

Context

Josh, a student in a second grade classroom, has been diagnosed with ADHD, but accompanying ODD is suspected. The student is new to the building but not the district. The second grade class Josh is a part of has a total of twenty-four students, six of whom are considered "at-risk". Josh does not currently have an IEP. He has been on several different medications without much success. He currently takes Focalin. The suburban school district includes a mix of rather affluent families, middle-class families, and low-income families whose students come from a neighboring district under school of choice. Josh is from an in-district, middle class family.

He lives in two different homes since his parents' divorce when he was in kindergarten. Each parent has taken a live-in significant other with children of their own. Josh has one other natural sibling who is not yet school age. Josh is on a varied and rotating schedule of whose house (mom or dad's) he stays at. His parents employ vastly different parenting and disciplining techniques. While his mother follows a permissive parenting style and is quite soft-spoken, his authoritarian father has strict rules and even stricter consequences.

Problem

The student lives in an environment in which ADHD and possible ODD problems are aggravated. Thus the behaviors (off task and sometimes dangerous) exhibited in the school environment inhibit the student's and other students' learning.

Course Research Findings

The course content overviews helped to summarize and better define ADHD, which Josh has been diagnosed with. In the "Introduction" page, the prevalence of the disorder is discussed along with the reality of its demands on the classroom teacher. In a typical class of 25 to 30 students, statistically there will be at least one student with ADHD. It is "often one of the most frustrating conditions for general education teachers to confront. Students with ADHD can be impulsive and hyperactive, they often have poor social skills, and they can be disruptive citizens of the classroom" (Okolo, 2009). This was indeed the case with Josh. He was hyperactive and quite disruptive to himself and those around him.

On the page "Characteristics of Children with ADHD", the defining features are listed as hyperactive, impulsive, and inattentive (Okolo 2009). Josh struggles in each of these areas. His hyperactivity and impulsive behaviors have led him to run around in the classroom and even grab playground balls and start bouncing them at inappropriate times. His inattentive tendencies caused him a great amount of difficulty when attending to lessons and directions due to the distractions of other students around him or various environmental distracters.

Another resource that helped to define ADHD was the video, *ADHD Help Video #3 ADHD Facts*. This informative video debunks some of the common myths about ADHD such as the theory that it is caused by bad parenting and the idea that it does not occur in females. It also explains that it has a biological cause, is common in families where there is one diagnosed member with the condition, and those with the condition cannot be "disciplined out of it". Finally, individuals with the condition can find it hard to empathize ("Help video #3," 2009). I found this to be true of Josh. He had a difficult time putting himself in someone else's shoes and understanding (or seeming to care) how his behavior effected others.

The National Institute of Mental Health's informative booklet on ADHD helped not only to define the disorder, but also mentioned possible coexisting conditions such as oppositional defiant disorder. According to this resource, coexisting conditions may include a learning disability, oppositional defiant disorder, conduct disorder, anxiety and depression, bipolar disorder, and Tourette syndrome (National Institutes of Mental Health, 1996). I found in working with Josh that the popular behavior management technique of ignoring misbehaviors in order to diminish them had quite the opposite effect. He would instead test the limits and continue a disruptive behavior to

the point of throwing furniture. This led me to further research the possibility of an accompanying oppositional defiant disorder and how I might better serve his needs under this possible condition.

The article from the United States Department of Education titled *Teaching Children with Attention Deficit Hyperactivity Disorder: Instructional Strategies* further confirmed that the co-morbidity of conduct or oppositional defiant disorder which ranges from 43 to 93 percent. The article goes on to suggest a three pronged approach to instructing students with ADHD. These include academic instruction, behavioral interventions, and classroom accommodations. In the academic arena, lessons should be carefully structured within the context of previous lessons and with clear expectations for learning and behavior laid out from the beginning. Detailed additional aspects for the lesson and ways to help in each particular subject area are explored in the article. For behavioral intervention, teachers should use verbal reinforcement or praise for appropriate behavior, specifically naming what was done well. These statements should be immediate, varied, consistent and sincere. The article recommends behavior contracts or behavior plans and systems of rewards as well. Changes that can be made to the classroom for students with ADHD include special seating arrangements, including near the teacher, a helpful role model, or in an area with few distractions, and using certain tools, such as pointers, egg timers, adjusting the lights, music, and properly used and sized furniture (United States Department of Education, 2004).

