Oppositional, Defiant & Anger Issues

in Children & Adolescents

Effective Interventions with Oppositional, Defiant and Challenging Behaviors

PRESENTED BY

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TO LEARN ABOUT **PERSPECTIVES ACADEMY** (ALTERNATIVE EDUCATION SETTING) VIDEO CLICK LINK OR PASTE IN BROWSER

https://www.youtube.com/watch?v=eNM2iFDiFH0

TO HEAR DR. BERK SPEAK VIDEO CLICK LINK OR PASTE IN BROWSER

https://www.youtube.com/watch?v=4TXLs8bighs

TO LEARN ABOUT **VIDEO GAME AND ELECTRONIC ADDICTION** TREATMENT VIDEO CLICK LINK OR PASTE IN BROWSER

https://www.youtube.com/watch?v=6Tgtcl-aHmk

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Dr. Berk is a licensed clinical psychologist in Ohio and Florida.

He is director of:

- Jay Berk Ph.D. and Associates (A practice with over 15 mental health professionals)
- Perspectives Academy (An Alternative Education Program)
- Center for Electronic and Video Game Addiction

He provides training throughout every US state and Canada including in-service and ongoing consultations. He also functions as a consultant in forensic and therapeutic cases. As a consultant, Dr. Berk also works with a variety of schools and organizations creating programs, reviewing existing programs, and revitalizing programs already in place.

Dr. Berk was a consultant to the United Nations-UNICEF for programs in Bosnia. He wrote a manual for UNICEF which was used by professionals to work with war traumatized children throughout that country.

Dr. Berk is adept at treating children with mental health and behavioral issues in outpatient, day treatment, partial hospital, hospital, public and private schools and residential programs. His experience includes working in several area children homes, public and private schools, and other programs for special needs children.

Dr. Berk has instructed paramedics in field management of behavioral emergencies, provided training and consultation to foster care agencies, and was a past director of a residential treatment program for children.Dr. Berk also served as a member of, and trainer for, the Greater Cleveland Chapter of the American Red Cross Disaster Mental Health Team. Dr. Berk functioned as a consultant to the Screen Actors Guild in New York City, and has, in the past, provided training for the Disney Channel.

Dr. Berk also facilitates 15 social skills groups for children/adolescents. He also has an alternative education an alternative education program for students who cannot attend traditional school settings.

Dr. Berk is the author of "A PARENT'S QUICK GUIDE TO ELECTRONIC AND VIDEO GAME ADDICTION"

A Note from the Instructor

Since I interact with these children every work day (that I am not teaching), I promise to provide you with practical and up-to-date strategies that you can use immediately with a diverse population of children/adolescents. Since there are a variety of people from many different settings attending today, you will need to use your creativity to "scale up or down/modify" the interventions to the specific population you work with. I will try my best to answer questions where possible, while keeping to my main objective of providing a wealth of practical strategies that can be applied immediately with these children/adolescents.

I hope you enjoy your day and benefit from the presentation!

AGENDA

Oppositional and Defiant Disorder and why children become oppositional/defiant/difficult in today's world

Interventions that do not work and how to restructure them to work

Break

Interventions that do not work and how to restructure them to work
(continued)

LUNCH (on your own)

Additional Interventions to utilize with children and their families

Dealing with Difficult Parents

Helping ourselves deliver interventions properly and avoid negative behavior

Evaluations

Practical Strategies for Today's Difficult Child / Adolescent

Presented By : Jay H. Berk, Ph.D.

PRIMARY WORKSHOP OBJECTIVES

- Understand the diagnosis of Oppositional and Defiant Disorder (O.D.D.)
- Examine Oppositional, Defiant, and Difficult Behaviors
- Oppositional vs. Conduct Disoreder
- Review of other related disorders
  Anxiety Disorder, ADD, Autism, Disruptive Mood Dysregulation Mood Disorder Conduct Disorder, Depression, Medical Issues, Language Issues and Learning Disabilities
- Comprehend the origins of the Oppositional and Defiant Behaviors
  How and why children become non-compliant
- Be aware of which intervention strategies do not work and how to revise these strategies to make them work
- Pitfalls in behavior plans and how to fix them
- How to assist these children with effective problem solving techniques
- How to effectively reach the child/adolescent unmotivated to change
- Utilize a wide range of additional intervention options in a variety of settings
- Learn strategies to align with both the child and the parent in the interventions
- Learn strategies to use with uncooperative and cooperative parents
- Keep ourselves, as the helper, able to assist the child and effectively deliver the interventions without being caught in the negative countertranference issues.

NOTES:

NINE DOTS GAME…..

THERE ARE NO OPPOSITIONAL KIDS, ONLY OPPOSTIONAL KIDS WITH

_____

WHAT MAKES KIDS OPPOSITIONAL?

MY THREE 5 PERCENTERS ARE:

INITIALS _____ DIAGNOSIS _____BEHAVIOR_____

INITIALS _____ DIAGNOSIS _____BEHAVIOR_____

INITIALS _____ DIAGNOSIS _____BEHAVIOR_____

NEW DIAGNOSIS:

DYSRUPTIVE MOOD DISREGULATION DISORDER (DMDD)

SOCIAL COMMUNICATION DISORDER

BYE BYE……. ASPERGERS SYNDROME

MORNING NOTES: NOTES:

THE MYSTERY?

HOW ARE ELECTRONICS CHANGING CHILDREN TODAY?

