

Brandon K. Schultz, Ed.D., NCSP Associate Professor East Carolina University





SchoolPsychologyTech.Org

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HOME

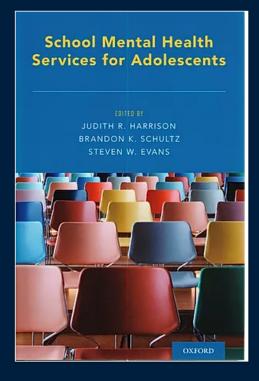
VITA

BLOG

PRESENTATIONS

RESOURCES

SchoolPsychologyTech.Org is a website dedicated to the use of technology to support best practices in school psychology. The content is based on the work of Dr. Brandon K. Schultz, associate professor at East Carolina University, and director of the school behavior consultation lab (bio below). We use this site to announce our work, summarize important findings, and provide free resources directly to teachers and school psychologists. Dr. Schultz's scholarly work is summarized in the two volumes below.



School Mental Health Services for Adolescents

This volume provides a range of expert guidance on implementation of school mental health services in secondary schools. The significance of this information cannot be overstated, as only 20% of children and adolescents who need such services receive them. Schools are a logical venue for service provision because emotional and behavioral problems interfere with academic achievement, and a lack of access to mental health services is a major barrier to treatment for youth. Authors discuss services that can be implemented by school-based professionals and methods of overcoming implementation barriers. Chapters cover the history and need for services, issues of identification and referral for treatment in schools, descriptions of evidence-based interventions, proposed service delivery models, assessment strategies, and integration of mental health programs in schools.

BUY IT NOW

All materials discussed today will be available on my website:

SchoolPsychologyTech.org

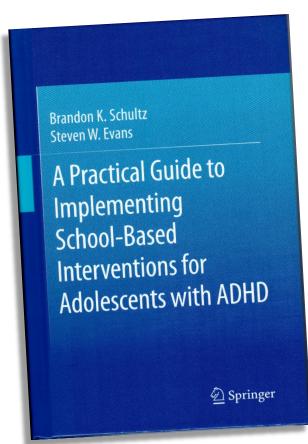
Go to the Resources tab for downloads

My Background: Challenging Horizons Program

(Schultz & Evans, 2015)

 Middle school treatment program for young adolescents with ADHD (started in 1999)

- Interventions
 - Organization of time, materials, and assignments
 - Academic enablers (note taking, study skills)
 - Interpersonal skills
 - Parent training
- Formats
 - After school program
 - Integrated model
 - High School
 - Mentoring" program ← Behavior consultation



Overview for Today...

• Four Sections:

- DSM-5 Diagnosis of ADHD: Special Considerations
- Cost-effective Assessment Materials to Inform ADHD Treatments

Morning

Afternoon

- Common Elements of Successful Psychosocial Treatments
- Flexibility within Fidelity: Making Interventions Work IRL

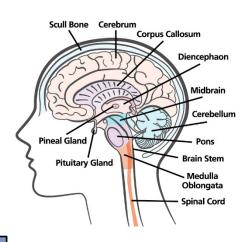
• Three Objectives:

- Examine the developmental trajectory of ADHD and its implications
- Explore the most promising psychosocial strategies for children 5-18yrs
- Anticipate barriers to successful implementation and plan modifications

DSM-5 Diagnosis of ADHD: Special Considerations

Implications of Developmental Trajectory

How Reductionistic Should We Be?





At the neuropsychological level, group differences emerge on specific tasks (e.g., spatial memory, set shifting), but lack sensitivity/specificity.



At the neurological level, there are clear differences between ADHD and normal peers, but tests are not sensitive/specific enough (or cost effective) for Dx or Tx monitoring.

At the genetic level, some candidate genes appear associated with ADHD, but only explain a very small proportion of variance.



To date, most knowledge of ADHD rests on symptoms and impairments in natural settings; i.e., phenotype

DSM-5 Definition & Prevalence

(APA, 2013)

- Attention Deficit Hyperactivity Disorder (ADHD) is the current terminology
 - Includes both "Predominately Inattentive" and "Combined" (inattention & hyperactivity) Presentations (formerly "subtypes")
- Thought to afflict roughly 5% of the population, with boys more commonly diagnosed than girls, at a ratio of about 2:1

Inattention: 6 or More:

(APA, 2013)

- Fails to give close attention to details
- Has difficulty sustaining attention in tasks
- Does not seem to listen when spoken to
- Does not follow through on instructions / fails to complete work

- Has difficulties organizing tasks and activities
- Avoids/dislikes tasks that require sustained mental effort
- Loses things necessary for tasks
- Distractible
- Forgetful in daily activities

Hyperactivity/Impulsivity: 6 or More:

(APA, 2013)

- Fidgets with hands or feet / squirms
- Leaves seat in class-room / other places
- Runs about / climbs excessively (restless)
- Has difficulty playing quietly
- Often "on the go" or acts as if "driven by a motor"

- Often talks excessively
- Blurts out answers before question is asked
- Has difficulty waiting for turn
- Interrupts or intrudes on others (butts into conversations or games)

DSM-5 Diagnostic Concerns

(APA, 2013)

- <u>Behaviors</u> (previous slides) must:
 - Be present for 6+ months & be present before age 12 (formerly AOC = 7)
 - Cause significant impairment in social, academic, or vocational functioning
 - Not better accounted for by another mental disorder, such as anxiety disorders or schizophrenia
- Several Symptoms must occur in two or more settings

The <u>impairments</u> caused by ADHD are predictive of long-term outcomes.

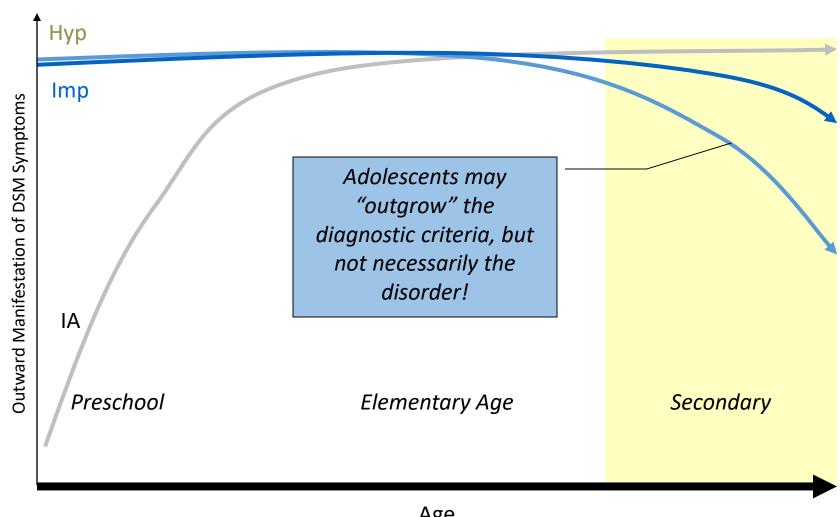
Developmental Changes over Time

(Evans, Vallano, & Pelham, 1995)

- Children often do not "grow out" of ADHD when they reach adolescence
 - For most, in fact, the symptoms persist
- However, the nature of the disorder changes in adolescence
 - Adolescents are less likely to be hyperactive, but they may appear "restless"
 - Adolescents are also generally less impulsive, except in cases of conduct disorder (delinquent behaviors)

Change over Developmental Periods

(Adapted from Barkley, 2006)



Social Skill (Performance) Deficits

(Dumas, 1998)

- Children with ADHD are more likely to exhibit the following social problems
 - Communication problems
 - tendency to be intrusive or to speak excessively at inappropriate times
 - dysfluent speech patterns
 - Deficient social problem-solving skills
 - interferes with the child's ability to generate appropriate responses in social situations
 - more likely to anticipate positive outcomes for aggressive behavior

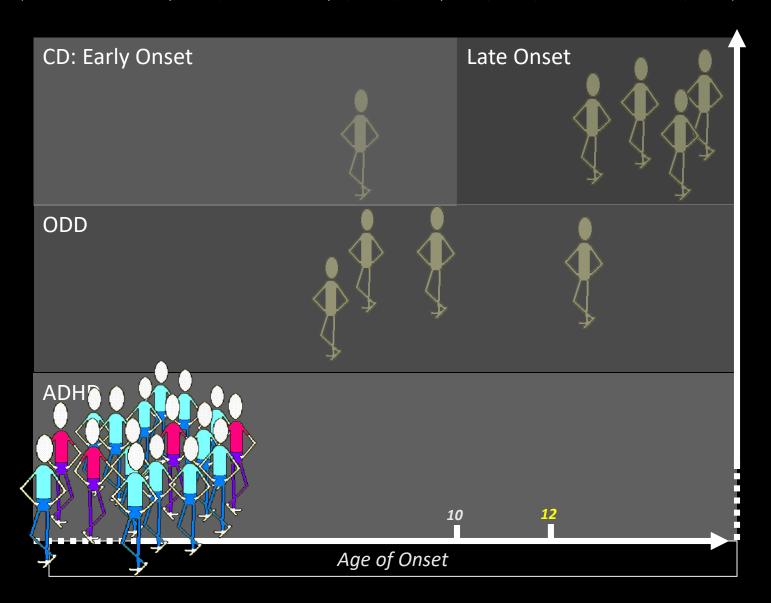
Disrupted Relationships with Adults

(Edwards, Barkley, Laneri, Feltcher, & Metevia, 2001)

- ADHD is associated with parent adolescent conflict, especially when ADHD is accompanied by oppositional behaviors:
 - Impacts mother/child relationship most
 - Parents use more aggressive tactics that increase in severity over time
- <u>Inconsistent</u> parental discipline is highly predictive of conduct problems in families of adolescents

The Result? DBD Trajectory

(Becker & McCloskey, 2002; Greene & Doyle, 1999; Lahey et al., 1998; McMahon & Kotler, 2006)



Summary for Section I

- The DSM-5 criteria for ADHD do not accurately reflect the developmental changes observed over time
- The DSM-5 ignores many cardinal features of ADHD, including poor social problem solving, which clearly complicate treatment
- The impairments associated with ADHD are most predictive of longterm outcomes and, as such, are the best targets for intervention

DISCLAIMER: I have no financial interest in any of the instruments that I will highlight in this section and do not recommend these specific instruments over others. My goal here is simply to show options that are readily available and affordable for practitioners.