Another practical resource with interventions for how to better serve Josh's needs was a link from the course website section, "Educational and Behavioral Interventions". The link on this page sites the following as possible interventions for home or school where applicable. One can employ "listening cues" such as "listen up" before speaking or giving directions. Many kids with ADHD will do better if they know that every day they can play at a certain time, so do certain chores at a certain time, homework at another time, and eat and sleep at a predictable time. This lessens the need to pay as much attention. Make sure the child has sufficient sleep and a regular bedtime. Provide structure, even during unstructured time such as recess. When utilizing behavior modification, target specific behavior, be consistent, individualize and use non monetary and non material rewards, strike a balance between reward and punishment, and make sure it is simple enough for the child to fully understand it. To improve social skills, involve the child in a group that is structured, thematic, geared to the child's interest, fun, and not a burden for the parent ("Non-medical interventions for,").

Additionally, sugar has been shown to have *no* influence ADHD; however, some preservatives and dyes *have* been shown to worsen the condition. Also, all of the following can affect a child with ADHD: a parent who is absent a lot, inconsistent, drinking, preoccupied with other problems, gives in too easily to the child, hard, cruel or abusive, fighting between parents, multiple significant others, custody battles, unequal authority of parents, certain children having greater authority than a parent. Family therapy is a solution should any of these conditions exist ("Non-medical interventions for,").

Again, from course content page Alternatives: Classroom and Tech Modifications (Soco1, 2007) the link to the article entitled *ADHD- Changing the School Environment*, recommends several alterations teachers can make in their classrooms to help students with ADHD. These include: allowing the student some free time at the start of the day to "collect" him or her-self, wearing a ball cap to focus attention and minimize distractions, use a phone for alarm reminders, note taking etc., make desks and chairs optional, allow student to "get away" if they need to step out for a minute so they can re-approach a situation or a task, use text-to-speech software, use software to speed up reading tasks instead of giving unlimited time on tests, and for parents at home-- don't insist on homework being completed immediately after school (Soco1, 2007).

Author Robert Reid, of *Attention Deficit Hyperactivity Disorder: Effective Methods for the Classroom*, describes four areas of accepted interventions including educational accommodations, promoting appropriate behavior, medical management, and ancillary support for children and parents (support groups etc). The article focuses on educational accommodations and promoting appropriate behavior. He offers practical guidelines for how to implement an ordered, well managed classroom including physical set up of the classroom. One example of a

solution he provides for an ADHD student is to have a standing desk or several work areas including a standing desk and study carol. Keeping students on track may also be helped by ensuring students have the necessary materials to complete the task, the difficulty is at the student's independent level or can be completed with 90% accuracy, the task is not too long requiring an extended attention span, and feedback should be frequent. Teachers can help keep students engaged with short lessons that incorporate students' interests. In regards to behavior modification, students should receive feedback (positive or negative reinforcements) immediately following behavior. Specific interventions for behavior include the techniques of response cost, time-out, token economy, peer tutoring, school-home notes, self-regulation techniques, self-monitoring, and self management (Reid, 1999).

Finally in considering ways to help Josh, one must also consider the other students in the class. His behavior currently affects them, and thus it is likely that the interventions will affect them in one way or another. The article *Classwide Interventions for Students with ADHD: A Summary of Teacher Options Beneficial for the Whole Class* describes some of the ways this is possible. It provides a menu of options that can be applied to the whole class including contingency management, therapy balls, self-monitoring, peer monitoring, instructional choice, class-wide peer tutoring, instructional modification, and computer-assisted instruction. Another benefit of this method is that it provides the specific student for whom it is intended with a level of anonymity while benefiting the entire class (Harlacher & Roberts 2006).