Service Delivery

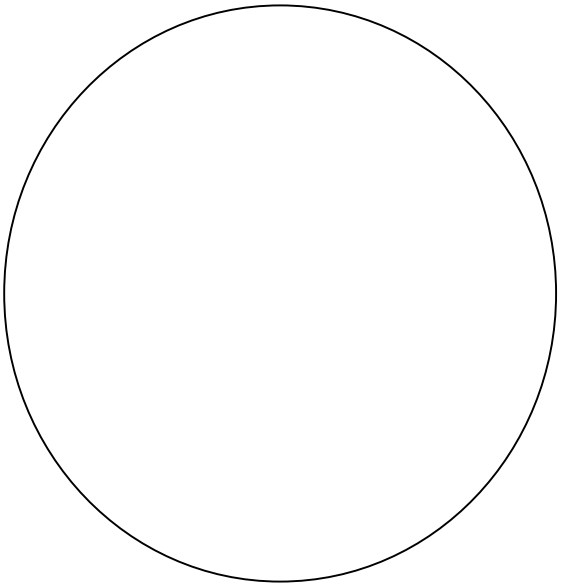
- **PRIVATE PRACTICE**
- **RED CROSS**
- **L.D. SCHOOL**
- **CLEVELAND PUBLIC SCHOOLS / AKRON CITY SCHOOLS**
- **RESIDENTIAL TREATMENT**
- **PSYCHIATRIC HOSPITALS**
- **ENGLAND, NORWAY, BOSNIA (UNICEF)**
- **SCREEN ACTORS GUILD (SAG) / THE DISNEY CHANNEL**

ACADEMIC INCREASE

1) THE REPETATIVE CYCLE OF BEHAVIOR AND INEFFECTIVE RESPONSES

GOAL:
BREAK THE
CYCLE

ACTION IN THE WORLD



CHILD
INAPPROPRIATELY
REACTS

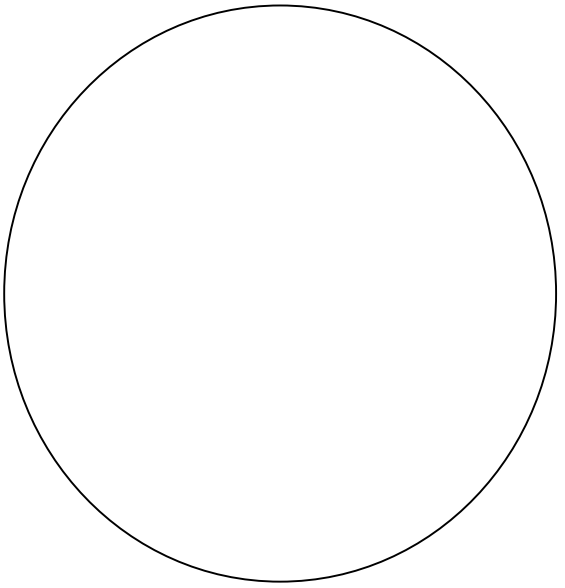
CHILD
REACTS IN
A LESS
THAN
EFFECTIVE
WAY

ADULT/WORLD RESPONDS TO THE
CHILD/ADOLESCENT IN A NEGATIVE
MANNER

YOUR STUDENT HERE

GOAL:
BREAK THE
CYCLE

ACTION IN THE WORLD



CHILD
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ADULT/WORLD RESPONDS TO THE
CHILD/ADOLESCENT IN A NEGATIVE
MANNER

Functional Behavior Assessment - Line of Inquiry Worksheet

Student: [redacted] School: [redacted] Grade: 8 Date: 10/ /02 Team Members: [redacted]

Slow Triggers (setting events)	Fast Triggers (Antecedents)	Problem Behavior	Perceived Function	Actual Consequences	Strengths
New to area from Delaware Attended separate facility for students with learning problems Learning Disability NeuroFibromytosis Type I – neurological disorder ADHD symptoms Easily distracted Picky eater IQ scores decreased in latest evaluation Needs glasses, others broken	Transitions When not in proximity of adult When does not perceive adult as in charge When cannot meet academic demand When he feels singled out in front of peers When feels work is too difficult When he is in small group setting (does well 1-1 or in large group, although needs assistance to do academics in large group)	Low frustration level Swears, uses inappropriate language to peers and adults Makes poor choices Non-compliant unless he is interested in activity Refuses academic work at times Breaks glasses and pencils, tears up his papers, throws objects in garbage Negative comments about others Does not tell adults when he needs help	To gain affirmation and approval by peers Lacks social skills, has difficulty verbalizing wants and needs Wants to be accepted by the group Avoids academic challenges	Ignore or downplay negative comments when rest of group is not affected Keep adult emotions on even keel to avoid showing "shock" reactions Other kids may react by laughing or staying away Removal to office Work with resource officer	Outgoing Likes to use hand-on manipulatives such as clay, tools Computer skills Likes to change date on board Likes attention of peers and adults Has been staying after school with Mrs. [redacted] to do homework Engaging, comfortable with adults Likes video games Persistent Focuses well on areas of interest and capability Responds well to Resource Officer Can de-escalate quickly

Hypotheses:

[redacted] is a new student at [redacted]. He has a neurological condition that affects his cognitive and behavior skills. He has symptoms of ADHD. When [redacted] has academic demands that he perceives as difficult, has to make transitions or doesn't have immediate reinforcement, he uses inappropriate language or makes negative comments, tears up work papes and becomes non-compliant with directions in order to access one-to-one adult attention and assistance, meet need for peer approval and avoid academic tasks. He lacks some social skills including his ability to use appropriate words to express feelings of frustration and ask for help.

Iceberg??????

ODD KIDS AND ODD PARENTS?

A B C RULES:

A: EDICT

B: DISCUSSION

C: THEIR CHOICE

Teeter - TOTTER

SPLITTING:

The rules are:

Identified bad guy and they are the innocent victim
If it was not for x, I would not have this problem

Talk about splitting BEFORE they split
Have a plan that includes communication
Get the plan signed by all parties

IF YOU DO THE SAME THINGS YOU HAVE ALWAYS DONE, YOU GET THE SAME THING YOU ALWAYS GOT"
"BEFORE THEY SHOW YOU WHAT THEY KNOW, YOU HAVE TO SHOW THEM THAT YOU CARE"

WHAT DOES THE **TEACHER** DO NOW?

TEACH
GUIDE
MODEL
SUPPORT
TEACH NORMS
PROVIDE MORE SUPERVISION
TEACH MORALITY
GUIDE PARENTS
TUTOR
DEVELOP CURRICULUM
IDENTIFY AT RISK CHILDREN
ADVOCATE
SURROGATE PARENT
PROVIDE STRUCTURE
PARTICIPATE IN THE TEAM
MENTOR
COORDINATE ACTIVITIES
GUARD THE HALLS
DISCIPLINE
FIGHT DRUGS
SUPERVISE LUNCH PROGRAMS AND OTHER BASIC SURVIAL NEEDS

AND DANCE VERY, VERY, VERY FAST

PLUS TAKE CARE OF THEIR OWN LIFE!!