Cost-Effective Assessment

Remaining sensitive to the developmental trajectory

What's Needed for an ADHD Diagnosis?

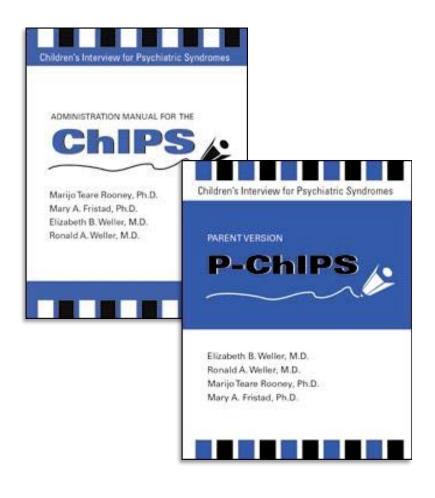
What does this give you?

A comprehensive evaluation includes:

 Diagnostic Interview with Caregiver
 Rating Scales from Parents and Teachers
 Academic History (i.e., school records)
 Classroom Observation and/or Analogue Assessment
 Rule out rater bias
 Academic assessment (i.e., achievement test)
 Cognitive assessment (i.e., "IQ" Test)
 No help (unless ID is suspected)

Diagnostic Interviewing for ADHD

(Weller, Weller, Rooney, & Fristad, 1999)



P-ChIPS/ChIPS:

- Offers screening items for common DSM disorders, followed by in-depth items (fast admin.)
- Scoring booklets are low cost (after initial purchase)
- Still relevant for DSM-5 in most instances



Diagnostic Interviewing for ADHD

(http://www.psychiatry.pitt.edu/node/8233)

K-SADS-PL:

- Freely available online
- Offers screening items for common DSM disorders, followed by in-depth items (supplements are <u>long</u>)
- Still relevant for DSM-5 in most instances

Diagnostic Interview

Kiddie-Sads-Present and Lifetime Version (K-SADS-PL)

Version 1.0 of October 1996

Permitted Usage

This instrument is copyrighted. Usage is freely permitted without further permission for uses which meet one or more of the following:

- Clinical usage in a not-for-profit institution
- Usage in an IRB approved research proto

All other uses require written permission of the principal author. Dr. Kaufman, including but not limited to the following:

- Redistribution of the instrument in printed, electronic or other forms
- Commercial use of the instrument

The latest version of the instrument, a pointer to the author's electronic mail address, and other useful information can be found at the following WorldWide Web URL: http://www.wpic.pim.edu/kasds

K-SACS-PL VANDO T-D CROSSAY THIS

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Benefits of Diagnostic Interviewing

- No matter which instrument you choose, a (semi-) structured caregiver interview provides:
 - DSM-relevant inclusion/exclusion criteria
 - Age-of-onset criterion (and duration)
 - Possibly: Some indication of functional impairments
 - Possibly: Medical history

A diagnostic interview is an absolute <u>MUST</u> <u>HAVE</u>

Broadband Rating Scales for ADHD

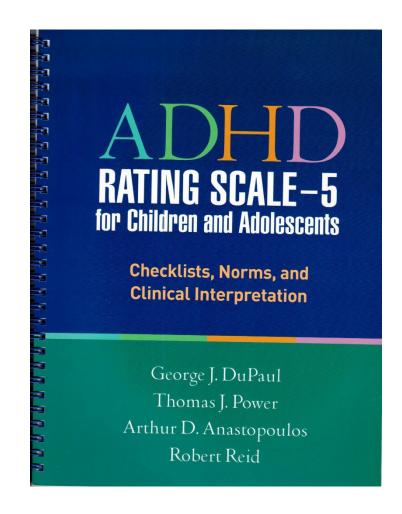
- Several broadband rating scales can help with ruling in/out ADHD as a possible diagnosis
- Typically these scales are <u>very</u> expensive and time-consuming
 - Sending these to teachers through the mail is often a lost cause!



Narrowband Rating Scales for ADHD

(DuPaul, Power, Anastopoulos, & Reid, 2016)

- If you have narrowed down your focus to ADHD through an interview, you can safely move to narrowband ADHD scales
- The ADHD-5 is an affordable, reusable scale with good psychometric properties



Narrowband Rating Scales for ADHD

(Pelham, Gnagy, Greenslide, & Milich, 1992)

Chil	d's Name: Form Completed by:				
Gra		al.			
	de:		know ti	ne answe	or .
Crie	to the column that best describes your this child. Flease write by next to any items for which yo	Not at		Pretty	Ven
		All	Little	Much	Muc
1	often interrupts or intrudes on others (e.g., butts into conversations or games)		2		
2	has run away from home overnight at least twice while living in parental or parental surrogate home (or once				-
	without returning for a lengthy period)				
3.	often argues with adults				
4.	often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)				
5.	often initiates physical fights with other members of his or her household				
6.	has been physically cruel to people				
7.	often talks excessively				
8.	has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and				
L	entering; forgery)		_	_	-
9.	is often easily distracted by extraneous stimuli		_	_	-
10.	often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking				
11.	often truant from school, beginning before age 13 years		_		_
12.	often fidgets with hands or feet or squirms in seat		_		-
13.	is often spiteful or vindictive				
14	often swears or uses obscene language				
15.	often blames others for his or her mistakes or misbehavior				-
16.	has deliberately destroyed others' property (other than by fire setting)				
17.	often actively defies or refuses to comply with adults' requests or rules				
18.	often does not seem to listen when spoken to directly				
19.	often blurts out answers before questions have been completed				
20.	often initiates physical fights with others who do not live in his or her household (e.g., peers at school or in the				
ㄴ	neighborhood)				
21.	often shifts from one uncompleted activity to another		_		_
22.	often has difficulty playing or engaging in leisure activities quietly		_		_
23.	often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities		_	_	-
24.	is often angry and resentful	_	_	_	-
25.	often leaves seat in classroom or in other situations in which remaining seated is expected		_	_	\vdash
26. 27.	is often touchy or easily annoyed by others often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace	_	_	_	-
21.	(not due to oppositional behavior or failure to understand instructions)				
28.	often loses temper				-
29.	often has difficulty sustaining attention in tasks or play activities				-
30.	often has difficulty awaiting turn				
31.	has forced someone into sexual activity				
32.	often bullies, threatens, or intimidates others				
33.	is often "on the go" or often acts as if "driven by a motor"				
34.	often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)				
35.	often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may				
_	be limited to subjective feelings of restlessness)				
36.	has been physically cruel to animals				_
37.	often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as				
38	schoolwork or homework)		_		-
38.	often stays out at night despite parental prohibitions, beginning before age 13 years		_	_	\vdash
40.	often deliberately annoys people has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)		_		\vdash
40.	has stolen while controlling a victim (e.g., mugging, purse shatching, extorsion, armed robbery) has deliberately engaged in fire setting with the intention of causing serious damage				-
42	nas deliberately engaged in the setting with the intention of causing serious damage often has difficulty organizing tasks and activities				-
43.	has broken into someone else's house, building, or car				
44	is often forgetful in daily activities				
45.	has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife,				
	qun)	l	I		

- The Disruptive Behavior
 Disorders (DBD) rating scale is a
 relatively strong (and <u>free</u>)
 alternative
- Based on older DSM criteria for ADHD, ODD, and CD

Rating Scales for ADHD

(Pelham, Gnagy, Greenslide, & Milich, 1992)

		Not at All	Just a Little	Pretty Much	Very Much
1.	often interrupts or intrudes on others (e.g., butts into conversations or games)				X
2.	has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)	X			
3.	often argues with adults			X	

Notes.

- Items are scored on a 0 to 3 scale: 0 = Not at All, 3 = Very Much
- Items ≥ 2 (i.e., *Pretty Much*) add to the symptom count
- Some items are left over from previous versions of the DSM and should <u>not</u> be scored (e.g., often swears and uses obscene language)
- Teachers typically do not know about CD symptoms

Impairment Scales for ADHD

(Fabiano et al., 2006)

- The Impairment Rating Scale is a good measure of ADHD-relevant impairments at home and school
- Two versions: One for parent and the other for teachers
- Assesses 6-8 domains, plus a question about a "best friend"

Impairment Rating Scale TEACHER Narrative								
ID# Form Completed by:								
Date Completed:								
Instructions: In the space below, please describe what you see as this child's pi describe how this child's problems have affected the following areas and compl his or her relationships with other children, (2) your relationship with him or her (4) your classroom in general, and (5) his or her self-esteem. Continue on a sep ratings, please mark an "X" on the lines at the points that you believe reflect problems in this area and whether he or she needs treatment or special services COMPLETE BOTH SIDES OF THIS FORM.	ete the rating at the end of each: (1) r, (3) his or her academic progress arate sheet if necessary. For the ct the impact of the child's							
(1) How this child's problems affect his or her relationship with other children								
No Problem	Extreme Problem							
Definitely does not need treatment or special services	Definitely needs treatment or special services							
(2) Regardless of whether this child is popular or unpopular with pecspecial, close "best friend" that he or she has kept for more than a fet								
YES NO								
(3) How this child's problems affect his or her relationship with you, the teacher	r							
No Problem Definitely does not need treatment	Extreme Problem Definitely needs treatment							
or special services	or special services							