Further Research Findings

Motivating the Child with Attention Deficit Disorder by Rick Lavoie noted that it is in a child with ADHD's nature to absolutely need stimulation (as one requires oxygen). If this need is not met, he asserts that the child will create stimulation for themselves. Thus the key to motivating them is to create that stimulation in the learning environment. Influencing factors may include the child's level of interest in the activity, the degree of difficulty of the activity, and the duration of the task. Also, collaborative tasks have a higher likelihood of providing stimulation than individual activities. Tasks should not be long and feedback should be immediate (Lavoie 2007).

Emedicine defines Attention Deficit Hyperactivity Disorder with specific breakdowns of the disorder, history, treatment, and description of the various medications, dosages, and side effects (Montauk, 2009). Particularly, Josh's medication and its specifics were listed here. Having this background knowledge about his existing diagnosed condition, I looked to the same source for some more information about oppositional defiant disorder.

Emedicine offered a definition of ODD as "a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months". After this definition it gave further symptoms and went on to discuss its prevalence and co-morbidity (a rate of 50-65% with ADHD). Finally, treatment options and suggestions were provided (Tynan, 2008).

Targeting Home-School Collaboration for Students with ADHD by Candace S. Bos et al stresses the importance of a strong connection between teachers and parents when collaborating over students. This can be especially helpful in the development of the behavior plan, monitoring medication levels, and coordinating homework (Bos, Nahmias, & Urban, 1999).

The website "Attention Deficit Disorder Resources" published an interesting article entitled *Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) in Children and Adolescents: Diagnosis and Treatment* by Jim Chandler. This article clearly outlines each of the disorders, how they are defined, diagnosed, and both medical and non-medical treatments. Many of the same recommendations that were made for students with ADHD are made for students with ODD and CD such as limiting TV and video games, discovering the child's interests, etc. The article also made a note about safety and how to make sure that everyone around the child feels safe and not worried that the child may overreact when told "no" and hurt someone (Chandler, 2002). Josh has had this tendency, reacting in dangerous ways when things did not go his way, and so this was of particular interest.

The article *Parenting Practices and Attention-Deficit/Hyperactivity Disorder: New Findings Suggest Partial Specificity of Effects* by Brandi Ellis, M.A. and Joel Nigg, Ph.D. studies a link between ADHD and ODD/ CD behaviors and parenting including discipline and involvement. The study noted that it has been shown that parenting practices with ADHD have been shown to exacerbate disruptive disorders. This study was intended to clarify if ADHD and behavior disorders shared similar parenting factors. One of the clearest results of the study was that fathers, especially those who practiced inconsistent discipline, had the strongest link to ADHD (Ellis, & Nigg, 2009).

The article *Family Correlates of Oppositional and Conduct Disorders in Children with Attention Deficit/Hyperactivity Disorder* again supported the high co-morbidity of behavior disorders with ADHD. And while the causal relationship is yet debated, the fact that the two coexist is clear. The study recommends enriching attachment and involvement of families as a help (Pfiffner, McBrnett, Rathouz, & Judice, 2005).

The article entitled *The Educational Implications of ADD/ ADHD* by Roberta Weaver and Mary F. Landers, defined the disorder, made recommendations for serving this population (and under what legislation) and discussed educational responsibilities and strategies and interventions. The four areas of intervention are environmental management, instructional accommodations, student-regulated strategies and medical management (Weaver, & Landers, 1998).