AND NOW TEACH SOCIAL SKILLS AND DIGITAL CITIZENSHIP

504 VS. IEP

BOTH SPECIAL ED?

SUSPEND VS. EXPELL

MANIFESTATION DETERMINATION

PRO-SOCIAL PUNISHMENT

- NOTEBOOK BABIES
- STICKMAN STUGGLES WITH ANGER
- FUNNIES COMMERCIAL EVER

WHAT SKILL IS MISSING

PUNISHMENT DOES NOT TEACH NEW SKILLS: It only reduces the frequency of a negative behavior

ODD KIDS NEED NOT BE VIOLENT

-
- NARCASSISTIC
- SOCIALLY ASOLATED

VIOLENT TEENS

- INJURE MULTIPLE VICTIMS
- NO SECONDARY CRIMINAL INTENT
- YOUNGER
- HISTORY OF SOCIAL ISSUES
- NARCISSISM

KIDS WHO MURDER

- COME FROM CRIMINAL VIOLENT FAMILIES
- HISTORY OF ABUSE
- GANG HISTORY
- ABUSE DRUGS OR ALCOHOL

ODDS OF MURDER HIGHER WHEN:

- USE WEAPONS
- PRIOR ARRESTS
- SKIP SCHOOL
- SCHOOL DIFFICULTY
- NEUROLOGICAL DISORDERS

WHAT AGE ARE CHILDREN WHEN THEY BECOME AGGRESSIVE?

BOOK:" GHOSTS FROM THE _____ " BY MORSE AND WILEY

BOOKS: "MAD" AND "HOW TO TAKE THE GRRRR OUT OF ANGER"

RELATIONSHIP: SECRET FACTOR

- **Diagnostic criteria for 313.81 Oppositional Defiant Disorder**

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

(1) often loses temper
(2) often argues with adults
(3) often actively defies or refuses to comply with adults' requests or rules
(4) often deliberately annoys people
(5) often blames others for his or her mistakes or behaviors
(6) is often touchy or easily annoyed by others
(7) is often angry and resentful
(8) is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

- **Diagnostic criteria for 312.8 Conduct Disorder**

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age- appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months

Aggression to people and animals

(1) often bullies, threatens, or intimidates others
(2) often initiates physical fights
(3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
(4) has been physically cruel to people
(5) has been physically cruel to animals
(6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
(7) has forced someone into sexual activity

- **Diagnostic criteria for 312.8 Conduct Disorder (continued)**

Destruction of property

(8) has deliberately engaged in fire setting with the intention of causing serious damage.
(9) had deliberately destroyed others' property (other that by fire setting)

Deceitfulness or theft

(10) has broken into someone else's house, building, or car
(11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
(12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

(13) often stays out at night despite parental prohibitions, beginning before 13 years.
(14) has run away from home overnight at least twice while living in parental surrogate home (or once without returning for a

lengthy period) is often truant from school, beginning before age 13 years

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder

LONG TERM OR SHORT TERM CONSEQUENCES?

ARTIFICIAL SUPEREGO

OPPOSITIONAL DEFIANT

V.S.
CONDUCT DISORDER

Oppositional Defiant

- Not in all environments
- More reactive with familiar people
- BAD TEMPERS IN PRE-SCHOOL
- PROBLEMS WITH SOOTHING SELF
- More likely with a history of disruptive child care
- Prevalent in families with harsh, inconsistent, or neglectful parenting
- Evident before age eight and more evident before adolescence
- Familiar pattern
- One parent with Mood Disorder, Oppositional Defiant Disorder, Conduct Disorder, Attention Deficit Disorder, Antisocial Disorder or Substance Disorder

As opposed to:

Conduct Disorder:

- Aggressive to people or animals
- Destructive to poverty
- Pattern of theft or deceit

The onset of symptoms must be before age 10, and a diagnosis should not be made for the first time before age 6 or after age 18.

Specific Symptoms of Disruptive Mood Dysregulation Disorder

1. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation

2. The temper outbursts are inconsistent with developmental level (e.g., the child is older than you would expect to be having a temper tantrum).

3. The temper outbursts occur, on average, three or more times per week.

4. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, friends).

5. The above criteria have been present for 1 year or more, without a relief period of longer than 3 months. The above criteria must also be present in two or more settings (e.g., at home and school), and are severe in at least one of these settings.

6. The diagnosis should not be made for the first time before age 6 years or after age 18. Age of onset of these symptoms must be before 10 years old.

7. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.

8. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder.

As with all child mental disorders, the symptoms also can not be attributable to the physiological effects of a substance or to another medical or neurological condition.

This diagnosis is new to the DSM-5. Code: 296.99 (F34.8)

Why Do Children Become Oppositional and Disruptive? (Not Exclusive Categories)

- Attention Deficit Disorder (with/without Hyperactivity)
  Need to be Active
  Distracted by Outside Noises
  Filtering Problems

- Medications

  Note: Reference Book " Straight Talk About Psychiatric Medications for Kids" P. Wilens

CHILDREN AND ADOLESCENTS
STIMULANTS

RITALIN (CONCERTA)
ADDERALL (ADDERALL XR)
#CYLERT
DEXADRINE
**DAYTRANA
FOCALIN
VYVANSE
***Quillivant XR

ADD (non-stimulant)

STRATTERA

NON-STIMULANT

INTUNIV (Guanfacine)

ANTIDEPRESSANTS
ZOLOFT*
LUVOX*
PROZAC*
PAXIL*
WELLBUTRIN
CELEXA
EFFEXOR
(* SELECTIVE SEROTONIN REUPTAKE INHIBITORS)

ANTI-HYPERTENSIVE
TENEX

ANTI-PSYCHOTIC
RISPERDAL GEODON
ZYPREXA ABILIFY
SEROQUEL
CLOZARIL

TOURETTE'S SYNDROME
ORAP
HALDOL
RISPERDAL
CLONIDINE

OBSESSIVE COMPULSIVE DISORDER
LUVOX
ZOLOFT
ANAFRANIL

BIPOLAR DISORDER
LITHIUM
DEPAKOTE

Medications Chart

Stimulant Medications

Brand Name Generic Name Approved Age

Adderall amphetamines 3 and older
Concerta methylphenidate 6 and older
Cylert* pemoline 6 and older
Dexedrine dextroamphetamine 3 and older
Dextrostat dextroamphetamine 3 and older
Ritalin methylphenidate 6 and older
**Because of its potential for serious side effects affecting the liver, Cylert should not ordinarily be considered as first line drug therapy for ADHD.*
Antidepressant and Antianxiety Medications

