Application of Behavior Therapy for The Management of Problem Behavior Among School Going Children

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Abstract:

Problem behavior among school going children is now an emergent areas of research worldwide. Because children with problem behavior not only suffer the maladies in day to day life it also affects their academic and other school related performances. Problem behavior among school going children are broadly categories in two main streams such as externalizing problem behavior and internalizing problem behavior. Externalizing problem behavior such as out of sitting behavior, stealing, making quarrel with friends' disobedience to the teachers and elders, etc are more common in Indian school going children. As Problem Behavior is a negligible area and not much concern is paid till now, especially in India, availability of treatment is also less. Since Behavior Therapy is one of the influential therapies to treat behaviors, so in the present study the researcher tried to use a combination of techniques of behavior therapy such as Reinforcement through Token Economy, Modeling through video and storytelling, Stimulus Control and relaxation through Jacobson Progressive Muscle Relaxation to treat Problem Behavior among children. Behavior therapy is targeted because it does not involve any single method rather it contains a number of techniques which help the children to improve undesirable behavior.

Key Words: *Externalizing problem Behaviour, Internalizing Problem Behaviour, Token Economy, Modeling, Storytelling.*

I. INTRODUCTION

Problem behavior among school going children is now an important matter of concern for both parents and teachers in Indian school setting. In this regard it is important to know the concept of problem behavior and its effective management. Problem behavior in classroom setting is called the classroom problem behavior. As a result the child creates problems for peers, teachers and even for parents. Problem behavior in mid childhood and teenage years is a predictable consequence of problematic adjustment in early childhood (Brook, Whiteman, Cohen, & Tanaka, 1992 et al). Longitudinal studies begun with children as young as age 3 years have revealed that there is a link between initial behavior problems and long-lasting indications of risk, including substance addiction during young adulthood (Caspi et al., 1998). The problem behavior is further categorized into two main categories such as Internalizing problem behavior and externalizing problem behavior. Some of the researchers (e.g. Achenbach & Edelbrock, 1978; Achenbach, Howell, Quay, & Conners, 1991) stated that children who face difficulties in their relations with peers can be grouped into two broad categories: those with externalizing problems (such as- have less control over their emotions, thoughts and behaviors) and those with internalizing problems (such as- excessively control of these processes). Externalizing and internalizing behaviors include the most common of children's responses to the confrontation of stress (Achenbach, & Edelbrock, 1981; Rutter & Garmezy, 1983). In the first category, the effects of low control, expressed by destructive, thoughtless, harmful and challenging behaviors, has a direct effect on others. In the second category, the excessive control, expressed in forms of public withdrawal, shyness, sadness, hopelessness or various forms of anxiety, leads to instant consequences for the child himself/herself. As a result of these children interact less in society and face difficulties in adjusting socially and psychologically during childhood (Aunola & Nurmi, 2005).

Many researches confirm that these problem behaviors during childhood leads to a number of problems like deficiency of effortful control (Murray & Kochanska, 2002), peer elimination (Wood, Cowman, & Baker, 2002) and academic problems (Hindshaw, 1992). Behavioral problems are also the indicator of future problems. Long term link between childhood externalizing problem and smoking (Helstrom, Bryan, Hutchison, Riggs, & Blechman, 2004), lower grades (Hinshaw, 1992), substance abuse (King, Iacono, & McGue, 2004), and disruptive results (Lynam, 1996; Moffitt, 1993), of unlawful substance use in early adolescence (King et al., 2004), and high Childhood internalizing behavior has been linked with major depression in adolescence (Reinherz et al., 1993), intake threats of high school dropout (McLeod & Kaiser, 2004).

The relationship of academic achievement and its relationship with problem behavior was also studied by numbers of researchers. In this regard Hobbs (1966), poor achievement indicate the presence of behavioral disorders in the children. Whelan, DeSaman, and Fortmeyer (1984) attempted to determine whether poor achievement anticipate

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achievement or, the reverse. It was found that in elementary school positive feeling towards the surrounding leads to academic achievements whereas in secondary school academic achievement leads to positive attitude towards the environment. So this finding indicates the successful instructional experiences are important for children with problem behavior.