Action Plan

Step one: Considering ODD

Oppositional Defiant Disorder, defined in a number of resources, is best explained in the following definition by emedicine: “The American Psychiatric Association’s *Diagnostic and Statistical Manual, Fourth Edition (DSM IV)*, defines oppositional defiant disorder (ODD) as a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months” (Tynan, 2008). In my experience working with Josh, this was most certainly the case. The implications of this disorder are twofold. One, that family relationships play a large part in the exacerbation of the disorder, and two, that this effects treatment and intervention. Emedicine’s description of ODD notes that the family may contribute to ODD: “Family instability, including economic stress, parental mental illness, harshly punitive behaviors, inconsistent parenting practices, multiple moves, and divorce, may also contribute to the development of oppositional defiant disorder” (Tynan, 2008). Of these factors, Josh has been affected by harshly punitive behaviors, inconsistent parenting practices between households, multiple moves between households and schools, and divorce. Research by Brandi Ellis, M.A., and Joel Nigg, Ph.D. again confirm a correlation between the family and behavior disorders: “recent conceptions suggest that parenting responses to ADHD may contribute to exacerbation into major disruptive disorders. A better understanding of unique relations of parenting practices to ADHD may thus inform prevention as well” (Ellis, & Nigg, 2009). Beyond the point of prevention in Josh’s case, I would recommend he be evaluated for the disorder, continue on medication for ADHD, and receive family counseling.

Step two: Medication

In terms of medication, emedicine recommends the following treatment, “given the high probability that oppositional defiant disorder (ODD) occurs alongside attention disorders, learning disorders, and conduct disturbances, an evaluation for these disorders is indicated for comprehensive treatment. Pharmacologic treatment (eg, stimulant medication) for ADHD may be beneficial once this is diagnosed” (Tynan, 2008). Another consideration with medication, and a strong reason for the importance of a good home to school connection, is the possible side effects. According to LD Online’s article *Targeting Home-School Collaboration for Students with ADHD* by Candace S. Bos, “Home school collaboration is an important key for the success of students with ADHD. Communication fosters common language and consistent expectation and engages students, parents, and teachers” (Bos, Nahmias, & Urban, 1999). This common language will be important when communicating concerning medication and behavior plans. With Focalin, the prescription medication for ADHD Josh is currently taking, the “adverse effects include nervousness, insomnia, decreased appetite, abdominal pain, and weight loss” (Montauk, 2009). Of these effects, Josh has complained of trouble sleeping, stomach aches and he has shown a

decrease in appetite, sometimes not eating any or very much lunch. With a strong school to home connection, these factors may be relayed to the family and physician to adjust the dosage. While I am not usually in favor of medicating, since Josh is currently taking Focalin and stimulant medication is helpful for ODD as well, in this case I would recommend his parents continue with the medication given that there is frequent communication between school, home, and physician.

Step three: Seek family counseling

Since family counseling has been recommended for both conditions, ADHD and ODD, I would strongly suggest his parents consider enrolling in family counseling. Although as the video, *ADHD Help Video #3 ADHD Facts*, clearly states, ADHD is not *caused by* bad parenting; certain aspects of the family life may certainly aggravate an existing condition ("Help video #3," 2009). According to the website link on the course page "Educational and Behavioral Interventions", "Many studies have clearly shown that what happens between family members can worsen ADHD or improve it" ("Non-medical interventions for,"). In Josh's case, many factors such as instability, parents fighting, divorce, and significant others, contribute in a negative way to the effects of his ADHD. The effects of these family situations may be lessened by the help of family counseling. In the article *Family Correlates of Oppositional and Conduct Disorders in Children with Attention Deficit/ Hyperactivity Disorder*, the benefits of family counseling may reach beyond just managing the behavior: "The clinician faced with treating ADHD with comorbid disruptive behavior disorders may be able to help families in ways that go beyond increasing structure and managing disruptive behavior. Enriching the quality of attachment and involvement using strategic activity prescriptions... and using other methods of enhancing family environments may add specific therapeutic value to other components of a comprehensive plan to treat ADHD and its comorbid behavior problems" (Pfiffner, McBrnett, Rathouz, & Judice, 2005).