Brand Name Generic Name Approved Age

Anafranil clomipramine 10 and older (for OCD)
BuSpar buspirone 18 and older
Effexor venlafaxine 18 and older
Luvox (SSRI) fluvoxamine 8 and older (for OCD)
Paxil (SSRI) paroxetine 18 and older
Prozac (SSRI) fluoxetine 18 and older
Serzone (SSRI) nefazodone 18 and older
Sinequan doxepin 12 and older
Tofranil imipramine 6 and older (for bed-wetting)
Wellbutrin bupropion 18 and older
Zoloft (SSRI) sertraline 6 and older (for OCD)
Antipsychotic Medications

Brand Name Generic Name Approved Age

Clozaril(atypical) clozapine 18 and older
Haldol haloperidol 3 and older
Risperdal (atypical) risperidone 18 and older
Seroquel (atypical) quetiapine 18 and older
(generic only) thioridazine 2 and older
Zyprexa (atypical) olanzapine 18 and older
Orap pimozide 12 and older (for Tourette's syndrome).
Data for age 2 and older indicate similar
safety profile.
Mood Stabilizing Medications

Brand Name Generic Name Approved Age

Cibalith-S lithium citrate 12 and older
Depakote divalproex sodium 2 and older (for seizures)
Eskalith lithium carbonate 12 and older
Lithobid lithium carbonate 12 and older
Tegretol carbamazepine any age (for seizures)

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- Drugs
  Not as Easy to Recognize

- In-Utero Exposure (Consider sensory integrated issues- consult Occupational Therapist)

  Fetal Alcohol Syndrome

  Crack Addicted Babies

  Sensory Issues Sensory diet 5 levels

  Get a good occupational therapist

Name:

The purpose of a sensory diet for is to assist him to maintain his optimum alert level through out the school day, so that he can participate in and learn from the educational material being presented to him. This sensory diet is an attempt to address the continuum of arousal states seen in during the school day going from low arousal to the over stimulated. can move from one level to another through out the day. Staff reports that they cannot identify behaviors associated with underarousal; therefore, levels 1 and 2 will be left blank. If behaviors appropriate for one or both of these levels are observed, the blank spaces will be filled in at that time.

	BEHAVIORS YOU MAY SEE	WHAT TO DO
Level 1		
Level 2		
Level 3	is on task, attending to directions and transitioning without difficulty. He is following daily routines and verbal directions. Johnny has been observed during this time to take a visual break from the activity in the classroom. This is the level we would like to maintain. This is the level at which can learn the best.	Build heavy work routines into the school day, starting as soon as he gets to school. A social story may be paired with sensory activities to prepare for the school day and for upcoming activities. See attached sheet for suggestions. When is seen to be taking a visual break let him continue this for a short period of time. This seems to be a coping skill he has developed to deal with the activity in the classroom. Build into the routine times, to stretch. may not know how to do this but staff can help him but making him reach for objects just out of his reach. Use alternative work positions, such as working on all fours for a short period or doing some work in standing. Build into the routine times to go for a steady paced walk, perhaps to run an errand.
Level 4	is beginning to have difficulty with the daily routine	Decrease verbal interaction and use gestures as much as possible.

	and with verbal directions. He runs around and can't focus on materials being presented. He may argue about verbal input or suggestions. He may perseverate on verbal directions.	If possible, dim the lights in the room or at least in the quiet area. If possible decrease the noise level in the room or have him listen to quiet music. may need a short break in a quiet area. While in the quiet area, give him a fidget toy to clam himself. A social story may help him to calm himself and anticipate upcoming activities. Have him go for a slow steady paced walk. As he becomes calm, have him do some heavy work to prepare him to refocus his attention on schoolwork.
Level 5	is running around and may beat on lockers. He may throw objects. He may throw himself on the floor and cry. He may beat on himself or pick at his nose.	Rely on visual cues primarily. If possible dim the lights and reduce the noise level. Give him some down time in a quiet area and allow him to use a sensory item to calm himself. He may benefit from being in a bean bag chair or under a weighted or heavy blanket. Silently show him a social story and/or his daily schedule to anticipate upcoming activities. Once calm, have him stretch and/or go for a slow steady paced walk. Have him do a heavy work activity to get ready to rejoin his group for schoolwork.

TRAUMA AND STRESS REACTIONS

CONCRETE THINKER

LEARNING ISSUES

MEDICAL ISSUES

DEPRESSION

ANXIETY

OCD

CAREGIVER ISSUES

ADDITIONAL REASONS

- **CONDUCT DISORDER**
- **ONLY STOPPED WHEN HIT**
- **GANG PRESSURE**
- **TRAUMA**
- **RISK IS WORTH IT**
- **BORED**
- **POOR PROBLEM SOLVING**
- **ATTENTION SEEKING**
- **FEAR OF FAILURE**
- **POVERTY ISSUES**
- **MASLOW**

A Guide to Asperger's Syndrome (AS)

Asperger's Syndrome is a neurobiological disorder on the autistic spectrum, affecting peer social interaction and communication. AS children have a rigidity of thinking, much like those with high-functioning autism, as well as a heightened sensitivity to noise and crowds, poor understanding of facial expressions, and tendencies toward isolation. There is a range of severity of symptoms within the syndrome, the very mildly affected child often going undiagnosed, appearing only odd or eccentric. Consequently, the issues facing the parents and teachers of AS students are many, as their communication can be both awkward and challenging.

Academically, AS students have trouble with auditory instruction and keeping themselves organized. They tend to be reluctant to accept change, and to be inflexible with thought. Not surprisingly, these children frequently have all absorbing narrow areas of interest. AS children typically are good with rote memory skills (facts, figures, dates, times etc.); many excel in math and science. It is not uncommon for AS students to have very uneven academic experiences. AS children tend to thrive in environments that are structured, patient and supportive; simultaneously, calm and specific.

