Oppositional Defiant Disorder and Self-Monitoring

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Abstract

The purpose of this study is to identify techniques teachers use for students diagnosed with Oppositional Defiant Disorder (ODD) and the effects of self-monitoring on school age children. Teachers were surveyed and asked what techniques they used to help control behavior and if those techniques were successful. An online survey was used to gather data from participants that included the following: types of classroom behavior modification techniques used, if medication was used and if so was it successful, and if self-monitoring techniques were used and if so, which specific techniques. Finally educators were asked if they had not tried self-monitoring techniques would they be willing to try them with their students.
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“For many people, one of the most frustrating aspects of life is not being able to understand other people's behavior.”  Unknown

Oppositional Defiant Disorder (ODD) is often misdiagnosed as Attention Deficit Hyperactivity Disorder (ADHD) because it displays many of the same characteristics. Some common characteristics include distractible, not being able to sit still, and interrupting conversations. However, this researcher proposes differences include being extremely argumentative and needing to have the last word when asked to do something they really do not want to do. Other studies show that ODD is closely related to anxiety disorder. This research explored teachers’ use of student self-monitoring for students with ODD to decrease the behaviors seen by teachers.

**Review of the Literature**

This review contains the definition, symptoms, and history of oppositional defiant disorders (ODD). A diagnosis of ODD has several co-morbid disorders that can present in a student. This review of the literature also covers treatment, and management strategies including self-monitoring, self-monitoring with reinforcement, self-reinforcement, and self-management. It also focuses on positive behavior supports, and studies related to teachers’ perception of students who have been diagnosed with ODD.

**Definition**

Oppositional defiant disorder (ODD) is a very common psychiatric disorder among children. It is defined as a pattern of negativistic, hostile, and deviant behavior that is severe enough to impair the child’s functioning for at least six months (Boylan, Vaillancourt, Boyle, & Szatmari, 2007). Some symptoms of ODD include children not following rules and becoming easily angered over what seems to be nothing. They are often disrespectful and quick to blame.
others for their mistakes, refusing to accept responsibility for their actions. It is true that most children exhibit these symptoms occasionally, but it is important to note that children with ODD exhibit these symptoms to a degree and frequency that it affects their functioning in all major life areas—home, school, community, and school/work (Children with Oppositional Defiant Disorder, 2011).

**History**

The diagnosis of ODD was first mentioned in 1966 but was not recognized and published in the Diagnostic and Statistical Manual (DSM III) until 1980 (American Psychiatric Association, 1980). This diagnosis interested many people and medical, social, and behavioral field trials on children with ODD began. In the year 2000, the DSM IV expanded its recognition of the disorder and listed it in the psychopathological group along with antisocial, aggressive, and socially disruptive behavior. There has been a great deal of controversy with this grouping since field studies all show similar but varying results (Steiner, & Remsing, 2007). Today, ODD is categorized as a disruptive behavior disorder. Many children with ODD have similar cognitive and social deficits along with the same behavior disorders as children diagnosed with attention deficit hyperactivity disorder (ADHD) and conduct disorder (CD) (Boylan, Vaillancourt, Boyle, & Szatmari, 2007).

**Co-morbidity**

Most published studies show a strong connection between ODD and ADHD; although, it is not noted how these two disorders are linked (Derks, Dolan, Hudziak, Neale, & Boomsma, 2007; Hazel, 2010). The only noted connection is that children with ADHD also exhibit some signs of ODD. Other disorders that can be found in conjunction with ODD are learning disabilities, mood disorders, including depression and bipolar disorder, and anxiety disorders.
(Derks et al., 2007). Studies show there is no treatment for ODD although medication may be helpful in treating coexisting disorders (Hazel, 2010).

Psychologists continue to study the similarities between Oppositional Defiant Disorder and Conduct Disorder (CD). Although many studies have compared similarities, there are some significant differences. Specifically, CD is most commonly found in boys while ODD was evident in both gender groups. There was also inconsistent information concerning age groups with ages overlapping in some groups and a wide gap in others (Maughan, Rowe, Messer, Goodman, & Meltzer, 2004).

Oppositional defiant disorder has been demonstrated to be a precursor condition to depression and conduct disorders, and children with conduct disorders display the same symptoms as those with ODD. Other behaviors children with conduct disorders display include poor verbal abilities, inappropriate social skills, and a higher rate of academic and peer difficulties (Pardini & Fick, 2012).

