



Development Of A Psychospiritual-Based Tot Model To Treat Oppositional Defiant Disorder Children

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Abstract

Oppositional defiant disorder (ODD) is a persistent pattern of negativistic, hostile and defiant behavior without any serious violation of social norms or the rights of others. The most common symptoms of oppositional defiant disorder include the following: frequently losing control, frequently arguing with parents, frequently actively defying or refusing to comply with parental requests or rules, often deliberately doing other things to annoy others, and frequently blaming others because of his own fault. Treatment so far has emphasized more on changing children's behavior and has not paid attention to the psychospiritual aspects needed in dealing with children with resistive behavior disorder. This article aims to convey thoughts regarding the development of a psychospiritual-based ToT (Training of Trainer) model to treat children with symptoms of resisting behavior. Providing lifelong learning services to the community, various concepts regarding non-formal education have arisen to be held, many parties are discussing non-formal education which is considered as education that is able to solve various problems of community education services, one of which is with training activities. to acquire knowledge or skills. While spirituality itself is a way, related to certain emotions or behaviors and attitudes of an individual. Being spiritual means being open, giving, and lovi.

Keywords: Oppositional Behavior, Training of Trainers (ToT), Psychospiritual.

Introduction

Facing the problem of deviation of the child's behavior will not be solved if faced with a reactive and tough attitude towards the child such as scolding him, hitting him, pinching or grabbing. If this harsh and abusive action is carried out on the child, instead of changing the child's behavior but the child will resist both verbally and physically such as retaliating with harsh words, resisting with his limbs, showing non-verbal reactions such as frowning, glaring, moody, shutting himself up and crying loudly. Parents will experience failure to correct the problem of child behavioral deviations and the intensity of deviations will increase.

The problem of oppositional defiant disorder or oppositional defiant disorder or ODD is a continuous pattern of negativistic, hostility and oppose behavior in the absence of serious violations of social norms or the rights of others (Kaplan & Saddock, 1997). Diagnostic and Statistical Manual of The fourth edition of Mental Disorder (DSM IV-TR) mentions that oppositional opposing disorders fall into the group of deficit disorders – attention and disruptive behavior disorders (APA, 2000).

The most frequent symptoms of oppositional opposing disorder are the following: frequent loss of control, frequent arguing with parents, often actively opposing or refusing to obey parental requests or rules, often deliberately doing other things to annoy others, and often blaming others for their own mistakes. Whereas the DSM-5 divides these disorders in severity, mild, moderate and severe (APA, 2013).

Epidemiological research into negativistic traits in non-clinical populations found disorders between 16 and 22 percent of school-age children. Disorders are more common in boys than girls before puberty, and sex ratios are likely to be the same after puberty (Kaplan & Saddock, 1997).

In some countries such as Canada, Queensland, and New Zealand shows that around 5 – 7% of children have a behavioral disorder (Grainger, 2003). In the United States, experts agree that the prevalence of ADHD is 3% - 5% in the child population (APA, 2013)

In Indonesia itself, although there is no exact figure, from the number of children involved in legal crimes and delinquency, it can be predicted that quite a lot of children can be said to have behavioral disorders. Ekowarni (2003) stated that data from the Child Psychiatry unit (day care) of Dr. Soetomo Hospital Surabaya showed an increase (by 3.33%) in the number of ADHD pediatric patients with various characteristics from 2000 to 2001, from 60 children to 86 children.

Data on the number of ADHD children with various characteristics at Dr. Soetomo Hospital Surabaya during 2001 were 30 children with ADHD who were not accompanied by other disorders (32.96%), 15 children with ADHD and behavioral disorders (16.48%), 8 children with autistic spectrum (8.79%), 12 children with ADHD and epilepsy (13.19%), 13 children with ADHD and language disorders (14.28%), 6 children with ADHD and threshold limit intelligence (6.59%) and 2 children with ADHD and antisocial (2.20%). It is quite interesting to note that the percentage of children who have ADHD has increased over time. In psychiatric diagnostics, ADHD often has comorbidities with oppositional opposing disorders or ODD (Pliszka, 2009). The Indonesian Child Protection Committee (KPAI) noted that in at least 2013 there were 15 children per month as perpetrators of violence facing the law, in total until April 2015 there were 2006 cases. (KPAI, 2015)

The large number of children with behavioral disorders needs serious attention to be given the right intervention immediately. Many studies have shown that this behavioral disorder has a very detrimental impact, not only for children and adolescents who experience it but also for society. This occurs due to the lack of treatment from the side of parental care, especially in improving the interaction between parents and children as a preventive measure so that this defiant behavior disorder does not become a more serious behavioral disorder.