Amongst their peers, children with AS have difficulty reading social cues. They often use language in a slightly odd way, and take literal meaning from what is read or heard. Making friends is very difficult because an AS child does not understand the social nuances necessary to do so, and other children frequently do not understand or accept the odd, and sometimes clumsy, manner an AS child might have. Lunch room, playground or any situations with unstructured activities can be the most difficult time of the day; conflicts that occur at these times can often drastically affect their concentration in the classroom.

The following is a list of issues which often arise with AS children, along with strategies which have proven effective in supporting them both academically and socially:

• Complex, large, fast-paced and/or unfamiliar classroom settings create major distractions	• Limit group sizes; limit distractions; allow additional time to process and assimilate information; reduce noise levels; reiterate instructions and directions often
• Verbal or vague instructions cause confusion	• Keep insturctions simple; visually supplement and support information; limit options; use clear, literal, unambiguous language
• Changes in schedule/routine and additions/subtractions to assignments result in late or incomplete work	• Pre-warn, when possible, of changes and deadlines; clarify schedules; communicate new expectations; help with reidentifying priorities
• Poor time management and disorganized work habits interfere with long term projects, tests, quizzes and lab work	• Schedule out assignments; discuss breaking up priorities on larger projects; remind of time constraints; inquire about issues periodically; allow additional time when possible; choose partners carefully
• Pace of maturity expected at rate of peers becomes a potential setup for failure	• Expect occasional lapses in independence; encourage responsibility for specific behavior
• Social conflicts, stressful situations can severly affect engagement and cooperation	• Be aware of stress triggers; look for overly rigid behavior; give specific solutions (ie., count to 10, breathe deeply), remove from environment if necessary

BEHAVIOR PLANS: The most common pitfalls

Mistakes	Change To…
When Eric gets 7 days in a row	When Eric completes 7 days (or part of a day)
He will get X reward	He can pick from a menu of rewards
He will go by himself to…	He can pick a friend to go with him to…..
He can go next week to….	He can go today to….
He must do X..	He has a choice to do X or Y and the consequences are……
Written without the parent	Written with the parent
The plan is for school	The behavior at school earns this privilege Or consequences at home
No warning Too many warnings	One clear warning
Uses only verbal cues	Uses body cues and touch
Written for the child	Written with the child
Adult always charts	Child charts themselves
Starts where it is hard to make the goal	Starts midzone (50-60%)
Privileges are normally gives	Privileges are earned
Adults “try” to work together	Seamless
Parent feels bad and gives in	Parent agrees this plan is the only way to Prevent larger problems
Promises go one way	Promises go both ways
Short-term perspective	Long-term perspective

STUDENT WEEKLY RATING

NAME Ben

DATE 2-18-22

Diligence 1

Honesty 1

Respect 1

Positive Attitude 1

Class Prep. 1

Homework 1

Goal for next week

Finish Weird Prospect early

1=Excellent, 2=Good, 3=Satifactory, 4=Needs Improvement

TEACHER WEEKLY RATING

Diligence 1

Honesty 1

Respect 1

Positive Attitude 1

Class Prep. 1

Homework 1

Comments

Ben is working hard and coming up with many good ideas (Just slow down a bit, Ben.) Mr. B.

SECRET LIST

Have I considered:

- Medical Issue
- Medicine Issue
- Peers
- Teacher
- Subject
- Sensory
- Depression
- Anxiety
- Trauma
- Learned Behaviors: Reinforced by Others?'
- Autism
- Speech
- Brain Trauma
- Processing Issues
- Working Memory
- And THE NEED FOR PERCEIVED CONTROL

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As you well know from this first hand experience, the seminars that I provide are of high quality and loaded with practical information. It can be quite a negative experience to plan a training program and then have a speaker who does not connect with your audience. As a result, I work specificlly with groups to make sure the material is relevant to their needs. What makes my seminars different than others is that I not only provide the training, but work with these children/adolescents everyday. As a result, the information in the seminars is relevant, up-to-date and extremely practical. You should be aware that the overwhelming majority of my seminar participants rate themselves as **very satisfied** or that the seminar **exceeded their expectations**! Some of the seminars which I currently present are:

1) **PRACTICAL STRATEGIES FOR TODAY'S DIFFICULT CHILD/ADOLESCENT: Effective Interventions with Oppositional, Defiant and Challenging Behaviors**

2) **EMPOWERING CHILDREN & ADOLESCENTS USING SOCIAL SKILLS**

3) **PRACTICAL STRATEGIES: FOR CHILDREN AND ADOLESCENTS WITH HIGH FUNCTIONING AUTISM**

4) **PRACTICAL STRATEGIES: FOR STUDENTS WITH MENTAL HEALTH ISSUES**

5) **PRACTICAL STRATEGIES: TO COPE WITH ELECTRONIC AND VIDEO GAME ADDICTIONS**

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Additional Major Magic Dust

I would like to thank everyone for coming to the program and provide you with additional strategies, ideas and techniques that you can utilize with oppositional defiant, angry and difficult children, adolescents and parents. These ideas and strategies will provide you with great techniques that you can use" right away".

MANY THANKS TO JACK HIROSE AND ASSOCIATES for the opportunity to teach for his wonderful company

NOTES;

NOTES;

NOTES I WOULD HAVE TAKEN

1. Prepare yourself for the fact that most strategies do not work forever. A strategy may work for a certain amount of time or may work for a certain percentage of time. The first part we need to decide is what is a relevant and successful percent.

   Of course, it is. Looking for 100% improvement is fruitless.

   There will always be naysayers and people who argue but, what we are looking at is the general trends

   Say "NO" to naysayers….

   Please speak with parents, teachers and colleagues about trending. If you look at any one day, one hour, one moment, you can have your information skewed by looking at that period of time. Overall, is your trending getting better?

   Against self?

   Against agemates/
   .

   It is very important to take a baseline. In other words, how often is the child acting out?

   Recently, this is the case I had when the parents were upset where the child was not making progress and I had to focus them on the fact that the physical aggression (sh) had almost disappeared. .

2. Take baselines. Take temperature reads. In sessions, I start off by having the child or adolescent state how they are doing on their goal. Every client that comes to my practice has a goal. We are very goal focused

   Why
   It changes as they get better
   Get credit

3. Having the child score himself applies an important skill, just like dieting. Tracking yourself makes you more aware of how you are doing and holds you more accountable.