**Treatment**

Oppositional Defiant Disorder is thought to be caused by a combination of biological, psychological, and social factors but has no specific treatment. Although, the co-morbidity of ODD and other anti-social disorders like depression and anxiety gives many psychologists a starting point, medication specific to treat ODD itself is not indicated (Boylan, Vaillancourt, Boyle, & Szatmari, 2007). However, treatment of the concomitant disorders may help to lessen the symptoms of ODD making it appear that the medication is having a direct effect. Foothills Behavioral Health Partners offers “8 Treatment Guidelines for Families of Children Diagnosed with ODD” and recommend that psychiatrists establish a therapeutic alliance with the child and the family (Eyberg, Nelson, & Boggs, 2008). They advise teaching parents how to relate to the
child and deal with their own frustrations as parents as essential for building a happy family. Next, they recommend being considerate of cultural differences and understanding that the cultural norms and standards of the family may differ from American standards in order for trust to be built. Third, they suggest developing an individualized treatment plan using multimodal interventions (Eyberg et al.).

Eyberg, Nelson and Boggs (2008) recommend combining a Parent Management Training (PMT) with family, individual, and group therapy as most beneficial for the child and indicate that parent and family interventions should be the main focus of treatment. Parents should be taught discipline, interventions, and reinforcements, and learn to be consistent. Individual psychotherapy is another suggestion (Eyberg et al.) and the authors suggest that during this time, self-awareness strategies such as relaxation, self-control, and self-monitoring can be taught to improve impulse control. For teenagers, group therapy is encouraged as peers can help peers who are struggling with this disorder by sharing techniques they use to help calm themselves. The next step is to avoid unhelpful interventions. The authors found interventions must last for at least four months to be considered effective. If a therapy only lasts for a short time then it is not useful in handling the problem. The final recommended treatment guideline is to establish and maintain connections with social support groups. Athletics, church groups, and community centers are all places where positive interactions can take place (Eyberg, Nelson, & Boggs, 2008).

Management Strategies

In the classroom, children with ODD can be very difficult to handle. There is no specific treatment and the most current information is that ODD can co-occur with several other disorders. Can self-monitoring be successful for children diagnosed with ODD? The self-
Oppositional Defiant Disorder

regulation theory describes a number of methods used by students with ADHD to manage, monitor, record, and/or assess their behavior or academic achievement (Reid, Trout, & Schartz, 2005). Self-regulation theory has long recognized the importance of a feedback cycle in which individuals systematically self-assess and self-evaluate their behavior. There are four forms of self-regulation: self-monitoring (SM), self-monitoring plus reinforcement (SM+R), self-reinforcement (SRF), and self-management (SMGT) (Pintrich & Zimmerman, 2000).

**Self-monitoring.** Self-monitoring is a multistage process of observing and recording one’s own behavior (Mace, Belfiore, & Hutchinson, 2001). This technique consists of deciding on a targeted behavior. Next, the student monitors him/herself and at given intervals or predetermined times and records when the target behavior is occurring. This technique provides immediate feedback as to when the behavior is taking place. Reid, Trout, and Schartz (2005) reviewed two types of self-monitoring techniques: self-monitoring for attention (SMA), and self-monitoring of performance (SMP). SMA involves students noting if they were paying attention at a designated time which may be indicated by a visual or auditable signal that cues the students. At that time, students self-record if they were on task and paying attention. SMP monitors how much work is being completed in a given time frame. The results are then recorded and typically graphed at the end of the day (Reid, Trout, & Schartz, 2005). This gives students a clear picture of how much work is being completed on a daily basis. The graph allows for an easy comparison from day to day and gives students a sense of accomplishment if improvements are noted.

**Self-monitoring with reinforcement.** Self-monitoring plus reinforcement (SM+R) includes the steps mentioned above and adds the element of reinforcement when the targeted behavior is achieved. Children with ADHD are often more successful when their success is
followed by an external reinforcer (Barkley, 1998). Since everyone likes to be rewarded for working and changing a behavior is hard work, students often respond positively to the availability of an external reinforcer.

**Self-reinforcement.** Self-reinforcement (SRF) has been defined as a process in which a person performs a behavior to satisfy a predetermined performance standard or criteria and then comes in contact with a stimulus that increases the probability of the behavior (Mace, Belfiore, & Hutchinson, 2001). SRF is very similar to SM+R in that a reinforcer is awarded when the target behavior has been accomplished. The main difference is that students award themselves a reinforcer if they conclude that the target behavior has been achieved (Graham, Harris, & Reid, 1992).