Impairment Scales for ADHD

(Fabiano et al., 2006)

- Raters place an "X" on a scale that is later converted to a score (0 to 6 scale)
 - Ratings ≥ 3 are "impaired"
- Raters can also provide qualitative responses, which helps in interpretation
- Very quick to complete, but sometimes confuses respondents

Impairment Rating Scale TEACHER Narrative							
ID# Form Completed by:							
Date Completed:							
Instructions: In the space below, please describe what you see as this child's primary problems. Also, please describe how this child's problems have affected the following areas and complete the rating at the end of each: (1) his or her relationships with other children, (2) your relationship with him or her, (3) his or her academic progress (4) your classroom in general, and (5) his or her self-esteem. Continue on a separate sheet if necessary. For the ratings, please mark an "X" on the lines at the points that you believe reflect the impact of the child's problems in this area and whether he or she needs treatment or special services for the problems. PLEASE COMPLETE BOTH SIDES OF THIS FORM.							
(1) How this child's problems affect his or her relationship with other children							
He has trouble making and keeping friends.							
No Problem							
(2) Regardless of whether this child is popular or unpopular with peers, does he or she have a special, close "best friend" that he or she has kept for more than a few months? (Please circle)							
(3) How this child's problems affect his or her relationship with you, the teacher							
He is often disruptive and difficult to redirect once he gets off-task.							
No Problem Extreme Problem Definitely does not need treatment or special services or special services							

Impairment Scales for ADHD

(Brady et al., 2012)

Date: Teacher	ct:										
Please read each item carefully and circle the number that best describes this student's behavior for the past 4 weeks, to the best of your knowledge. Always Sometimes Never											
Brings necessary materials to class.	1	2	3	4	5						
2. Completes class assignments.	1	2	3	4	5						
3. Completes homework on time.	1	2	3	4	5						
4. Records assignments consistently.	1	2	3	4	5						
5. Turns in completed work.	1	2	3	4	5						
6. Completes long-term assignments.	1	2	3	4	5						
7. Attends to instructions in class.	1	2	3	4	5						
8. Arrives to class on time.	1	2	3	4	5						
9. Cooperates/participates in class.	1	2	3	4	5						
 Demonstrates skills in reading assigned tests and materials. 	1	2	3	4	5						
 Demonstrates adequate spelling and writing skills in work. 	1	2	3	4	5						
12. Takes notes in class to study.	1	2	3	4	5						
13. Performs satisfactorily on tests.	1	2	3	4	5						
 Completes assigned work with accurate computation/detail. 	1	2	3	4	5						
15. Completes assignments legibly.	1	2	3	4	5						
16. Relates positively to teachers.	1	2	3	4	5						
17. Demonstrates respect for property.	1	2	3	4	5						
18. Relates positively to peers.	1	2	3	4	5						
 Communicates own needs or asks questions. 	1	2	3	4	5						
20. Accepts assistance when needed or offered.	1	2	3	4	5						

- Another free option is the Classroom Performance Scale
- Measures classroom impairment relevant to ADHD, as rated by teachers
- Norms are available for adolescents (see reference)

Benefits of Rating Scales

- Narrowband ratings of ADHD symptoms and impairments give you:
 - DSM-relevant symptoms across multiple settings
 - Evidence of social and academic impairments

• 2+ settings (typically home and school) and evidence of impairment are both **MUST HAVES**, so ratings are helpful

Recording Observations

Interval Recording:

Time is divided into equal intervals and then instances are recorded, along with contextual information

Behavior Codes: T = On Task	% of Time	Behavior Descriptor: Working on classwork	Teacher and Peer Reaction AA = Attention to All	% of Time
V = Verbal Off Task		Verbalizations out of turn	A+ = Positive Attention	
M = Motor Off Task		Out of seat	A- = Negative Attention	
P = Passive Off Task		In seat, but not working	Ac = No Attention to Pupil	
O = Other			O = Other	

	Time	Pupil	Compari- son	Anecdotal Notes on Behavior	Teacher Reaction	Peer Reaction
1.	1:00:00	T	T		Ac	Ac
2.	:20	T	T		Ac	Ac
3.	:40	P	T	Distracted by object in desk	Ac	Ac
4.	1:01:00	P	T		Ac	Ac
5.	:20	P	T		Ac	Ac
6.	:40	ν	T	Attempted to talk to neighbor	Ac	A-
7.	1:02:00	ν	T		Ac	A -
8.	:20	T	T	Verbal off-task corrected by teacher	A ~	A -
9.	:40	T	T		Ac	Ac
10.						



Must we Determine the Function?

(Miller & Lee, 2013)

- School practitioners also assess the "function" of problem behaviors (e.g., to gain attention, to escape aversive demands)
- Interventions informed by FBAs are more effective than those that skip this step, but both approaches can be very effective

Table 6 Mean effects and mean ranks: function-based and non-function-based interventions

Function-	SMD			PEM			IRD		
based	М	MR	95 % CI	M	MR	95 % CI	M	MR	95 % CI
Yes	3.94	93.79*	3.43-4.38	93.53	94.21*	92.06–94.93	84.95	96.70*	83.07–86.73
No		2.63 75.4	2.63 75.42 2.35–2.92 88.92	88.92	75.06 87.04–90.79	73.54	72.87	71.05–75.97	

MR mean rank, * p < .013

Summary for Section II

- Comprehensive evaluation of ADHD does not need to be expensive, but it does require clinical interviewing, input from caregivers and teachers, and (when possible/necessary) independent observations
- Broadband rating scales are only helpful in the early stages of assessment and can be safely skipped if a thorough caregiver interview is conducted
- Narrowband ratings of impairment often provide good progress monitoring tools, and many are sensitive to change (e.g., IRS)
- IQ and achievement tests are <u>not</u> necessary! FBAs can help but are not necessary in all cases.

Common Elements of ADHD Treatment

Most promising medicinal and psychosocial strategies according to the research



Recommendations from the AAP

(Wolraich et al., 2019)

- "Key Action Statements" include:
 - For preschool children (ages 4-6):
 - Parent training and possibly medication (methylphenidate off-label)
 - For elementary school-age children (ages 6-12):
 - FDA-approved medication along with parent training and/or classroom intervention
 - For adolescents (ages 12-18):
 - FDA-approved medication with adolescent's assent and possibly behavior therapy, if available

Among medications:

1. Stimulants

(methylphenidate and amphetamine)

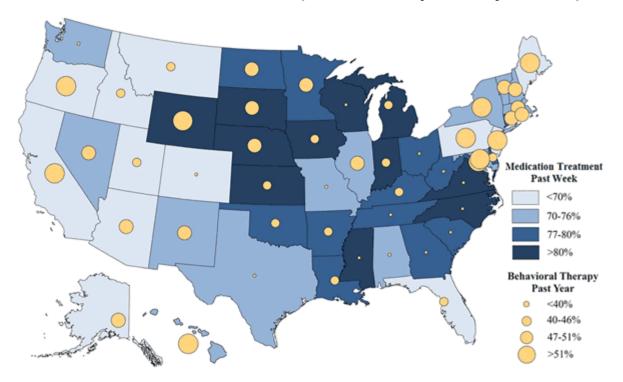
- 2. Atomoxetine (XR)
- 3. Guanfacine (XR)
- 4. Clonidine (XR)



Rates for ADHD Medications and Behavior Therapy

(Visser et al., 2015)

• Prior to these recommendations, behavior therapy was used in just 44% of all cases nationwide ("in the past year")...



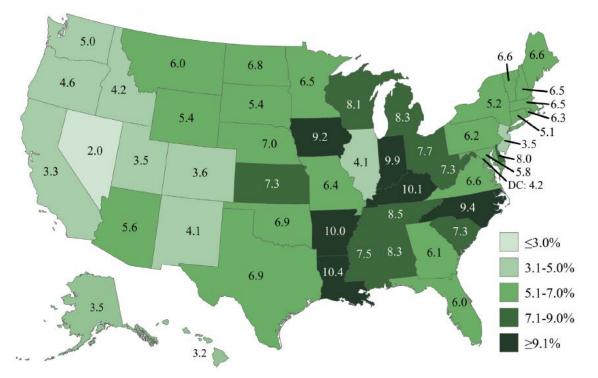
Note: Where there is little engagement in behavioral options, there is generally more med usage!

NC is a <u>prime</u> example.

Rates of ADHD Medication Use among Children

(Visser et al., 2014)

• ...and there were varying rates of ADHD medication treatment around the United States (average was 6.1% of school-age children)...



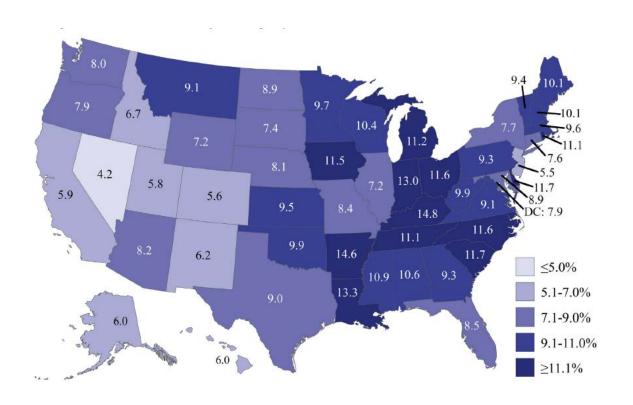
Note that NC has one of the highest rates of med use...

Nationwide, 69% of kids with ADHD are taking meds; in NC it is 81%.

Rates for Current ADHD Diagnosis among Children...

(Visser et al., 2014)

• ...as well as varying rates of "current" diagnosis (average was 8.8%).