Children and adolescents who are in therapy with me know I am going to ask them how they are doing in terms of their view of the situation. Sometimes, the client reports it is going well except that the parent is still yelling or screaming at them. This reflects on a situation where one must be working on the family therapy aspect of the situation; i.e., it is not always the child with the issue.

Don't blame parents

4. Approaching parents. I do not do what I call "Starbucks Therapy". Children are not dropped at my office for therapeutic sessions without parent involvement. **The magic dust is to state that parents aren't necessarily causing the problem, but they can always see part of the solution**.

   Case example: I have an 8-year-old boy in session who are videotaping: a technique I am going to talk to you more about in a minute. Apparently, this situation was not getting better according to the mother

5. Videotaping as a technique. Almost every parent, child, adolescent and anyone now has access to a video camera in their pocket. The video camera technique can be a very powerful intervention strategy. In the aforementioned case of the 8-year-old, the dad was at the door and the child was screaming about shampoo issues. It turns out the issue was sensory. The sensory issue was soap in the eyes. The solution, once I saw the video, was simple. ……

   .

6. Videotaping out of control behavior often creates a system where the child will stop. They do not want the therapist or others seeing this behavior. This is a definitive litmus paper test to see, "can the child control himself? If the child cannot control himself, they will become more aggressive and out of control when being videoed. If, when being videoed, they stop and slow down their actions, it is suggestive of the fact that they have more control than they think they do. This is a great technique for teaching control and how much control the child has. If the child is out of control, i.e., they cannot stop themselves when being videoed, it is likely time to look at medication interventions for that child. This may be even with a parent who is adverse to medications to say that even in this situation they cannot control themselves.
   How significant.!!!

7. Videotaping calm times. With my 8-year-old example, I wish to bring up that he also went to a store and calmly lent his sister my when she did not have enough money to buy what she wanted to buy. I had the parents video this as well. They were able to show me this in session. He was able to watch, smile, and be very happy about his success. Videotaping success can be a very powerful tool to utilize. Of course, you have to be aware of any HIPAA protection if you are in a school setting, but with the proper releases this is not an issue.

8. Reinforcing before the kid blows it. With many of my clients, it is only a matter of time before they are going to have a problem. Thus, the reinforcement schedule is very important to think about. What I asked parents to do is to reinforce quickly with reinforcers that are easily applicable. The problem with most charts and behavior plans is that students/clients are not able to utilize them because of the extended

period of time.

Case in point, when you have a child with anger problems, simply a hug, a special treat, a meal for that evening, staying up late are all reinforcers that can work quickly. In other words, the trick is to get the reinforcer in place before the child acts out and blows it. In other words, they are going to have another episode and once they have had another episode it is counterintuitive to reward them after they have had another problem. Thus, the trick is to get the reinforcer in quick before they blow it.

NOTE: Don't let them get too much power.

NOTE; Careful of buybacks

9. If your reinforcement plan is not working, consider the following: How quickly am I getting my reinforcer in place? Is my reinforcer easily applied? Easy application of a reinforcer is another important aspect of the situation. Parents sometimes are waiting for trips the store. Teachers are waiting for special meetings with principals. Waiting can be difficult because of the problem. Preparing ahead of time, i.e., having a prize bag in the car for going somewhere. Having help in the home situation where you can apply a reinforcer and not need to worry about siblings, etc., is very important. Easy application works well.

10. Younger needs more immediate.

11. People time is one of the best reinforcers. What does this mean? Attention and people time are some of the best reinforcers that we can create. Most children and adolescents respond to good attention. Remember, good attention or bad attention, I'm going to get attention either way. Can you set up a situation where attention is immediately applied to the child or adolescent who is acting in a positive manner? Do not forget to catch them immediately as they are being good. Once again, this can be difficult if they have been acting problematic previous to this but catching it in the act is so important. Also, who is the most important person to them? Could it be you? Could it be a teacher? Could it be the maintenance person? Who is it that is going to reinforce them the most? You need to know their hierarchy of interest to people. Case in point, in my groups I will come out after group and tell a parent how well a child did. We have children that are voted person of the day. I will send a text to a parent telling them how well their child did while the child watches me send the text. These are immediately applicable reinforcers that make a difference.

12. Don't get in their face…. bottom line still power and attention

13. *** One of the most important techniques I can teach you from my practice is starting off the session with what went right. If you were at my office working with difficult children day in and day out, what parents want to talk about is what the child did wrong, and I understand that. They frustrated. They are paying me to "fix their child".

    What I find as a therapist and what helps me be successful, is that I ask them to wait with that information. I ask them to patiently think about times when they had done well. I ask the child or adolescent to continue to think and to give me examples of times where they could have acted out but didn't. This sets a very different tone in the session. What it does is it makes people focus on the times that the child is behaving that are overlooked and the over focus on the times when the child acts poorly and everyone pays attention

    My next technique is to focus on why they were able to be successful in that situation. Was it their mood? Was it the time of day? Was it something that was added there? One of the most important techniques I can teach you to be able to do this is to focus and stop the session on what is right.

    Case in point: One boy that I was working with, a 13-year-old, broke into tears. He said, "You are the first therapist that has ever done this. Everybody always talks about what I do wrong." He said, "There were ten times today where I could have punched a person who was bothering me, but I didn't, but the eleventh time I did." I think it is important to focus on the times that you didn't as much as the times that you did.

    NOTE: Better when older

    By the way, once they have already punched somebody, they have already had consequences likely from the school and the situation has already happened.

    Not just the action, but the cognition is important to focus on in this circumstance. What do I mean? I focus a lot on what were you thinking when you were able to stop yourself from punching someone? What made this situation different from all others? That is an important key to success. There is something that you thought about, something that you did and you thought it up. Notice, the perception of control I am giving the client. I am giving them the power to say you are able to do this.

    NOTE: What do I need to think…thought drives feelings

14. Particularly difficult clients are clients with attachment disorder. Attachment disorder is generally thought of when the child or adolescent has a difficult time attaching to their family. Attachment bonding therapy has been put in place, which is controversial in terms of its outcomes.