**Self-management.** Self-management (SMGT) requires that a person monitor, rate, and compare some aspect of his or her behavior to an external standard or criteria (Mace et al., 2001). SMGT is similar to self-monitoring in that SMGT requires students to self-assess and self-record a behavior at set or cued intervals (Shapiro & Cole, 1994). Along with that, SMGT adds another dimension; an external observer also documents the behavior and the meeting of the criteria. The two sets of documentation are compared and checked for accuracy. Students are then rewarded if their results are the same or close to the results of the observer (Reid, Trout, & Swartz, 1995).

**Efficacy**

In a review by Reid, Trout, and Schartz (2005), data were gathered and calculated from 16 clinicians studying the four self-monitoring techniques described in the previous section. Data was gathered from a total of 51 participants ranging in age from 6-15 that included 48 males and three females, all diagnosed with ADHD and with a variety of comorbid conditions.
Diagnosis included oppositional defiant disorder, conduct disorder, behavior disorder, seizure disorder, and minimal brain dysfunction. Self-monitoring techniques were used and results were recorded. Every method of self-monitoring resulted in an increase in the desired behaviors, which included students being less defiant and a decrease in the undesired behaviors of acting out and being disruptive. Overall, the results show that SM, SM+R, SMGT, and SRF interventions can be useful components in an intervention program for children with ADHD (Reid, Trout, & Swartz, 1995).

**Positive Behavior Supports**

Positive behavioral support (PBS) is a group of intervention strategies that are highly individualized based on scientific principles and empirical data, grounded in person-centered values, and designed to prevent the occurrence of challenging behaviors (Conroy, Dunlap, Clarke, & Alter, 2005).

A comprehensive meta-analysis of studies related to positive behavior interventions (PBS) used with young children with challenging behavior reported the findings from 73 studies. Participants included children ages 1-6 with a variety of challenging behaviors. The overall findings indicated that positive behavioral interventions were noted to have a positive effect on participants. Documentation that the interventions used were *evidence-based practices* was present and gave the findings more validity. The need for more research in the area of children with challenging behavior was noted (Conroy, Dunlap, Clarke, & Alter, 2005).

The study focused on eight non-mutually exclusive diagnostic label subcategories: no identified disability, risk factors associated with emotional and behavioral disorders (EDB), intellectual disabilities, severely emotionally disturbed (SED), attention-deficit/hyperactivity
disorder (ADHD), developmental delays/autism/pervasive developmental disorder (PDD), speech delays, and physical disabilities (Conroy, Dunlap, Clarke, & Alter, 2005).

The dependent measures documented were: destructive behavior (property destruction, aggression, self-injurious behavior); disruptive behavior (noncompliance, talking out, out-of-seat behavior); stereotypy (hand-flapping); engagement (completing a task); social interaction behaviors (playing with a peer); skill performance (engaging in a specific skill); and psychosocial skills (tests, scales, instruments to examine levels of psychological, intellectual, and adaptive functioning or potential) (Conroy, Dunlap, Clarke, & Alter, 2005).

Self-monitoring interventions such as providing instruction to target participants regarding self-management/monitoring of behavior were used. Other interventions used in the study were antecedent interventions, instructional interventions, multi-component interventions, and studies that included only an assessment component (Conroy et al., 2005).

**Teachers’ Perceptions of Students with Oppositional Defiant Disorders**

Elementary classroom teachers are often the main informants of a child’s behavior in schools because they are able to observe the child extensively at different times and in different settings (Kelter & Pope, 2011). Often times these behaviors leave teachers confused, bewildered and reassessing their career choice. One study from the University of Wollongong focuses on teachers in isolated areas teaching in New South Wales. The study focused on four specific teachers: two recent graduates, one with 3 years experience as a temporary teacher and one teacher with 20 years experience. At the time of this study, all four teachers were currently teaching a student with ODD.

The results of the study were overwhelmingly clear. The three less experienced teachers stated they had received no education in their college classes to prepare them to deal with
students with ODD. They all felt their stress levels were continually increasing due to unrealistic workloads, expanding curriculum, and lack of skills in dealing with students with ODD. All teachers expressed the need for support personnel in the building and classes or training workshops outside the classroom. They all stated; however, that missing school for training was in and of itself detrimental to classroom behavior. All four teachers stated that behaviors of children with ODD affect the staff and students and can erode well-established positive classroom environments (McLean & Dixon, 2010).