Note that NC has one of the highest rates of diagnosis, too!

...gives rise to ADHD Myths

- Unfortunately, inconsistent treatment fuels persistent myths about ADHD
 - https://youtu.be/zDZFcDGpL4U?t=216

Fact Check: ADHD Medications

(Schultz & Evans, 2015)

- Medications do not cure ADHD but can help in ≈80% of cases
- Medications are controversial
 - Option of choice when no other options exist (think of the maps above)
- Long-term medication use is understudied
- Medication studies rarely include adolescents
- Medication compliance is poor



Levels of Evidence for <u>Psychosocial</u> Interventions

(Evans, Owens, & Bunford, 2014; Evans, Owens, Wymbs, & Ray, 2018)

	Preschool	Childhood	Adolescence
Level 1: Well-established	Parent Training, Classroom Management, Combined Behavior Mgt	Parent Training, Classroom Management, Behavioral Peer Intervention, Organization Training, Combined Behavior Mgt	Organization Training
Level 2: Probably Efficacious			Combined Training Interventions (lots of rehearsal)
Level 3: Possibly Efficacious	I'll come back to this - in a moment	Neurofeedback	Parent Training (with behavior contracting)
Level 4: Experimental	ín a moment	Cognitive Training, Parent Training (modified to target parent needs)	Combined Training Interventions (short-term with CBT)
Level 5: Questionable		Social Skills Training, Physical Activity	Omega 3/6 Supplements

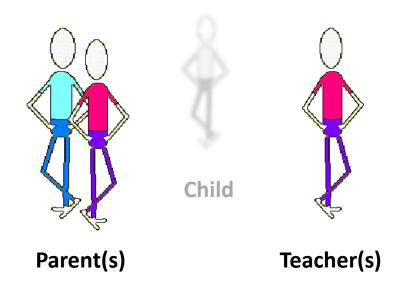
Note. Levels of evidence are as defined by APA Division 53 criteria. CBT = Cognitive Behavioral Therapy



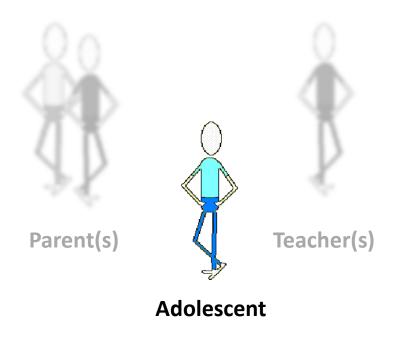
Where Do We Focus?

(Evans, Owens, Wymbs, & Ray, 2018)

For Preschool and Child Clients:



For Adolescent Clients:



Quick Aside: Three Broader Questions:

1. Does sequencing matter? In other words, should we start with meds or behavior interventions?

2. When we use behavioral practices, what proportion of kids actually get *better*?

3. What about alternative, technology-based interventions I've heard about online? Aren't there new options?

1. Does Sequencing Matter?

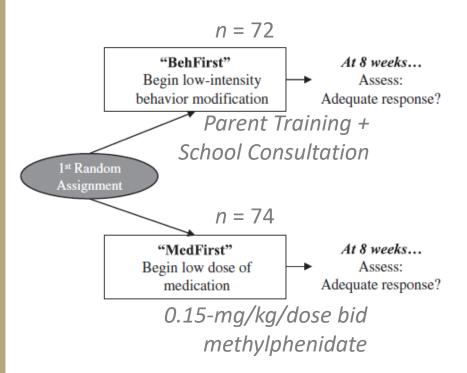
(Pelham et al., 2016)

- In practice, treatments are adapted over time based on response
 - e.g., medication titration
- So the question is:
 - Does it matter if we start with medications or psychosocial treatments?
 - What should we do if the child does not respond to the initial treatment?

Modality	Initial Treatment	Secondary/Adaptive Treatment
Medication	8-hr stimulant equivalent to 0.15 mg/kg methylphenidate b.i.d.	
		 Added evening/weekend doses

1. Does Sequencing Matter?

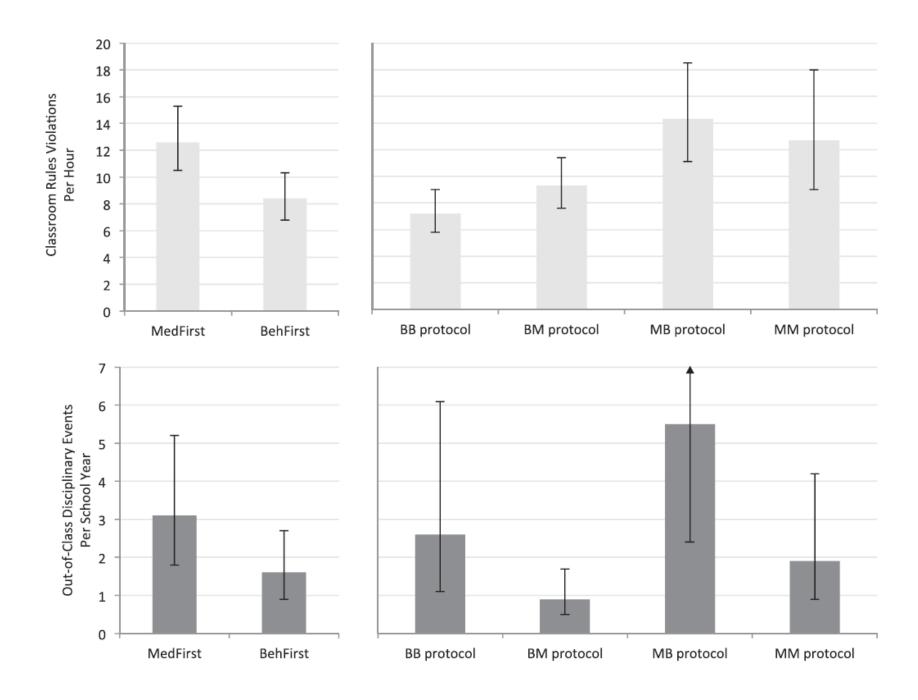
(Pelham et al., 2016)

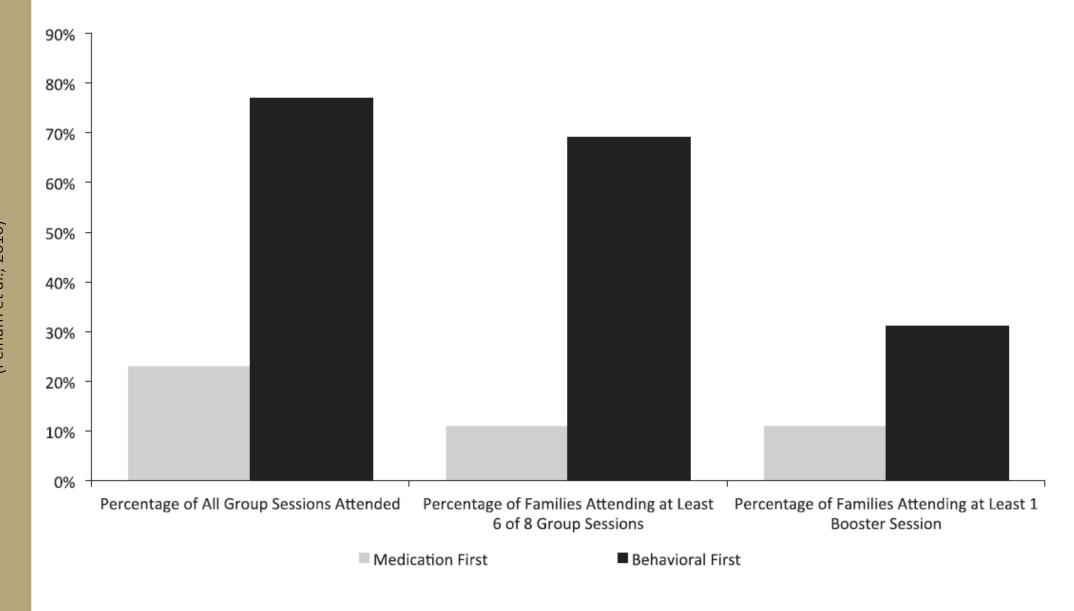


- Sequential multiple assignment randomized trial (SMART)
- Six treatment paths...

Results

(Pelham et al., 2016)





2. What Proportion of Kids get *Better*?

(Evans, Owens, Wymbs, & Ray, 2018)

Folks are often shocked by how few kids experience meaningful improvement (e.g., normalization) after receiving an EBP

Intervention Type	Proportion of Children Experiencing Meaningful Outcomes
Modified PT (focus on parent)	< 20%
Parent Training (PT)	< 35%
Atomoxetine with/without PT	46.9% and 45.2%, respectively
Coaching (50+ sessions)	51.5%

Note. Meaningful outcomes is variously described as "normalization," "recovery," or "responder."