Further, Kauffman (1981), indicate that "behaviors which may be disordered in one setting or context may not be so in other setting or context because of differences in behavioral expectations". In this sense it can be said that there is difference between disturbing behavior and disturbed behavior. For example, if the child demonstrates behavior not acceptable in class such as use abusive language and tearing notes in the presence of a particular teacher but doesn't show such behavior in presence of others teacher or in any other setting is disturbing behavior. But if the child shows such destructive behavior in front of all the teachers or even home settings and other context then that behavior is termed as disturbed behavior. His behavior is not dependent on a particular setting, person, place and time. The considerations of behavior whether normal or problematic is also differ from situation to situation and one developmental stage to other. In this regard, it can be said that behavior which is considered normal at one developmental stage, may be considered pathological at another developmental stage (Barr, 2000). For example, crying as a cue for food or attention is considered normal at infancy but may be seen as problematic during adulthood. In many cases it is observed that all children demonstrate disobedient, mischievous and impulsive behaviors which are quite normal but problem arises when their difficulty crosses the norm of their age. The most common disruption problem behavior may include-oppositional defiant disorder (ODD), conduct disorder (CD) and attention deficit hyperactivity disorder (ADHD).

II. INTERNALIZING BEHAVIOR

Fear and phobias:

A phobia is an extreme fear of something which in reality have minute or no danger. Common phobia and fear comprise of snakes, insects, heights, closed-in places, water, driving and needle. According to LaPouse & Monk, 1959; MacFarlane, Allen, & Honzik, 1954, mild, temporary fear responses are common in childhood. So the main task of the clinician is to decide whether the child's fear is severe enough, that it requires any sort of treatment or not.

According to Grazianoe et al (1979), systematic desensitization has been frequently used to treat childhood phobias. In this clients are first taught relaxation techniques and then told to develop a hierarchy of fear situations. They are then told to imagine the least feared situation in the hierarchy and gradually move up the hierarchy as they learn to relax in each of the situations. Another most widely used behavioral treatment for children's fear are modeling-based interventions (Graziano et al, 1979; Morris & Kratochwill, 1983). This include the use of multiple models (Graziano et al,1979); participant modeling (Rosenthal & Bandura, 1978); and 'coping' models, in which the child originally demonstrates fear, then gradually masters the problem (Meichenbaum, 1971). Thus it can be said that modeling based intervention is very effective in treating childhood fear. Exposure therapy may also include flooding or graduated techniques.

Obsessive-compulsive Disorder:

Obsessive-compulsive disorder is a type of Anxiety Disorder. Obsessions are intrusive thoughts, images or impulses whereas compulsions are repetitive behaviors that the person feels compelled to perform to satisfy its obsession. According to Adams (1973), obsessive compulsive disorder is very rare in childhood comprising less than 2 percent of the clinical population. In childhood, child may have combination of obsessions and compulsions, although either occurs alone. Children diagnosed with OCD generally have more than average IQ, joint with active imaginary lives and a propensity to present themselves as excessively mature for their age (Adams, 1973; Judd, 1965).

Stanley (1980) successfully employed a combination of response prevention and contingency management for the treatment of 8 years old boy. Family members carried out the treatment by verbally prohibited her from engaging in the rituals and altered their actions which previously reinforced such rituals. Systematic desensitization was also successfully used by DiNardo and DiNardo (1981) for treating a nine years old boy with severe contamination fears, and hand washing and touching compulsions. In this boy was given systematic desensitization with coping imagery, and family members were trained to stop cooperating with his rituals.

Social Isolation:

social isolation refers to complete or nearly complete lack of contact with people or society members. Social isolation may affect up to 25 percent of all preschool children, decreasing to approximately 1 percent to 3 percent in the primary grades (Hops & Greenwood, 1981). The leading behavioral model of peer isolation is a social skill deficit model (Asher & Renshaw, 1981; Hops & Greenwood, 1981). The main assumption of the model is that social isolates have cognitive and/or behavioral discrepancies that hinders with their interpersonal functioning.