Step four: Create a consistent behavior plan

The website www.addressources.org, speaks to ODD and its treatment: "There are hundreds of psychological techniques that have been tried, but no specific ones have been found to be always successful. They involve behavior modification, working with families, and tight supervision. The best results have been found with what is called "multi-system therapy". This means providing a lot of different actions at the same time. It means you should not rely on just one type of intervention" (Chandler, 2002). Thus, in considering non-medical treatment options, more than one action is important. The first of these is the development of a behavior plan. According to the United States Department of Education article titled *Teaching Children with Attention Deficit Hyperactivity Disorder: Instructional Strategies*, for behavioral intervention, teachers should use verbal reinforcement or praise for appropriate behavior, specifically naming what was done well. These statements should be immediate, varied, consistent and sincere. The article recommends behavior contracts or behavior plans and systems of rewards as well (United States Department of Education, 2004). Thus while implementing the behavior plan for Josh, consistent language and praise was used to help support positive behaviors. On the course page "Educational and Behavioral Interventions", the link on this page recommends using "listening cues" such as "listen up" before speaking or giving directions. This technique was used while implementing the behavior plan to make certain that Josh was listening when directions were given. When utilizing behavior modification, the website directed users to target specific behavior, be consistent, individualize and use non monetary and non material rewards, strike a balance between reward and punishment, and make sure it is simple enough for the child to fully understand it ("Non-medical interventions for,"). In coordination with the school social worker, the individualized behavior plan developed for Josh targeted one specific behavior at a time. The first was not to throw things. For every half hour block he was able to accomplish this goal, he would receive a star on his chart. If he earned a certain number of stars in a day, he would be allowed to eat lunch with the principal (whom he adored). If he did not earn a certain minimum number of stars, he would not be able to eat lunch with his friends and would have to eat alone. This balance of reward and punishment helped to further motivate him. This behavior plan was reviewed in person, in full detail, with both his parents so that they could consistently enforce the plan at home as well (with a slight variation on the rewards and privileges to fit the home environment).

Step five: Make changes in the school environment

LD Online's article *Motivating the Child with Attention Deficit Disorder*, stimulation is key. In order to prevent undesirable behaviors, it was important to keep Josh motivated and engaged. The article mentioned that tasks must be appropriate in difficulty, duration, and feedback must be timely (Lavoie, 2007). In order to avoid frustration and prolong engagement, some of the techniques provided in Ira Socol's blog proved helpful. The changes implemented for Josh included allowing him some free time to start the day so he could regroup from the morning rush out the door and whatever may have occurred on the bus and on the way into school. Desks and chairs were made optional. Josh was allowed to "get away" when he felt overwhelmed (Socol, 2007). Sometimes he would become exceedingly upset over a situation and would not know how to handle it (other than throwing or acting in some other dangerous way). Thus, when this occurred, he would show the teacher an "angry card" that would allow him to walk down to the social worker's office to talk about it. One area of particular academic frustration for Josh was writing. According to emedicine's definition of ADHD, it may adversely affect one's ability to plan, organize, and remember details in the working memory or short-term memory (Montauk, 2009). Since these are all necessary functions to effective writing, the process was inordinately frustrating for Josh. Using speech to text for technology for writing allowed him to circumvent these demands as well as his perfectionist tendencies and get his thoughts down. Finally, using self-monitoring for the whole class benefited not only Josh, but the entire class. In the article *Classwide Interventions for Students with ADHD: A Summary of Teacher Options Beneficial for the Whole Class*, the strategy of self-monitoring is explained and recommended for whole class use. In this strategy the student rates themselves on a scale for a desired behavior. Points are awarded for how closely their rating matches the teacher's rating (Harlacher, 2006). This strategy was useful for Josh's self-monitoring as well as the other students in the second grade class who are still learning appropriate school behavior as well being so young.

Conclusion

In my research I found the course resources to be exceedingly helpful in the defining and better understanding of the current circumstances surrounding Josh's ADHD. These resources were helpful for possible nonmedical interventions. These resources also suggested the possibility of a coexisting condition: ODD. Additional research provided clarification of the disorder and possible treatment options. With these resources in mind, the proceeding plan for action naturally developed. Josh was evaluated for oppositional defiant disorder, a solid school to home/home to school communication avenue was established and it was recommended that the family enroll in family counseling and continue with Josh's Focalin medication, a behavior plan was developed and implemented, and finally, changes to the school environment were made.

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