    What I want to share with you is that attachment bonding children and adolescents also have another issue, it can be overattachment. They do not understand boundaries and over attach to individuals that they just meet.

    What we are working on is healthy boundaries with people. What is a healthy boundary? What are the circles of friendship? Who do we tell what to? A huge part of my practice is working with the parents, the child or adolescent on levels of friendship. This is an acquaintance friend. This is a good friend. These are the types of things that we share differently between an acquaintance friend and a good friend. Why does this make them different? This is an important aspect of growth.

    I also work with the parents on the fact that they might have done nothing wrong. A lot of my attachment disorder children are those that are adopted or in foster care. I believe that the attachment issue is a protective mechanism that the child or adolescent acquires to keep themselves from being hurt, but at the same time gets them hurt.

    Teaching healthy boundaries is an important aspect of this.

15. A comment about medication. It is a very difficult decision for parents to make about when to medicate a child or not medicate a child or adolescent. There are some confounding variables, of course, in there. One is understanding that if the child is diabetic, you would give them insulin. This is often said. Parents have a hard time understanding that psychiatric issues can be the same and I understand this difficulty.

    Some things to think about:

    A. Pacing the medication. In other words, giving it a period of time of therapy to try it without medication; i.e., an agreed amount of time to see if there is progress.

    B. Trying medication for a prescribed period of time. This can be worked on with a physician to say we are going to try this for a 6-month period of time.

    C. Working on the parent's or child's concerns about the medication. These can be discussed. Some of these are very valid concerns: Appetite, weight gain, diabetes, etc.

D. As children grow into adolescents, they are less likely to be taking medication as prescribed. Parents need to work on the fact that they cannot necessarily trust the child to take the medication on time or as prescribed.

E. Is the adolescent selling their medication; i.e., does it have street value?

F. Has the medication been reevaluated? I often see children and adolescents who are on medications pre and post puberty who have not changed their medication. They have been on the same dose forever. Making sure you are an advocate, helping them make sure that as the child grows the medication is adjusted accordingly.

G. Is it time for medication holiday? In other words, if the child is doing better is it the medication? Is it the child's behavior? Or, is it both? It is very hard to tell. There may be a time where you suggest to the parent to talk to the physician about decreasing the medication to see if the child has learned the skills needed and they are actually utilizing the skills and it is not as much the medication as it is the skill building that is occurring.

H. There are times when both parents do not agree on medication. This is important to have a discussion with the parents and to decide what would be an indicator that they would try the medication; i.e., how bad does it need to get before you try medication? Once again, since we are not prescribing, this is a physician decision.

I. Inquiring about medication without necessarily following through. I often suggest to parents to get the information. They do not necessarily need to give the child the medication, but getting medication information is important.

J. What prescriber are you going to use? Often times a pediatrician is prescribing. A consult with a child or adolescent psychiatrist can be more fruitful, as they can delve deeper and do off-label prescription use. Sometimes, the pediatrician will follow afterwards with the medication, but having a check-in with a child or adolescent psychiatrist is important.

K. Preparing the parents for the session. They should come with notes, charts and keep notes on how the child is doing. If not, they tend to report the most recent information, which may or may not be an accurate rendition of how the child is doing overall on the medication. (Whack a mole)

L. Understanding that some medications do not need to be given in the summer or every day. For example, stimulants half-life is very short, whereas antidepressants need a blood level. Parents need to understand this.

M. Rescue medications. There are rescue psychiatric medications that can be prescribed. These can be

given or PRN….as needed. Some parents need to talk to the physician and ask about a PRN. medication. This strategy can be helpful when the child is having a panic attack, an anger issue, etc.

Example: Hydroxyzine

N. Consistency. When you have an oppositional kid, you probably have inconsistent parenting, grandparenting, school staff etc. What is very important is to get the whole group together and talk about how much they "love" the child and if they love the child, consistency is key.

When get help

Type of help

Homework hassle

This can be particularly difficult when you have parents are divorced and the child lives in separate houses. I have had many such situations. Case in point, I have a 9-year-old who is allowed to play shooting games at his father's house and his mother does not let him play video games that are violent video games. Of course, he sides with his father, feels his mother is mean, etc.

What I am able to focus on with the father is what are you teaching your son? The video games are a tool to teach. Consistency with your ex-wife is more important and noting the situation, is this really realistic in terms of what is expected in society, i.e., case in point with my 9-year-old client, I asked the father is he aware that other 9-year-olds are not playing these shooting games and that when the 9-year-old brings up the shooting games in group, other 9-year-olds and 10-year-olds say they are not allowed to play these games and that this child would not be invited over other people's houses. This creates a social issue for his child. Question to the father, do you want your child left out of social situations?

Once again, the focus is on the child and not on the parents' differences of opinion.

16. Living with a terrorist. This is a very difficult situation, as many parents are caught in a dilemma. The dilemma is they are afraid to take away video games, set consequences, etc., because the child will blow up. The older the child gets, the more difficult this is; the younger the child is, the easier it is to intervene.

Parents ask me my position on this and I say:

A. Understand that if your child learns they can do this at home, they will take it other places in the

community. I call it "leaking over behavior". When you leak over behavior, they will get in trouble for the same things that they do not get in trouble for at home. This will be very confusing.

B. Your job as a parent is to teach your child to be independent. If they are learning inappropriate behaviors that will get them in trouble in the community, they will be confused and be in trouble.

C. Sometimes you need a higher power. This is a very difficult discussion to have with parents. It involved, in Ohio, filing unruly charges, which means the child will not listen at home. Usually a trip in front of a magistrate and doing community service helps the child understand that they cannot do these behaviors.

D. Once you negotiate with a terrorist, you always negotiate with terrorists. This is a problem in that we need to set rules on what you will and negotiate on. This is problematic for parents to understand in that as soon as they start negotiating it is a "slippery slope" involving this. This, of course, involves students at school settings, too. What is negotiable, what is not negotiable?

E. What if a child says my parents let me do this at home? This applies an important rule underlying different rules, different places. This is difficult for children to understand sometimes and will be addressed in the next paragraph…. Does it serve a purpose?

F. NO PHYSICAL DISCIPLINES

F. CPS\

G. Restraint training

17. Different rules, different places. A child grows up in the intercity. They are told not to hit at school. They walk home from school and are in the projects and somebody asks them to fight. If they do not fight, they are easy fodder for others.