An interesting method to the treatment of peer isolation includes the use of peers as 'therapists'. Peers have been fruitfully qualified to cue and reward socially appropriate behavior in withdrawn children, and to serve as models for social skills (Strain &Fox, 1981). However, as Strain (1977) has noted, peer intervention techniques may not be effective with extremely socially withdrawn children.

III. EXTERNALIZING PROBLEM BEHAVIOR

Oppositional defiant disorder (ODD):

ODD usually occurs in the preschool period and very rarely in adolescents. ODD usually precedes conduct disorder. Children with ODD do not necessarily develop conduct disorder. It affects about 6 to 10 percent of children. It is characterized by a adverse set of behaviors in a child directed toward the adults in their life.

Behavioral therapy in children with Oppositional Defiant Disorder is grounded on learning theory.

Behavioral therapists basically set up conditions wherein children can "unlearn" unsuitable behaviors and, in their place, learn new, more suitable behaviors. After studying the problematic interactions between ODD children and their parents and other authority figures, behavioral therapists help parents to draw up a behavioral contract that specifies in detail, which adverse behaviors are to be discouraged, and which positive behaviors are to be rewarded. Methods that will be used for discipline and reward are also stated in detail, so that the whole plan for changing children's behavior is as explicit and clear as possible. Parents are trained to be consistent in their use of approved reinforcements (rewards) and, as necessary, punishment techniques. By learning to take better and more consistent control over the reward landscape of their children's environment, parents gain more control over how their children behave. Over time, some rewarded behaviors become habitual, and (more usefully) become reinforced by the environment itself (rather than by parent's actions) such that children start engaging in those actions on their own. For example, parents may create conditions which promote their children's completion of homework, which in turn may result in their getting better grades and experiencing a greater mastery of the subject matter being taught, which causes them to want to avoid homework less.

Conduct Disorders:

Conduct Disorder is a set of emotional and behavioral disorders that can occur in childhood and early teens. It tends to be seen by age 9. Children with this usually display repetitive violation of rules, disobedience, physical and verbal aggressiveness, lying, temper tantrums, stealing. According to Quay, 1977 " The Conduct Disorder cluster represents behaviors that clearly differ from school and community expectations in almost all situations. These behaviors are aversive to both teachers and other children or young persons.

Treatment:

The arrival of behavior therapy techniques has made the outlook brighter for children who manifest conduct disorder (Kazdin & Weisz, 2003). To control the problem behaviour of children, it is important to train the 'control techniques' to the parents of such children seems to be effective as they reinforce the desirable behavior and change the environmental situations leading to such maladaptive behaviors. Changes may happen only when parents consistently reward and accept the child's positive behavior. Other techniques such as family therapy or parent counseling are used to guarantee that the parent or person answerable for the child's discipline is adequately confident to follow through on the program. Conduct disorders are often the early signs of ADHD.

Attention deficit hyperactivity disorder (ADHD):

ADHD is the common childhood disorder that continues till adolescence and adulthood. It refers to a complex of maladaptive behaviors reflecting the following central problems (DSM-III-R, APA, 1987): (1) age-inappropriate over activity; (2) attentional problems and (3) impulsivity. Commonly associated features include aggressive or oppositional misconduct (Safer & Allen, 1976), peer rejection (Pelham & Bender, 1982), and the academic difficulties (Safer & Allen, 1976; Silver, 1981).

Numbers of studies indicates that, the rate of Hyper-activity affects approximately 5% to 10% of all school-aged children, (Lambert, Sandoval, & Sassonc, 1978; Safer & Allen, 1976). Boys are more hyperactive than girls, by ratio of 3:1- 10:1 (Safer & Allen, 1976). Although psycho stimulant medication is the most popular treatment for hyperactivity (Laufer & Shety, 1980), the current non-medical treatment is Behavior Therapy (Barkley, 1981). Two different types of behavioral treatments have been used: contingency management carried out by parents and/or teachers and cognitive-behavioral interventions with individual hyperactive children.