If early interventions are not in place, Oppositional Defiant Disorder can lead to more serious behavior disorders. Children with the disorder are argumentative, disruptive and sometimes hostile. In a classroom, these behaviors can disrupt the learning process for everyone. This study explored teachers’ perceptions of whether children with ODD learn to self-monitor their own behavior and use these strategies to increase awareness and ultimately improve overall behavior.

**Method**

This study used an online survey to investigate teachers’ perceptions and use of self-monitoring techniques for their students diagnosed with ODD. Educators were also asked their opinion on the use of medications, and behavior modifications for these students.

**Participants**

An online survey was created using Qualtrics (an online survey tool) and a link to the survey was sent via email to approximately 100 teachers located in a rural Appalachian county in a Midwestern state. Four weeks after the initial survey was sent a follow-up to non-respondents was sent requesting completion of the questionnaire. A total of twenty-eight surveys were
completed and returned for a response rate of approximately 28%. Participants ranged in experience from 1 to 25 years. (See Figure 1).

*Figure 1. Number of participants by number of years taught.*

The respondents varied in the area they were licensed to teach ranging from general education to special education (See Figure 2).

*Figure 2. Percent of participants by area of licensure*
The majority of respondents (n = 20) taught children diagnosed with ODD. (See Figure 3).

![Students' Taught](chart)

*Figure 3. Number of participants who taught students with ODD*

**Instrumentation**

A researcher-developed survey was created using Qualtrics, an online survey tool. The survey contained a total of seventeen questions; eight forced-choice and nine open-ended. Forced-choice questions asked the respondents to rate the use of medication to change behavior and whether or not behavior modifications were used. The open-ended questions encouraged respondents to elaborate on their responses to the forced-choice questions.

**Location**

The Midwestern Appalachian county where this study took place has an estimated population of 147,066 residents, covering 504.41 square miles. The closest cities are approximately a 40 minute drive to the north or to the south. The local Educational Service Center (ESC) that serves the region currently provides services for eight school districts. Many of these school districts are located in rural areas. The ESC currently has thirteen units (classrooms) serving children identified with multiple disabilities, emotional disabilities, and hearing handicaps. These units
include: three K-2, three 3-6, two 7-9, three high school classrooms, and one school serving children with mild to intensive needs. The county also provides preschool classes along with home schooling.

**Procedures**

An online survey was created using Qualtrics and a link to the survey was sent via email to approximately 100 teachers in one county. Two weeks after the initial survey was sent a follow-up to non-respondents was sent requesting completion of the questionnaire. The survey contained eight forced-choice questions, each followed by an open-ended question asking the participant to comment/provide explanation for the previous answer. The open-ended questions permitted respondents to describe various techniques they used in the classroom that worked for their students to achieve success.

**Data Analysis**

For each survey question, means variances, and standard deviations were calculated when applicable. Based on aggregated responses, percentages were calculated to determine which strategy was perceived to be the most effective. The educators were asked to reflect on their responses to the force-choice questions and their comments were analyzed for common themes.

**Results**

Described in the following paragraphs is a detailed analysis of the responses given by the participating educators. The variables of the current study are shown if Figure 4 and correspond to the questions asked. Table 1 shows the number of responses (n), the mean (M), standard deviation (SD), and the corresponding variance (V) for each type of intervention.
Table 1.

*Teachers' Rate Various Interventions for Students with ODD*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Ratings of Use</th>
<th></th>
<th></th>
<th>Ratings of Effectiveness</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>V</td>
<td>n</td>
<td>M</td>
</tr>
<tr>
<td>Medication</td>
<td>20</td>
<td>1.35</td>
<td>.49</td>
<td>.24</td>
<td>18</td>
<td>1.33</td>
</tr>
<tr>
<td>Behavior Modification</td>
<td>21</td>
<td>1.05</td>
<td>.22</td>
<td>.05</td>
<td>19</td>
<td>1.26</td>
</tr>
<tr>
<td>Self-Monitoring</td>
<td>19</td>
<td>1.58</td>
<td>.51</td>
<td>.26</td>
<td>14</td>
<td>1.57</td>
</tr>
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<td>1.07</td>
<td>.26</td>
<td>.07</td>
<td>15</td>
<td>1.07</td>
</tr>
</tbody>
</table>

**Use of medication.** Participants were asked if medication was used to change students’ behaviors. Of the respondents 65% (n = 18) reported that medication was used to change behavior, whereas 35% (n = 2) reported no medication was used. The remaining eight responded they never taught a student who was diagnosed with ODD.