2. What Proportion of Kids get *Better*?

(Schultz & Gaither, 2020)

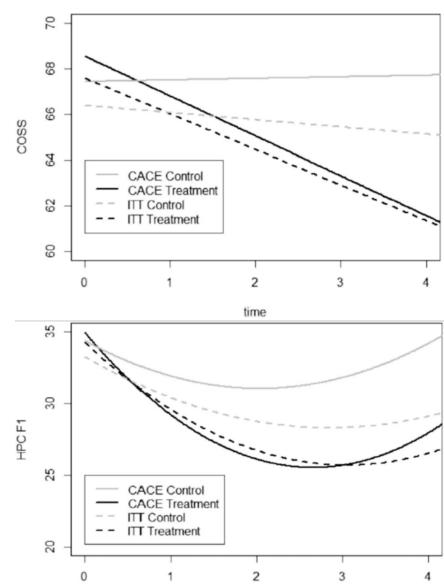
	n	Strong Negative Effect	Moderate Negative Effect	No Effect	Moderate Positive Effect	Strong Positive Effect
Token Economy	13	0 (0.0%)	1 (7.7%)	9 (69.2%)	1 (7.7%)	2 (15.4%)
HOPS	<mark>07</mark>	0 (0.0%)	0 (0.0%)	1 (14.2%)	<mark>2 (28.6%)</mark>	<mark>4 (57.1%)</mark>
Daily Report Card	7	0 (0.0%)	0 (0.0%)	5 (71.4%)	2 (28.6%)	0 (0.0%)
Check In/Check Out	5	0 (0.0%)	0 (0.0%)	2 (40.0%)	2 (40.0%)	1 (20.0%)
Other	5	0 (0.0%)	0 (0.0%)	5 (100%)	0 (0.0%)	0 (0.0%)
Total	37	0 (0.0%)	1 (2.7%)	22 (59.5%)	7 (18.9%)	7 (18.9%)

Note. Convergent Evidence Scaling based on visual analysis, SMD, PND, and PEM; showing row percentages. HOPS = Homework, Organization, and Planning Skills

2. What Proportion of Kids get *Better*?

(Schultz et al., 2017)

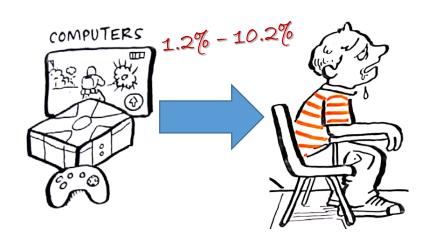
- Statistical significance—the test at the heart of EBP—is <u>not</u> the same as clinical significance
- Research suggests that the real benefit of EBP is that kids in comparison groups tend to fare much worse over time
- In other words, our EBPs largely prevent worse outcomes



3. What about Tech-based Treatments?

(Nikkelen et al., 2014)

- There is a correlation between ADHD-related behavior and media use (more symps = more use)
 - TV/video games and inattention: *r* = .32
 - TV/video games and impulsivity: r = .11
 - TV/video games and "combined": r = .12

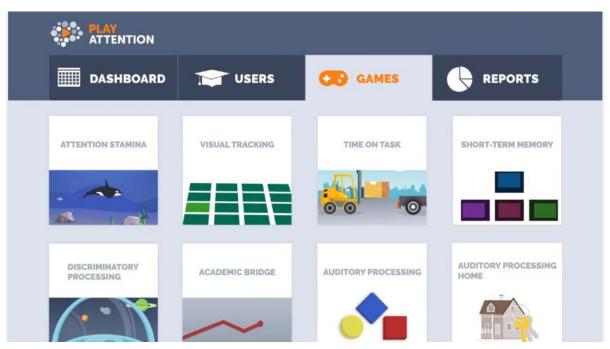


- Poor social
skills lead to
solitary play.
- Media often
"babysits" the
difficult child.

3. What about Tech-based Treatments?

Neurofeedback/biofeedback

- Provides feedback to player based on brain activity (EEG)
 - Supposedly builds "new circuits" in the brain
- Others provide biofeedback (e.g., heartrate)
- No evidence for long-term far transfer to the classroom



Play Attention includes a neurofeedback device, worn on the arm, to allow hands-free control of game objects.

3. What about Tech-based Treatments?

Cognitive Training

- Companies develop and market games with outlandish claims about neuropsychology
- But there is little or no evidence to support far transfer
 - More examples here: https://www.additudemag.com/braintraining-game-adhd-apps/
 - And here: https://youtu.be/yMBDosb7d18



Project: EVO is a recent tablet-based game. The designers refer to it as "digital drug" to correct deficits of attention and inhibition. It doesn't.

Overview of the Next Section

- Defining behaviors
- Parent training
 - Praise
 - Homework compliance
- Daily Report Card
- Organization
- Assignment tracking
- Social problem solving

Defining Behaviors

The most crucial step—if you can't define it, you can't change it!!!

- Defining observable and measurable behavior
 - Approaches to teacher and parent consultation vary, but typically starts with defining behavior clearly
 - Here are some examples:

Behavior	Operational Definition
Compliments	A child exhibits a verbal or non-verbal behavior directed at a peer or adult that would
	typically lead to another person feeling good about himself or his behavior.

Behavior	Operational Definition
Contributing	A student makes a statement or asks a question that is <u>relevant</u> to the immediate event or conversation and is <u>not redundant</u> during an activity without violating classroom rules. (Responses such as "I don't know" or "I have nothing to say" may meet criteria for contributing.)
Attention Check Questions	Questions asked of a student regarding the contents of a statement or discussion occurring immediately prior to the question. These questions are used to assess whether a student is paying attention to a discussion or activity while also functioning as a prompt.

Behavior	Operational Definition
Aggression	A child exhibits a behavior that would typically cause physical pain or restrict the movement of another. Behavior that would typically cause physical pain or restrict movement that is part of a game (e.g., running into someone while going to make a lay-up) is not considered aggression unless the behavior is judged to be directed at the target and against the rules of the game.
Repeated Noncompliance	A child does not comply promptly (i.e. 10 seconds) to a request that is repeated <u>once</u> .
Property Destruction	A child exhibits a behavior that would typically result in a reduction in the value, function, or aesthetic appeal of an object.

Behavior	Operational Definition
Teasing	A child exhibits a verbal or non-verbal behavior directed at a peer that would typically offend or annoy another youth.
Verbal Abuse	A child exhibits a verbal or non-verbal behavior directed at an adult that would typically offend or annoy an adult.
Stealing	An object that belongs to someone other than the child who is found to be in possession of it and there was no prior consent given to possess that object. NOTE : taking a ball (or some other community property) out of someone's hands is considered teasing and not stealing

Behavior	Operational Definition
Complaining	A child demonstrates verbal or non-verbal communication indicating displeasure, resentment, or disapproval of a person, activity, or statement. If the communication meets the criteria for teasing or verbal abuse, then teasing or verbal abuse should be recorded and not complaining.
Blurting	A child creates a noise or distraction that interrupts the speech or activities of another. NOTE: Appropriate exceptions should not be recorded as blurting (e.g., quietly saying, "Bless you" when somebody sneezes, warning someone that they are about to spill something, etc.).

Case Study – "Ben"

Ben is a Seventh Grade student who tries hard to make friends at school, randomly walking up and talking to other kids and even inviting other kids to participate in chess club, but so far only one similarly unpopular peer has responded positively.

Recently Ben became infatuated with Riley, a <u>very</u> popular girl in his class and he has tried unsuccessfully to engage her in conversation. Generally she is nice about it, but it is clear to everyone except Ben that she is not interested in being friends.

One day Ben decides to make his intentions crystal clear, so he writes Riley a "love letter" and pushes it through the vent in her locker. When she discovers the letter between classes she is upset and confronts Ben in the hallway, angrily telling him to never bother her again. Humiliated, Ben follows Riley into their Language Arts class and loudly calls her a "bitch" in front of their peers and the teacher.

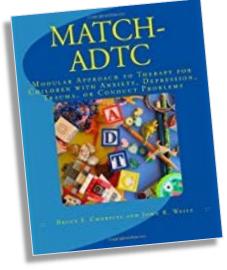
Parent Training

We can't cover all aspects, but a couple components are illustrative...

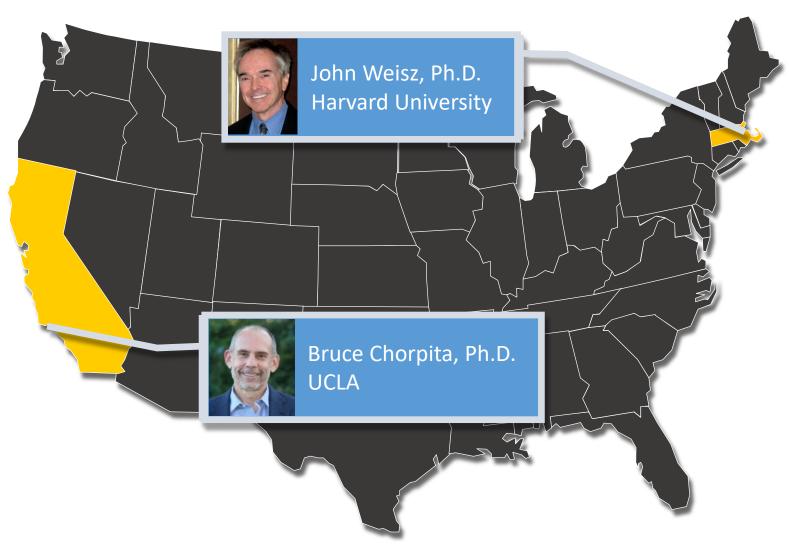
Family Relations

(Barkley et al., 1990; Barkley et al., 1991)

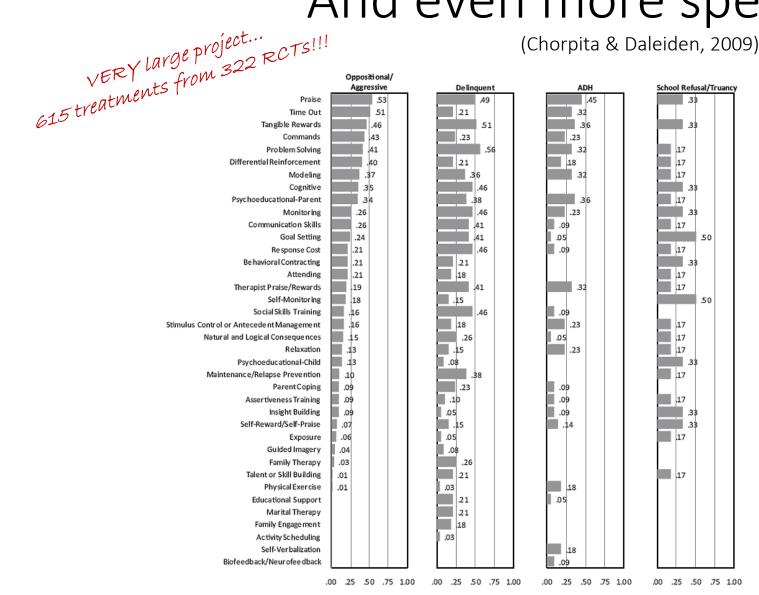
- Families of youth with ADHD have more conflicts than families without an adolescent with ADHD
- Parent-adolescent dyads demonstrated more negative and controlling verbal behavior than control dyads
- Divorce three times more common in families of adolescents with ADHD than control families
- Families moved more often and fathers changed jobs more often than controls



What are the Common Elements?