Behavior Therapy:

Behavior therapy emerged as a technology of behavior change in the early 1930 and is considered as a milestone in the development psychology as behavioral science. Graziano and Mooney (1984) conceptualized behavior therapy as a pathology-linked and adult-oriented approach confined to clinical applications only, its methods are equally applicable to clinical problems as well as enhancement of normal adaptive functions, including prevention, education and rehabilitation. Several techniques of behavior therapy available for the treatment of problem behavior are based on the theories of Classical Conditioning and Operant Conditioning.

Classical Conditioning:

Classical Conditioning was originally developed by Ivan Pavlov. It is one way to alter behavior. Classical conditioning or respondent conditioning is a result of learning connections between different events. Some of the techniques used in this approach to behavior therapy are-

Systematic Desensitization:

'Systematic Desensitization' as a behavior technique was first established by Joseph Wolpe, (1958) for the treatment of fear and anxiety. Systematic Desensitization was developed more systematically as a clinical technique of counter conditioning. Counter conditioning is the reverse side of the Pavlov's Classical Conditioning. In Counter Conditioning the severity of the Conditioned Response, example anxiety, can be reduced by establishing conflicting response (example, relaxation) to the conditioned stimulus (example snake). Systematic Desensitization involves the following three phases of training-

Relaxation training:

In relaxation training, clients should be taught the method of making themselves relax. Several techniques are available for relaxation. These are used depending upon the client's capacity and the expertise of the therapist. Various other techniques available are meditation, yoga, hypnosis. However the most commonly used relaxation technique is *'Jacobson's Progressive Muscle Relaxation Technique'*. JPMR helps to reduce anxiety by reducing muscle tension. In this context Fung To and Chan (2000), conducted a research on, *"Evaluating the Effectiveness of Progressive Muscle Relaxation in Reducing the Aggressive Behaviors of*

Mentally Handicapped Patients". In this study pretest and posttest measures were taken. In the post test it was found that practice of relaxation helps the patient to reduce aggressive behavior. There was a reduction of 14.7 percent of aggressive behaviors in patients.

Techniques of constructing an anxiety hierarchy:

In this technique, clients are usually instructed to prepare a hierarchy of events or scenes which leads to anxiety, in descending order. The bottom of hierarchy contains scenes which leads to least anxiety and the top of which contain those events which lead to extreme anxiety. These scenes are those which either actually happened in the clients life or clients feared with the occurrence of those scenes.

Desensitization Procedure:

This procedure begins after when the clients develop mastery over the relaxation technique and ready with the list of anxiety provoking hierarchy. During the process of relaxation, the client relaxing himself by lying down on the sofa or coach and the instructor instructed the client to imagine the anxiety provoking scene. This will be repeated until the client feels relaxed by imagining that scene. After becomes comfortable with the least scene, the instructor introduced the next scene and repeat the procedure again. It continues until the client remains relaxed and vividly imagines the scene.

Flooding:

The history of flooding techniques indicates that, flooding techniques was originally developed by Thomas Stampfl during the year mid-1960s. Flooding and Systematic Desensitization, both are classified under exposure-based treatment methods. In former method, first the client is trained with relaxation method and then asked to image or expose to anxiety provoking stimulus. Whereas in the latter method client is directly exposed to the anxiety provoking situation until he will get rid of the fear and this will be done in the presence of the therapist. In this method therapist try to prevent the individual from escaping or avoiding the situation. For example, if the individual is extremely feared from balloons then the individual along with the therapist enter the room and stays there until the individual realize that balloons will cause no harm to the individual.