**Effectiveness of medication.** Of the 18 educators who reported having students who used medication for ODD, they were asked if the medication was successful. The results showed 67% (n = 10) stated the medication was successful, and 33% (n = 5) responded the medication was not successful. Three educators did not respond to the effectiveness of the medication.

The educators who believed that medication was successful said the medication was taken at home prior to the school day beginning. A few teachers said when the parents forgot to give their child the medication it was very evident. One teacher stated, “the student did not take medication on the weekends and her behavior was worse on Mondays.”

**Use of behavior modification.** Participants were asked if they used behavior modification to change students’ behavior. Of the total responses, 20 indicated they used
behavior modification and one did not. Seven respondents did not answer this question.

Educators who responded they used behavior modification were asked to describe the strategies used. The most frequently reported behavior modifications included positive reinforcement techniques, rewards, behavior plan/charts, and offering the student choices. Other techniques included reverse psychology, distraction, breaks, and being allowed to leave the room when frustrated. Since all students are different, what works for one student may not work for another. One educator responded, “As educators we need to use a variety of strategies to ensure the success of all our students.”

**Effectiveness of behavior modifications.** For those educators who reported using behavior modification strategies, they were asked to report if they were successful. The results indicate that 74% (n = 14) believed that behavior modification was successful, and 26% (n = 5) did not feel the techniques were successful. The two remaining educators did not comment on the effectiveness of behavior modification. Respondents who stated behavior management was successful were asked to describe how it was useful in changing behavior. Most educators responded that it helped their students to focus on the task at hand, and the students began to make better choices when opportunities presented themselves. The respondents who indicated behavior management strategies were not effective gave the following responses: “sometimes they would work and sometimes they would not,” and “on certain days they would work for a while, and then you would have to change strategies.”

**Use of self-monitoring.** Teachers were asked if self-monitoring was ever used to change student behavior. Of the 19 who responded to this question, 42% (n = 8) replied yes, and 58% (n = 11) said they had not used self-monitoring with their students. The respondents who indicated they used self-monitoring were asked to describe the techniques used with their students.
Responses included: students tracked their own behavior on a chart then at the end of the day and discussed it with the teacher, homework self-monitoring charts, and timers to keep track of how long the undesired behavior lasted. One teacher said; “Techniques are always used as an attempt to get students to self-monitor their own behavior.”

**Effectiveness of self-monitoring.** Participants were asked if self-monitoring techniques were successful in changing behavior. Of the 28 respondents, fourteen responded to this question. Of the 14, fifty-seven percent (n = 8) said self-monitoring techniques were not successful. The remaining 43% (n = 6) believed they were effective. Of the six who believed self-monitoring to be effective, most agreed self-monitoring techniques were successful some days, but not on other days. Other responses indicated self-monitoring was fast and effective, but usually did not last and it gave students time to prepare for teachers’ requests.

**Willingness to use self-monitoring techniques.** Finally, respondents were asked if they had never used self-monitoring techniques, would they be willing to attempt them as a way to modify behavior. Of the fifteen responses, 93% (n = 14) said yes, and 7% (n = 1) said no they were not willing to attempt self-monitoring techniques. Seven of the fifteen individuals who responded to this question stated they would be willing to try anything that would benefit their students. One teacher stated,

Teaching children to self-monitor and recognize when they are ready to have an outbreak would help to deter or lesson the outbursts. Having a system for the child to use to notify the teacher of a possible outburst would be helpful. Giving the child techniques to control their behavior instead of using meds would benefit the child for life!
Other educators responded that students would be more involved by making them accountable for their own behavior. The one educator who responded negatively said he/she tried self-monitoring techniques in the past.

**Discussion**

This study was designed to determine if educators believed self-monitoring techniques were successful for students diagnosed with Oppositional Defiant Disorder. The results of this study were consistent with other findings indicating that teachers perceived a combination of medication and self-monitoring techniques provided the greatest success for their students.

Of the educators surveyed, 67% believed that medication alone was successful when working with students who have been diagnosed with ODD. Additionally, they felt that behavior modification was necessary to change the student’s behavior. Almost half the participants also agreed that the use of self-monitoring techniques were successful when it came to changing students’ behavior.