The child's life is largely determined by its existence through a form of support from the family, this can be seen if the family support is very good, the child's growth and development are relatively stable, but if the child's family support is not good, then the child will experience obstacles to himself that can interfere with the child's psychology (Alimul, 2005).

ODD is mostly caused by the daily care and care of parents besides it can also be caused by pathological factors in the growth and development of the child's brain and other psychosocial factors. Individual factors such as temperament and hormonal influences, family factors such as parenting and family stability and environmental factors such as the quality of peer relationships are contributing factors to ODD (Hairina, 2013)

Hertinjung (2010) revealed many factors involved in behavioral disorders, one of which is the pattern of parent-child relationships, especially mother-child relationships. The maladaptive pattern of mother-child relationships will increase the likelihood of the child facing many psychological disorders, and one type of mother-child maladaptive relationship is the high expression of maternal emotions expressed in the form of critical, hostile and emotional comments on the child's behavior.

Broadly speaking, therapies for children with defiant behavior disorders are distinguished over pharmacotherapy and non-pharmacotherapy. Pharmacotherapy is a treatment therapy for children who have problems with their behavior, physique and growth, while non-pharmacotherapy therapy is aimed at providing intensive stimulation of the emotional and behavioral aspects of the child. The effects of the pandemic led to the emergence of various emotional and behavioral problems of the child. Handling so far has emphasized more on changes

in children's behavior and not paying attention to the psychospiritual aspects needed in dealing with children with opposing behavior disorders.

On the basis of the above, researchers are interested in developing a Psychospiritual-Based ToT Model for Treating Children with behavior Resisting Disorders. This training was held by the Beloved Kanti Malang Child and Family Psychology Clinic, for prospective therapists who deal with children with defiant behavior disorders. In addition to the hard skills competencies taught, soft skills competencies are also provided for prospective therapists.

To complete the curriculum, it is considered important to include psycho-spiritual elements in the therapist's soft skills. The psycho-spiritual element can evoke and form a more responsible, sincere mental attitude, always being a learner and fortifying oneself from various improper handling practices. In addition, the therapist's understanding of psycho-spiritual can motivate parents to always be optimistic and enthusiastic in accompanying children.

Problem Formulation

How is the Development of a Psycho-Spiritually Based TOT Model to Deal with Behavior Disorders Opposite it?

Research Benefits

Benefits for the Development of Science

1. Increase the characteristics of science, especially about the handling of defiant behavior disorders.
2. Can be a reference for research in the field of child clinical psychology and spiritual psycho
3. Can inspire the development of soft-skills of prospective therapists opposing behavior disorders.

Benefits for Children with Defiant Behavior Disorder

1. More optimal and comprehensive treatment by therapists who meet the competencies of hard skills, soft skills and spiritual skills.
2. Minimize the possibility of malpractice in the treatment of defiant behavior disorders.

Benefits for Parents

1. Gain greater insight into child care
2. Give consideration to handling children comprehensively
3. Provide motivation in parenting and accompanying children

Literature Review

Training of Trainers (ToT)

Understanding

Providing life long learning services to the community, various concepts about non-formal education emerge to be held, many parties discuss non-formal education which is considered as education that is able to solve various problems of community education services, one of which is with training activities. The term training is inseparable from training because the two have a close relationship, practice is an activity or work of training to acquire proficiency or proficiency.

Meanwhile, the purpose of training activities is to improve one's knowledge and skills so that those who are trained get knowledge and skills in dealing with the problems faced according to the expectations and goals desired to participate in training activities.

Goldstein and Gessner (1988) in Kamil (2010, p. 6) define training as a systematic effort to master skills, regulations, concepts, or ways of behaving that have an impact on improving performance. Furthermore, according to Dearden (1984) in Kamil (2010, p.7) which states that training basically includes the process of teaching and learning and training aimed at achieving a certain level of competence or work efficiency. As a result of the training, participants are expected to be able to respond appropriately and according to certain situations.