And even more specifically...



 The most common elements for externalizing disorders include praise, time-out, rewards, goal setting, and problem solving

 Note the predominance of behavioral and cognitive techniques!!!

Praise

- Praise is the single most common element in parent training programs for externalizing behavior problems
- Fits the "catch them being good" concept
- https://vimeo.com/carc1/review/138875832/e3b5279a8f

Praise

(Chorpita & Weisz, 2009)

- What makes praise effective? (handout here)
 - When it is in response to acts of compliance
 - When it happens quickly—immediately after the desired behavior
 - When it is labelled:
 - "Good work!" versus "I really like the way you picked up your clothes so neatly!"
 - "Thank you" versus "I really appreciate your coming inside so quickly when I called."

Homework Management Plan

- Things a parent cannot change:
 - Not knowing when assignments are due
 - Whether or not the required materials are brought home
 - Unfamiliarity with the subject material
- Things a parent CAN change:
 - Amount of time spent on academic work
 - Academic productivity

Homework Management Plan

• Parents enforce:

- Amount of time doing academic work
- Quality products at end of time

Details

- Amount of time is negotiated based on grades
- If no school work brought home, parents assign work
- Home privileges contingent on completion of time

The Written Plan (Behavior Contracting)

Homework Contract (Sample)		
Guidelines:		
1. My goal for the next report card is: No grades less than a C		
2. I will work on my homework Sun ~ Thur at this time: 7:00pm		
3. I will work on my homework for this amount of time each day: 30 minutes		
4. What will happen if I'm not working during homework time? Add 5 minutes		
5. I understand that even if I do not have homework, I will use the homework time to study for tests and quizzes, or as an alternative: Mom or Dad will give me an assignment to do		
Additional Terms: When homework time is completed, I will have		
access to the computer and Playstation for 2 hours, not to go past 10:30		
By signing this contract, I <u>Bobby Person</u> (print name) understand the terms that		
are described above. This agreement will start today and will be renegotiated		
when I receive my next report card / mid-term report, and changes will depend on		
how I am doing at that time.		
Student Signature: Date:		
Parent Signature: Date:		

- Contract includes:
 - Goal (tied to report card)
 - Days that plan will be enforced
 - Times that homework will start
 - Amount of time for homework
 - Plan for off-task behavior
 - What to do when there is "no homework"
 - Rewards (that can be realistically withheld)
 - Signatures

Case Study – "Allie"

Susan, a single-mother of 11-year-old Allie, became increasingly concerned by Allie's oppositional behavior at home, especially around issues of homework. After meeting with a psychologist, Susan attempted a behavior contract but two problems were clear. First, Susan wrote most of the plan prior to meeting with Allie. Second, Susan was excited about the contract and decided to add in several expectations outside the target behavior (homework compliance), including the completion of household chores and the avoidance of "arguments" and "temper tantrums." In her attempt to tackle all of these problems, Susan had scribbled notes in the margins of the contract, with additional notes on the back of the page.

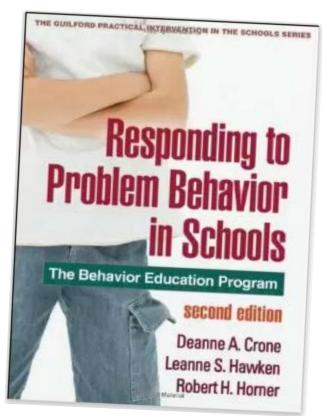
Daily Report Card

...and its many, many derivatives

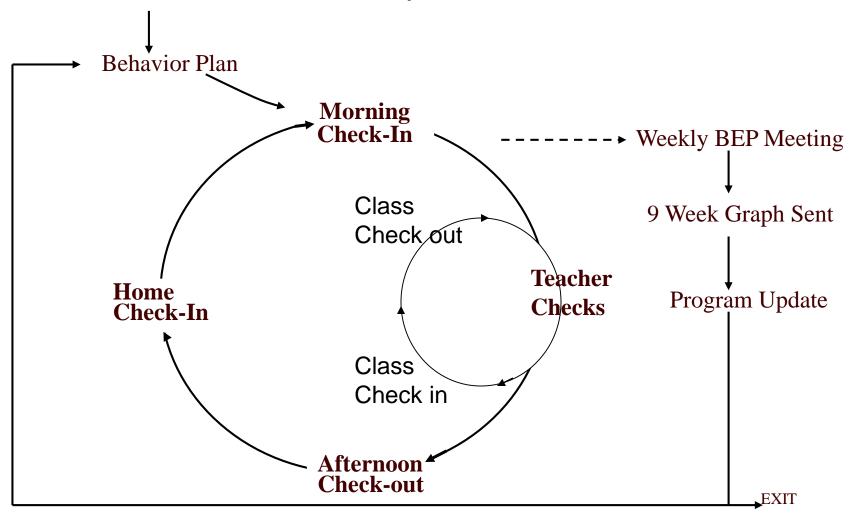
Daily Report Cards (many versions)

(Crone, Hawken, & Horner, 2010)

- My personal take on the literature is that most current school efforts are simply daily report card (DRC) reboots; also known as:
 - Home-School Notes
 - Daily Behavior Report Cards
 - Daily Progress Report
 - Direct Behavior Ratings
- The version du jour is Check In/Check Out (CICO)



Check-in Check-out Cycle



CICO Record

Name:				Date:	
	0 = Need work.	1 = "OK"	2 = Nice Job		

		Safe		R	espons	sible	R	espe	etful
Check In	0	1	2	0	1	2	0	1	2
Block 1	0		2	0	1	2 (0	1	2
Before Lunch	0	1	2	0	1	2	0	1	2
Block 2	0	1	2	0	1	2 (0	1	2
Check Out	0	1	2	0	1	2	0	1	2
Today's goal 24	•			Tod	lay's to	tal poi	nts [20	

Comments:

CICO Report
Student _____Teacher_____ **Date** _____

0 = Not Yet		Be Sa	ıfe	Re	Be espect			Be Y	Teacher initials				
1= Good 2= Excellent	Keep hands, feet, and objects to self				kind v id acti		(Follo direction		W	orking class		
Class	0	1	2	0	1	2	0	1	2	0	1	2	
Recess	0	1	2	0	1	2	0	1	2				
Class	0	1	2	0	1	2	0	1	2	0	1	2	
Lunch	0	1	2	0	1	2	0	1	2				
Class	0	1	2	0	1	2	0	1	2	0	1	2	
Recess	0	1	2	0	1	2	0	1	2				
Class	0	1	2	0	1	2	0	1	2	0	1	2	
Total Points = Points Possible =	50				Today			_%		(Goal		%

Another Style...

(Kidding: This is a "Daily Report Card" from Dougherty & Dougherty, 1977)

Period/Time		Beh	BYIOI			School	olwork			Home	ework		Teacher
1.	1	2	3	4	1	2	3	4	1	2	3	4	
2.	1	2	3	4	1	2	3	4	1	2	3	4	
3.	1	2	3	4	ī	2	3	4	1	2	3	4	
4.	1	2	3	4	1	2	3	4	1	2	3	4	
5.	1	2	3	4	1	2	3	4	1	2	3	4	
6.	1	2	3	4	1	2	3	4	1	2	3	4	
7.	1	2	3	4	1	2	3	4	$\overline{1}$	2	3	4	

Case Study – "Kelvin"

Five-year old Kelvin was a constant disruption in his kindergarten classroom. He frequently grabbed toys from other children, had difficulty completing activities with the constant support of the teacher or aide, and often failed to comply with adult directions. His behavior was especially problematic during transitions and naptime. He had trouble waiting in line and would push or bother the children standing near him, and during naptime he would wander around the room rather than resting. When his teacher or the aide would attempt to redirect or correct him, he would put his hands over his ears, pull away from them, or attempt to kick or hit them. Screening measures indicated that his receptive and expressive language skills were in the average range, but he had so much difficulty attending to instructional activities that his early literacy skill were beginning to lag behind those of his classmates. Although his teacher had talked to Kelvin about his behavior and offered numerous incentives for positive behavior, these strategies were only occasionally effective, and Kelvin's aggressive and noncompliant behaviors were increasing as the school year continued.

Organization

Perhaps the most effective training intervention

Training Interventions

- We recommend moving beyond behavior interventions to help children and adolescents develop good habits (coping skills), including:
 - Organization
 - Assignment Tracking
 - Social Problem Solving

Why Organization?

(Robin, 1998; Zentall, Harper & Stormont-Spurgin, 1993)

- Disorganization is common among students with ADHD—often leading to:
 - difficulties with homework,
 - misplaced materials,
 - missing assignments, and
 - problems tracking long-term projects
- Organizational demands clearly intensify in secondary schools



Get Organized!