These findings are consistent with literature that is beginning to accumulate to support this concept. A study conducted by Kelsberg and St. Anna (2006) found interventions such as behavioral therapy for the child, parents, and the whole family reduces conflict behaviors in adolescents with ODD. Since ODD most commonly does not occur as a solitary diagnosis but with other medication-responsive comorbid conditions, medical treatment reduces overall symptoms (Kelsberg & St. Anna, 2006).

Teachers in this study indicated that as with other behaviors, no one approach is right for all children, but rather a combination of approaches may help many students, but not all students. Many studies have been conducted that have supported the findings of this research.
One study found that treatment usually includes medication, teaching parenting skills, family therapy, and consultation with the school (Snircova, Kulhan, Nosalova, & Ondrejka, 2012).

Many studies that were reviewed for the research paper focused on only one aspect of ODD. Medications specifically for ODD are not focused on since they only treat the comorbid conditions and not the ODD itself. As evidenced by the studies reviewed in the current literature, as well as the findings from this study, medication along with behavioral techniques are perceived to be the most effective, as well as demonstrate the greatest gains in improving targeted student behaviors.

**Recommendations**

The findings from this research confirms the belief of this researcher that a combination of behavioral therapy, including self-monitoring, along with the use of medication should be used for the treatment of ODD. Although there is no cure for ODD, comorbid conditions can be treated to help decrease unwanted behaviors. Behavior therapy is used to treat ODD symptoms, but is also used to treat a variety of the comorbid conditions that are displayed by students diagnosed with ODD.

Several limitations presented themselves throughout this study. First, of the approximately 100 surveys distributed, only 28 participants responded, and not all of those educators responded to all of the survey questions. Other areas of concern include a limited understanding of the range and impact of students’ comorbid conditions. Additionally, it was unclear how often teachers communicate with parents about the students’ current behavior, and whether the same techniques are being used at home as well as at school.

This study left many unanswered questions that should be addressed in future research such as if self-monitoring techniques were successful, which specific techniques were the most
successful. Several techniques need to be researched further, as almost all the educators stated the students used a chart to monitor their own behavior. Another question that needs to be addressed is consistency among educators. Are all teachers that work with a particular student all using the same technique to benefit that same student? Another question to explore might be whether or not parents and teachers rely too heavily on medications to control the symptoms of ODD. Further research needs to be conducted to answer questions such as the ones that have been left unanswered by this research.

**Implication for Practice**

The findings of this study can be very beneficial for educators who are looking for self-monitoring techniques, or would like to know more about behavior management techniques and the use of medications. Most educators will do everything within their power to improve their students’ success and are always looking for more techniques to put into their tool kits. The more information educators have, the better off their students will be.

This researcher believes many of the educators who participated in this study did not use these strategies because they had tried one or two strategies in the past and they did not solve all of the students’ issues. Therefore, the educators felt it was not worth the time and effort involved in implementing a new self-monitoring strategy. From an educators’ and researchers’ point of view; more workshops need to be mandated for all educators to learn various techniques and ways to individualize them to meet their students’ needs.

The interventions discussed in this research have demonstrated their ability to improve educational practice and help students achieve success. Clearly, these students have a need for a set routine and as with students who exhibit ADHD, those diagnosed with ODD need help establishing and maintaining a consistent routine they can adhere to. Consistency is a major
factor in the lives of these children because they do not like change, so educators need to ensure they are kept on a consistent routine on a daily basis, and to try to use the same self-monitoring techniques and behavior modifications for as long as they are effective.

Conclusions

Children with Oppositional Defiant Disorder become increasingly difficult to live with, play with, and teach. Children with this disorder demonstrate negative and defiant behaviors by being persistently stubborn and resisting directions. They may be unwilling to compromise, give in, or negotiate with adults. They may deliberately or persistently test limits, ignore orders, argue, and fail to accept blame for misdeeds. Hostility is directed at adults or peers and is shown by verbal aggression or deliberately annoying others (DSMV-IV, 2000).

Self-monitoring techniques require children with behavior disorders to monitor their own behavior and document the results. The literature reviewed for this research was found to support the use of self-monitoring techniques with children whose primary diagnosis is ODD. It seems with all of the characteristics of ODD, children conforming to monitoring and recording their own behavior could simply be “just another battle”. Can self-monitoring techniques be successful if used to help manage the behavior of children with ODD? Would these techniques have to continue forever or can positive replacement behaviors be taught in place of the negative behaviors? The behaviors are complicated and the questions are many. Continued research should identify effective strategies that can be used to help these children over time and generalize them to different settings.
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