Sastrodipoera (2006) in Kamil (2010, p.152) gives the definition of training as "one type of learning process to acquire and improve skills outside the human resource development system, which occurs in a relatively short time with methods that prioritize tactics over theory".

Furthermore, Sastra dipoea (2006, p.121) mentions also that training can be considered as a process of conveying knowledge, skills, and coaching attitudes and personalities. Based on the opinions of experts that have been stated above, it can be concluded that training is a form of assistance in an organized and systematic learning process with a relatively short period of time to improve the knowledge and skills of trainees that are practical in nature in order to achieve certain goals.

Furthermore, the transfer of training is a very important process in this ToT. There are not many studies that show intervention efforts in improving the transfer of training through individual internal factors. One of the studies that illustrates this is that carried out by Machin and Fogarty (2004), which showed that the intention to implement training results was influenced by self-efficacy before training as well as learning outcomes and activities to increase the transfer of training during training.

Tan (2002) found that the orientation of learning goals, whose construct is based on intention, is significantly related to post-training behavior. One of the important outcomes of training is the intention to implement it (Machin & Fogarty, 2004), in the form of detailed action plans that include a determination of when, where and how the action will be carried out. The action plan itself is a statement of stated intention or intention (stated intention). As Sniehotta, Schwarz, Schulz, and Schüz (2005) argue, planning is necessary as something of great value in the process of behavior change because it bridges the intention of behavior and its actual behavior.

Purpose and Objectives of Training

Mills in Artasasmita (1987, p.20) states that the purpose of training is to help trainees acquire skills, attitudes, and thinking habits efficiently and effectively. The understanding of the purpose of the training clearly reveals that training must be a means of meeting the needs of trainees to be able to develop skills, knowledge, attitudes that can be utilized by trainees after attending the training in accordance with their competencies as an effort to develop a business.

Meanwhile, according to Marzuki in Kamil (2010, p. 11) there are three main objectives that must be achieved by training, namely:

- a. Meet the needs of the organization.
- b. Gain a complete understanding and understanding of work with established standards and speed and under normal and safe circumstances.
- c. Assist the leaders of the organization in carrying out their duties.

In addition to the goal, some experts put forward their opinions regarding the benefits of training. M. Saleh Marzuki (1992, p.28) explains the benefits of training as follows:

- (a) Training as a tool to improve the appearance / ability of individuals or groups in the hope of improving the performance of the organization
- (b) Certain skills are taught so that employees can carry out tasks according to the desired standards

With the description above, it can be concluded that getting changes in attitudes, knowledge, and skills that have been obtained from the training implementation process. As well as being useful for trainees in improving performance in tgas or jobs that have become their responsibility.

Training Components

In a training event there are several components that are interrelated with each other. Training components are factors that affect the quality and quality of a training and are the main key in compiling a training program. Seen as a system, Sudjana (1996) in Kamil (2012, p.21) puts forward the following components of training:

- a. Instrument input

That includes all resources and facilities that support learning activities. Input means in this training include curriculum, training objectives, learning resources, learning facilities, costs needed and training managers.

b. Raw input

Namely trainees with various characteristics, such as knowledge, skills and expertise, gender, education, learning needs, socio-cultural background, economic background and study habits.

c. Environmental input (environment input) That includes environmental factors that support the implementation of training activities, such as training locations.

d. Process

Namely educational interaction activities that occur in the implementation of training activities between learning resources and learning residents of trainees.

e. Output (output) That is graduates who have experienced the learning process of training.

f. Other inputs

Namely the carrying capacity of training implementation, such as marketing, employment, information and the developing socio-cultural situation.

g. Influence (impact) That is related to the learning outcomes achieved by trainees, which includes improving the standard of living, further teaching others, and increasing participation in social activities and community development.