Get organized! Be able to find your assignments and turn them in! Be able to locate your notes to study for tests! Open your binder and go down the checklist: for each item, write a Y (for yes) if you meet the question <u>fully</u> or an N (for no) if you do not meet the question fully. When finished checking divide the number of Ys recorded by 11 and record this in the last space as the percentage of your binder that's organized.

			DAT	<u>E</u>		
BINDER	1/18	1/22				
Is the assignment notebook secured by three rings so that it is the first thing you see when you open your binder?	Y	γ				
Is your binder free of loose papers (are all papers secured in folder pockets or attached by three rings)?	Y	γ				
Is the Homework Folder attached by three rings behind your assignment notebook?	N	Y				
Inside the homework folder: are homework assignments need for even days in the even day pocket?	γ	γ				
Inside the homework folder: are homework assignments need for odd days in the odd day pocket?	N	N				
Is there a pocket for papers you parents need to see, and only these papers are in it?	N	Y				
Is there a folder for each class you are taking? (1. Math, 2. Science, 3. English/Reading, 4. Social Studies, 5. P.E./Health, 6. other extracurricular courses)	γ	γ				
Within each subject folder: Are all non-homework papers for that subject in the right pocket of the folder?	N	N				
Are the notes from each subject organized from oldest to newest behind the subject folder and secured by the three-rings in the binder?	Υ	γ				
Are all papers in the correct section of the binder? (no papers in the wrong section)	N	Y				
Are all the papers that are in the binder school related? (no drawings, scrap paper, notes, etc.)	N	N				
What percent of your binder is organized? Divide the number of Y's by 11 and then multiply by 100.	45	73				



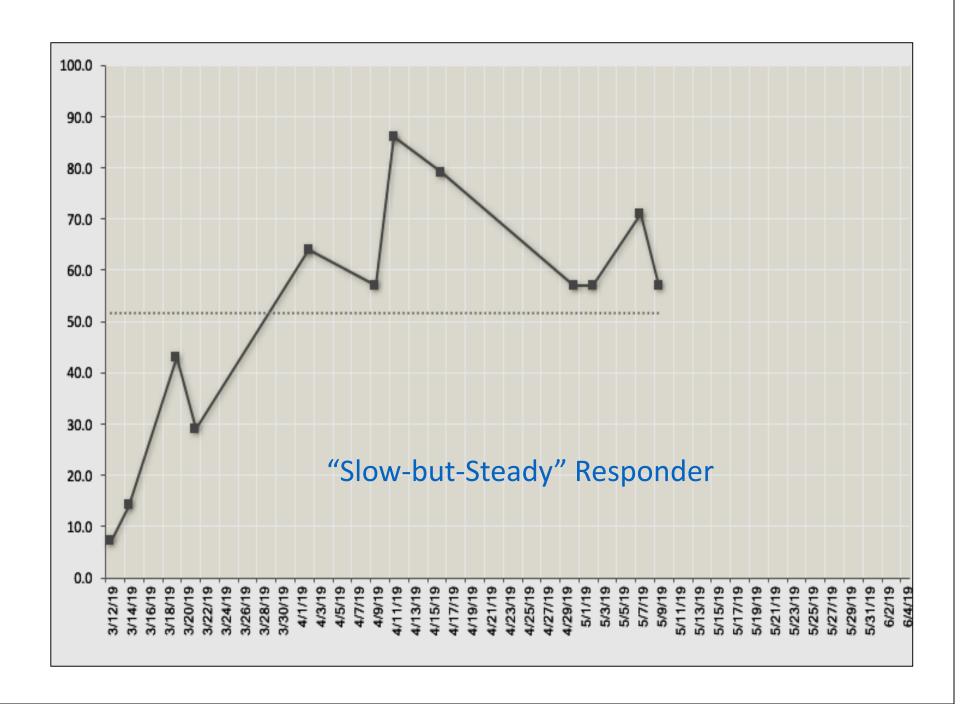


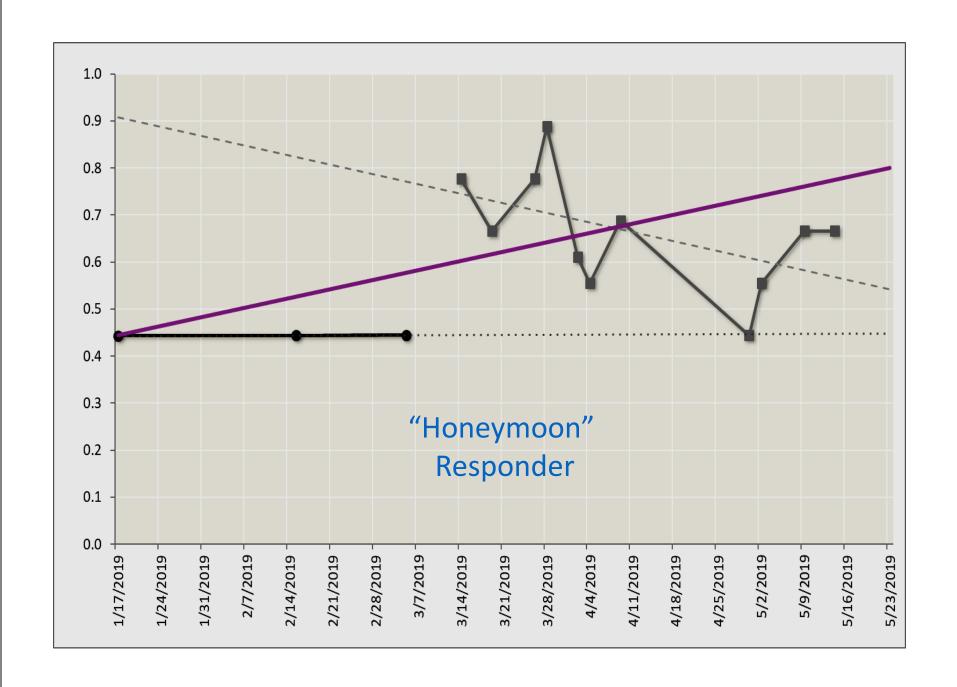


Don't forget your bookbag and locker! Organize them too! Open your bookbag and locker and go down the checklist: for each item, write a Y (for yes) if you meet the question <u>fully</u> or an N (for no) if you do not meet the question fully. When finished checking, divide the number of Ys recorded by 4 for the book bag and record this in the last space as the percentage of your bookbag that's organized. Repeat this for the locker and divide the number of Ys by 3 and record.

DATE

BOOKBAG					
Do you have the books you need to complete tomorrow's homework?					
You don't have books in your book bag that you don't need to complete the homework for the next three days or long-term assignments?					
Is your bookbag free from unnecessary clothing?					
Is your bookbag free from loose papers and objects (pens, toys, magazines, etc)?					
Percentage of criteria met (# of Ys/4)*100					
LOCKER					
Are the books neatly stacked (or shelved) with the spines facing out so that you can easily grab one in between classes or after school?					
Is you locker free of loose objects (papers, pencils, pens, toys, magazines, etc.)?					
Is you locker free from unnecessary clothing?					
Percentage of criteria met (# of Ys/3)*100					





Organization = Better Grades?

(Evans, Schultz, White, Brady, Sibley, & Van Eck, 2014)

		Change in C	Grades follow	ing Baselii	ne
Items	L.A.	Math	Science	S.S.	GPA
Assignment notebook?	.32*	.43**	.08	.23	.35**
Folder for each class?	.30*	.26*	03	.19	.21
Are the notes organized from <i>oldest to newest</i> ?	.11	.05	.09	.21	.20
Pocket for home communication?	.24	.26*	16	.15	.18
Everything school related?	.23	.06	.00	.16	.18
Odd day homework pocket?	.19	.41**	.07	02	.18
Even day homework pocket?	.19	.33*	.06	06	.15
Homework folder attached?	.16	.26*	01	.02	.15

^{*}*p* < .05; ***p* < .01

Case Study – "Eric"

Eric was a 10-year-old boy in the fourth grade with a previous diagnosis of ADHD. Eric was prescribed a psychostimulant and a hypotensive medication to treat the symptoms of ADHD and had been taking those medications consistently for several years. He lived with his mom, stepfather, and sisters. Eric had recently moved back into his school from another nearby school, and he made it clear that the move had been difficult for him. When asked to name his friends, for example, Eric only named family members and friends from his previous school.

During an intake evaluation, Eric's mother identified concerns relating to aggression and conduct problems. It was reported that Eric would occasionally get explosively angry towards siblings and peers—a concern shared by his teacher. Eric's impulsive reactions to interpersonal frustration, as well as his lack of coping strategies for regulating his emotions, were conceptualized as contributing factors to his conduct problems. Eric and his mother also reported concerns related to anxiety and depression. A particularly pressing concern was Eric's disorganization and inability to manage his materials and assignments. The teacher reported that Eric had a "messy" notebook and backpack, and these problems were hindering his academic performance. Further, Eric did not record his assignments in his planner or discuss schoolwork with his mom in the evenings.

Assignment Tracking

Perhaps the second most effective training intervention

Assignment Notebook Tracking

- Establishes a routine that helps the students to accurately record daily homework assignments and plan for quizzes, tests, and projects.
- This intervention can require teacher cooperation in obtaining initials during class or after school, or other strategies of assignment verification prove insufficient
 - Teacher initials are generally considered the "gold standard" method for assignment verification, but other less-intrusive systems might prove useful.

Assignment Notebook Tracking

Counselors review and record Assignment Notebook performance data on the appropriate paperwork.