Case #2: Parents rules are different at different houses.

This is an important thing to talk to children and adolescents about. They may not be in control of situations, but they need to understand that different behaviors apply different places. One parent may tell the child to hit, another parent tells the child not to hit. Hitting gets you in trouble in school. Flat out, even if the father or mother says when I was a child… I did this. Hitting gets you in trouble in school nowadays. It is a good way to teach that behavior in that situation.

If the child says, but at home I am allowed to hit my brother or sister. Case in point, I have a 10-year-old whose father told him if your brother bothers you, hit him so that he learns not to bother you. I cannot control that situation. I can teach the parent that that behavior will get that child in trouble in school, but different rules, different places, which I do not have control over. I can educate the child. I, as a therapist or person intervening, can teach them the information, but I do not have control over the situations

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18. Who is in control? If nobody is, I am out of control. We work with children and adolescents on the fact that they need to feel the aspect of control in their own life. What parents, teachers and other educators need to understand is that when a child feels as though the adults are not in control it makes the child feel unsafe that they are too powerful for the situation.

    Case in point, I have a 17-year-old client whose parents buy them everything. He has a brand-new SUV, he has credit cards, everything he wants he has. The parents are concerned that if they don't give him things, he will temper tantrum and be out of control, so they let him be in control. Recently, he threw a gym bag out the window while driving a car. His mother went to get it for him, as she felt he would get in trouble by the police. Who is in control? Adults need to demonstrate that they are in control of the situation and they will keep the situation safe. Allowing the child to feel unsafe creates more acting out behavior.

19. Fair versus equal. Children and adolescents are having a hard time today more than ever understanding the difference between fair and equal. Fair means you get what is appropriate for you. Equal means the same. Some parents do this as an ongoing process. You buy one child something, they have to buy the other child something. This, once again, is a way to teach inappropriate behavior, i.e., the story that I will share with you.

    Teaching children that they will get what they need from the adults is the best thing to teach. We will apply things such as an IEP to certain children, where other children will not have an IEP. This is important to understand and to be able to teach the entire class or family situation about how you will meet each person's needs; i.e., if one child is sick you will attend to them more in your house at that period of time than the siblings.

    This leads to a situation where parents need to be careful to keep an important balance in the house with a child who creates more problems, 95% of the time may go to that child. This creates an imbalance in the family.

    Teaching the family to make sure there is time for the other children or they will start acting out, too, hiring sitters, asking grandparents to help, etc., making sure that the other children get their own time is important.

    The same applies in a school setting. Five percent of the children/adolescents eat up 95% of the time. Thus, it is important to understand that we must reinforce the positive behavior. Fair is not always equal.

20. Hiring an individual to help in the house. This is one of my favorite techniques that I can tell you. There are many times families are overwhelmed with a child who is oppositional or defiant and they struggle because they have no out. What is important to teach the parents to do is to search for a local college, high school, etc., where they can gather help. In gathering help, they can then split the family situation to be leaving that child behind in situations where they do not deserve to go. Lots of times a family is "stuck" taking the child because they need to and have no help. Also, it is a good way to get positive attention to the child. Some children need more attention than they are getting. This can be a positive way to do this situation.

21. Sending powerful statements to the child. Recently, I had a set of triplets where one triplet was acting out and making the family situation intolerable. The parents love and appreciate all of their children. They are an affluent family who can afford to go places. Once I brought up not taking the child on their family vacation with the family, they cried, but followed through. This is an importantly strong message to the child saying that you have to behave to get the privileges of the family.

    Children today think they are owed certain things, cell phones, cool clothes, vacations, etc. Yet, we want to teach that you have to earn these. The strong message was sent to this child about not going on vacation with the rest of the family. Secret information: This was actually harder for the parents to do than the child.

    Team problem solving

    Wisdom of Columbo

22. Partial punishment. Taking away part of something is a better plan than taking away all of it. Why is this? Because once a child loses it, i.e., oppositional kids, depressed kids, don't care

23. Community supports. Many times, a coach can be more powerful than the parent. The marching band leader can be more important, the stage crew person, etc. What I teach parents to do is to utilize the adults around them. What does this mean? If the child cannot go to the play or the hockey game because they have been misbehaving, they need to call the coach. They need to explain why. This is a powerful tool, as it exposes the child's behavior to public scrutiny. Many children and adolescents who are oppositional act incognito; i.e., they are a terror at home and behave fine in the community. The parents are often terrified to have the child acting out, but it is a very powerful tool to use community-based reinforcement by using the adults involved in their life.

24. The secret to dealing with adults is tone. What a lot of children and adolescents do not understand is that adults get oppositional with you when you use the wrong tone. They may or may not have the intentions

to use the wrong tone. They may or may not understand tone. For example, a lot of individuals with autism have trouble reading tone in their delivery. A lot of depressed individuals have a flat tone. A lot of anxious individuals have pressure tone. Teaching children and adolescents to manage tone is a secret to reducing oppositional behavior. Showing them, they can have power by using the right tone to adults gives them a position that they seem to benefit from and comprehend, as well as understand how powerful a tool it can be. Case in point, the MOM game.

25. Lying is double trouble.

26. Another secret to success that children and adolescents who are oppositional can learn is to wait for adults to finish. It is a simple strategy, but interrupting adults often enrages them. Giving adults the opportunity to finish and teaching children and adolescents to say "I hear your point" is an important aspect of growth for them. I teach the clients I work with that no matter how angry and frustrated they are, that if they want to have their point heard to wait for the adult to finish and they will have much more likelihood of success of being heard. It is a small secret, but it actually makes a big difference. Wait for the adult to finish and say, "I understand".

27. How to disagree. Disagreeing gracefully is an important tactic oppositional children and adolescents need to learn. Disagreeing gracefully means understanding how to say I have heard your point, I see how you might understand things that way, but let me explain to you why I might see it differently. Acknowledging the other person's point of view is a very important strategy. Children and adolescents who are oppositional feel disempowered, thus giving them a power through such strategies can be a very important aspect of growth for them. Teach them this skill and it is a skill that will last a life

28. Kid who’s not going to change

29. Parent who not going to change

30. Teacher who is not going to change