Principles of Training

Training is part of the learning process and is an activity to improve one's skills in doing something. According to William B. Werther, the principles of training are as follows:

- a. The Principle of Learning Participation will usually be faster and more lasting if participants learn to be actively involved. Participation will increase motivation and empathy for the learning process. With in-person engagement, participants can learn faster and understand it longer.
- b. Principle of Repetition Repetition will reinforce a pattern into one's memory. Learning by repetition of the key keys of ideas will easily be recalled when necessary.
- c. Principle of Relevance Learning will be more effective if the material studied is meaningful or has relevance to one's needs.
- d. Principle of Transfer of Knowledge and Skills The closer the needs of the training program Come into contact with the needs / implementation of the work, the faster a person will learn to master the work. In other words, the transfer of knowledge and skills can occur due to the application of the theory in a real situation or due to practice of a simulated nature. This means that the knowledge and skills gained in the simulation can be easily transferred in the actual situation.
- e. Feedback Principles Through the feedback system, trainees can know whether the training objectives are achieved or not. That is, with feedback the participant is motivated to know the changes that occur in him, both abilities, skills, and personality and motivated to customize their behavior with the demands of competence

Training of Trainers

This ToT (Training of Trainer) program was compiled by Amelia Azis Daeng Matadjo, a clinical psychologist and parent of children with special needs. The program consists of core programs, governance programs and supporting and practical programs. The total number of hours is about 20 hours combining the scientific principles of clinical psychology, behavioral psychology and various empirical experiences as a clinical psychologist. This program has been carried out since 2015 and has graduated 3 batches. Along with the increasing need for training for prospective therapies, this Tote needs to be developed by adding psycho-spiritual elements.

Defiant Behavior Disorder

According to the DSM-5 (APA, 2013) oppositional defiant disorder (ODD) is a pattern of anger or irritable, argumentative/ defiant, or revenge mood that lasts at least 6 months as evidenced by at least four symptoms from one of the following categories, namely anger / irritable mood that appears to be a symptom (1) frequent loss of patience, (2) irritable or irritable and (3) irritable. Argumentative/oppose that appears to be a symptom of (4) often opposing authority figures,

children in adults, (5) often actively opposing rules or requests of authority figures or regulations, (6) deliberately disturbing others, and (7) often blaming others for the mistakes they make). Visible vindictiveness in the form of symptoms (8) often grudges at least twice in the last six months). This circumstance is shown as long as the individual interacts with at least one individual who is not a brother. The DSM-5 complements by dividing the severity of the disorder including mild, moderate and severe. The severity of this disorder is made based on the setting of the event, where the degree of mildness if the symptoms only occur in one setting (home, school, workplace or with peers). Medium degree when occurs in at least two settings and heavy degree when occurs in three or more settings. (APA, 2013).

For the diagnostic criteria of oppositional opposing disorders, eliminating the exclusive criteria of behavioral disorders (Frick, 2012), of particular relevance to the DSM-5, this diagnosis cannot be given if it meets the criteria for behavioral disorders. (Pardini & File, 2010; White SF, 2013). Whereas Ford, (Quy & Stringaris, 2012) states that oppose oppositional disorder in general is associated with a substantial decline for children and their families and with various worse adjustment results to subsequent development.

Chronic ODD almost always interferes with interpersonal relationships and school performance. Children are often without friends and view human relationships as unsatisfactory. Despite having adequate intelligence, they are bad or fail at school, because they do not participate, defy outside demands and persist in solving problems without the help of others. (Kaplan & Saddock, 1997). When examined in depth, it will be seen that children's behavior has excessive intensity and frequency. The duration of his behavior also lasts longer than that of normal children of his age. (Mahabati, 2006; Diller, 2009)

Psychospiritual

1. Tischler (2002) says that spirituality is similar or in a way, related to certain emotions or behaviors and attitudes of an individual. To be a spiritual person is to be an open, giving, and loving person.
2. Schreurs (2002) gives the notion of spirituality as a personal relationship to the transcendent figure. Spirituality includes the inner life of the individual, idealism, attitudes, thoughts, feelings and expectations of the Power.
3. Ashmos (2000) defines spirituality in the workplace as an introduction that employees have an "inner life" those nurtures and is nurtured by meaningful work that takes place in a community context.
4. Tischler (2002) i.e., spirituality as a thing related to certain behaviors or attitudes of an individual, being a spiritual person means being an open, giving, and loving person.

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