlines these strategies for educators. In Chapter 6, approaches for teaching adaptive skills are reviewed. Chapter 7 reviews approaches to training interventions that are useful for promoting the development and use of adaptive skills. Chapter 8 deals with medications commonly used to treat disruptive behavior disorders. Chapter 9 discusses common strategies for employing integrated and engaging interventions for family units over long periods of time, an approach that is likely to be needed for the majority of youth experiencing problems in functioning due to disruptive behavior. Finally, Chapter 10 provides an overview of how the strategies reviewed in this book might be deployed within school systems in a problem-solving framework.

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