Implosion:

Implosion therapy is the variation of the Flooding and is developed by Stampfl and Levis (1967). In this therapy client is asked to imagine the anxiety provoking situation then the therapist adds to the situation. This addition may be unrealistic and may even not possible to happen in real life. He does this in order to increase the intensity of fear. For instance, if the person is extremely afraid of spiders may be ask to imagine a situation in which he cuts a bite of sandwich and a spider comes out. He adds the description like that spider is crawling inside your mouth and even biting your tongue.

Aversion therapy:

The aim of the aversion therapy is to lessen undesirable behavior. In this technique the undesirable stimulus (alcohol) is usually combined with discomfort (vomiting). This pairing usually leads the individual to reduce performing undesirable behavior. It can be helpful to reduce a number of problems like- bad habits, alcoholism, aggressiveness, smoking and gambling. For example, if the person is very fond of alcohol then the therapist require the client to have alcohol under the effect of nausea- inducing drug. Even the sipping of alcohol is followed by vomiting. This is repeated number of times and leads the individual to avoid alcohol because of unpleasant experience (vomiting). Aversion therapy is doubted because of its long term effectiveness. It may be effective in the therapist office under the influence of drugs or electric shocks but may not be as effective in the outside world where no drugs have been taken.

Operant conditioning:

Operant conditioning also recognized as instrumental conditioning is a form of learning through rewards and punishments. In Operant Conditioning the organisms study to associate behaviors and its consequences. The major academics for the expansion of *'operant conditioning'* are Edward Thorndike, John Watson and B.F Skinner.

Some of the other important techniques used in this approach to behavior therapy are-

Token Economy:

Token economy is a reward giving system designed for behavior modification to rise the desired behavior and decline the undesired behavior by the usage of tokens. In this system, tokens are provided to the child for each acceptable behavior and later on these tokens are exchanged for rewards. According to Kazdin 1977 "A reinforcement system, which is based on delivery of tokens are referred to as token economy." Token economy is widely used in classroom settings, juveniles and even in clinical settings. The most easily available reinforces are social reinforces like praise, touch, attention and smile. In this regard review of research conducted indicates that some people are less responsive to social reinforces (Patterson et. al. 1968, Wahler 1967).

T.F. McLaughlin (Spring 1981) demonstrated, *"the effects of a classroom token economy on math performance in an intermediate grade school class"*. He found the when students were given points for increased performance and decreased time for completion of work, then performance increased and time decreased whereas when points were given for reversed situation then the performance decreased and time for performance increased.

Modeling and observational learning:

Modeling is defined as the learning of new and complex behavior by only matching the behavior of model. Modeling is grounded on the social learning theory. This theory stressed the significance of learning from imitation by seeing the behaviors of models. Model can be real or symbolic one. Real models include parental figures, peers, authoritative figures, siblings whereas symbolic models involve characters in the cartoons, television shows, pictures. Modeling has been extensively used to treat phobias, attention deficit hyperactivity disorder, obesity, linguistic skills, and social skill deficit. According to Bandura (1971), practically all of the learning that people can acquire through their own direct experience could also be acquired vicariously

(that is, at second hand by observing someone else). The person observes a model (someone else) engaging in the behavior of interest, and observe the consequences of the model's behavior.

Painter, cook, silver man (1999) conducted study on, *"The Effects of Therapeutic Storytelling and Behavioral Parent Training on Noncompliant Behavior in Young Boys".* This study basically tried to find out the effectiveness of telling stories with behavioral parent training on the disobedient habits of boys. Two conductions were made. In the first conduction, followed by storytelling with one behavioral parent training and in second conduction this procedure was reversed. From the result of the study, it was found that both treatments tend to reduce noncompliance and frequency of disobedient behaviors in boys.

Summary:

From the present study we can conclude that Problem Behavior especially externalizing problems is on the upsurge among school going children. In school these problems are neglected by the teachers and even by parents at home, so there is an increasing need to focus on these problems and creating awareness among parents and teachers regarding these problems. We can also conclude that boys are at the greater risk of having these problems than girls. To minimize these problems Behavior Therapy proves to an effective one.

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