Class/Subject	Thursday <u>11-10</u>
Math	Teacher Initials <u>BKS</u> Odd number problems pp. 110-112 # Missing Assign. <u>0</u>
L.A.	Teacher Initials Reading journal due!!! # Missing Assign. 1

Date:	11/10
Short-term as	signments
1. Number of teacher signatures obtained	1
2. Number of teacher signatures expected	2
Percentage of criteria met (# of teacher signatures obtained/ # of teacher signatures expected)*100	50%
3. Number of classes for which assignments are written with sufficient detail	2
4. Number of classes for which assignments are expected	2
Percentage of criteria met (# of classes in which assignments written with sufficient detail/number of classes in which assignments expected)*100	100%

Assignment Notebook (in student's binder)

Assignment Notebook Tracking Sheet

(in counselor's treatment folder)



		1									i	_
ASSIGNMENT NOTEBOOK Date:												
		Short-	term	assign	ment	5	 					
Number of teacher signatures obtained												
2. Number of teacher signatures expected												1
Percentage of criteria met (# of teacher signatures obtained/ # of teacher signatures expected)*100												
Number of classes for which assignments are written accurately with sufficient detail												
4. Number of classes for which assignments are expected												
Percentage of criteria met (# of classes in which assignments written with sufficient detail/number of classes in which assignments expected)*100												
	Long	g-term	proje	cts/as	signm	ents						
Has a long-term project/assignment, in any class, been recorded since the last session of CHP?												
2. Was the subject recorded in which the assignment is due?												
3. Was the due date of the assignment recorded?												
Was there sufficient detail recorded in order to complete the project?												
Percentage of criteria met (# of Ys/4)*100												ı

Case Study – "Michael"

Michael was an 11-year-old boy in the fourth grade with a history of academic impairments, resulting in two previous grade retentions. Michael lived with his mother and several siblings in an impoverished neighborhood that can be unsafe. Michael reported that his father and an uncle had been incarcerated in the past, and that he did not have a good relationship with his father. He also reported that one of his older brothers was recently incarcerated for gang activity. Michael's teacher reported that Michael rarely turned in his homework, resulting in failing grades. In addition to academic struggles, Michael had a long history of disruptive behavior at school, including fighting and talking back to adults, which had led to frequent disciplinary actions. Cognitive distortions (a tendency to make hostile attributions) as well as behavioral contingencies (the attention Michael received from peers for his conduct problems) were clear factors contributing to Michael's disruptive behavior. Parent and teacher ratings were highly elevated in regards to externalizing problems and attention problems. Prior to the your involvement, Michael had never received psychotherapy and was not taking medications.

Social Problem Solving

Social skills interventions are tricky, but this might be our best option

Model of problem-solving: WILBUR

- What is the problem?
- How would I like this to end up?
- List all possible solutions.
- Pick the Best solution.
- Use the solution.
- Review how well solution worked.

- Define the problem:
 - Jenny: "I feel bad when the other kids on my softball team hang out, but don't invite me."
- Encourage "I" statements.
 - "I feel bad" rather than "My teammates are really mean and always exclude me."

- This is the goal—what the child or adolescent ultimately wants to happen with the problem.
 - "I want to have fun and hang out with my teammates."
 - "I want them to leave me alone."
 - "I want to quit the team but my parents won't let me."

- Brainstorming: List all solutions at this point, no matter how bizarre or unrealistic they are.
- Do not pass judgment on solutions.
 - "I'll have a party and not invite my teammates."
 - "Talk about how much fun I have with my other friends."
 - "Ask a teammate that I get along with to hang out."
 - "Start conversations with teammates more often."

- Vote up or down on each solution until the best solution is reached.
- Cue child to consider possible outcomes of solutions and how they line up with the problem statement and goal.
 - Counselor: "How might your teammates feel if you have a party and don't invite them?" "How would that help you achieve your goal with this problem?"

- A homework assignment is given to use the solution that the child or adolescent chose.
- The goal is to get clear plans:
 - "I really like talking to Lesley. I will invite her to come over next Saturday afternoon. We can play video games."

- Reviewing effectiveness of the solution models how adults evaluate how well things worked out.
- Gives the counselor the opportunity to provide feedback on the outcome of the solution.
 - Counselor: "How did hanging out with Lesley go?
 - Adolescent: "We had fun! And she is going to the mall with Annie tomorrow and invited me to go with them!"

Summary for Section III

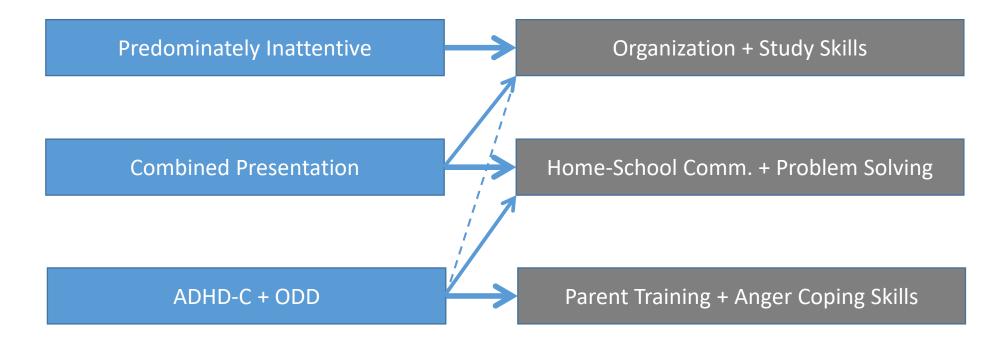
- Effective psychosocial interventions are premised on first defining problem/desired behaviors in objective & measurable terms
- Once behaviors are defined, effective interventions involve frequent monitoring and feedback
- Home-school efforts (i.e., DRCs) are highly effective, but require coordination that is difficult to maintain long-term
- Parent training is often necessary, typically focusing on one or two specific concerns through behavior contracts/point systems

Flexibility within Fidelity: Making Interventions Work IRL

Anticipate barriers to successful implementation and plan modifications

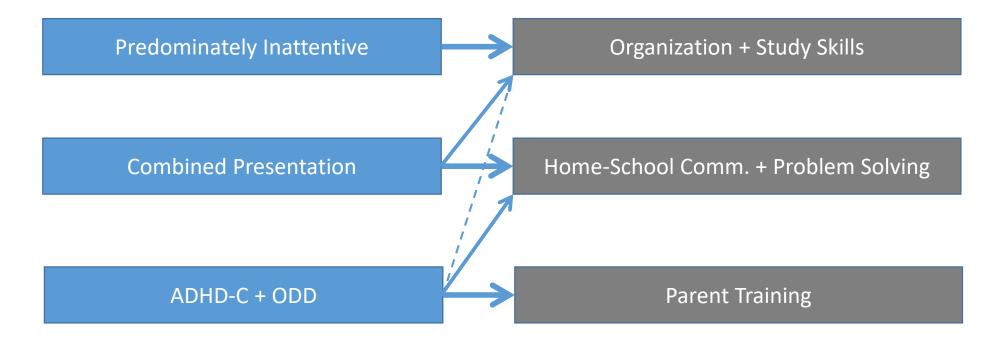
Basic Rules of Thumb

 Generally speaking, there is evidence to suggest the following prescriptions:



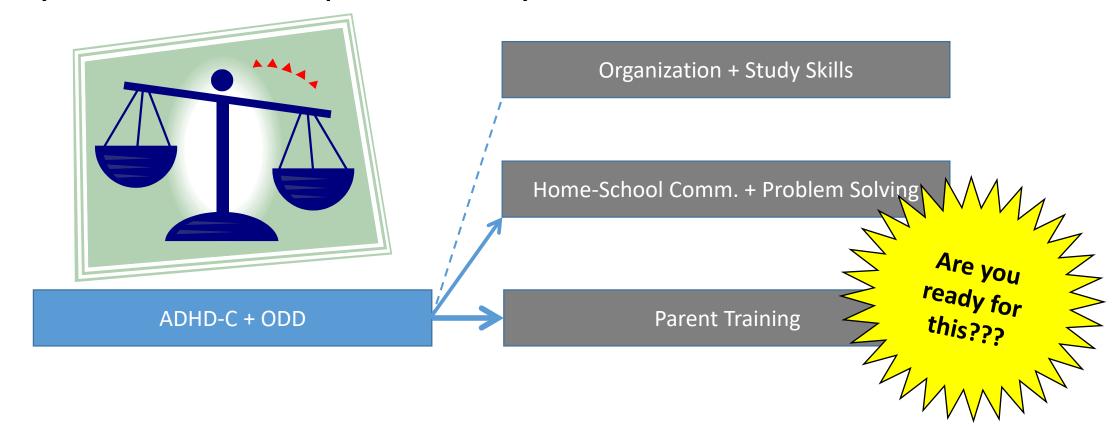
Basic Rules of Thumb

 Notice, however, that the adults who are the most stressed are required to engage in the most intervention:



Basic Rules of Thumb

 So it is perhaps not surprising that these same families are likely to discontinue prematurely:



Stages of Change

(Miller & Rollnick, 2002)

Maintenance

 Already made a change and now the challenge is sustaining it; "Relapses" are still possible

Action

• Visible changes are being made, but some ambivalence might still exist; self-efficacy is a crucial component

We want parents/teachers to be ready to act, but this is most often not the case!

Stages of Change

(Miller & Rollnick, 2002)

Preparation

 Ready to change and on verge of action, but needs to develop an action plan; "I'm so ready!" but no real plan; this is a cost-benefit analysis

• Contemplative

 Acknowledges the problem, but is highly ambivalent about change; Cannot combat the temptation of old behaviors

Precontemplative

 Unaware of the problem; unwilling/discouraged from changing behavior; reluctant ("resistant")



An everyday scenario in schools...

Cons of Helping a "Bad" Kid

- Nothing I could do would even scratch the surface
- The parents should be doing this stuff
- Kids like this are typically sent to SPED/the alternative school
- The role of the teacher is to teach this will only interfere
- No one will appreciate the effort I put into it
- I'm not good at working with kids like this

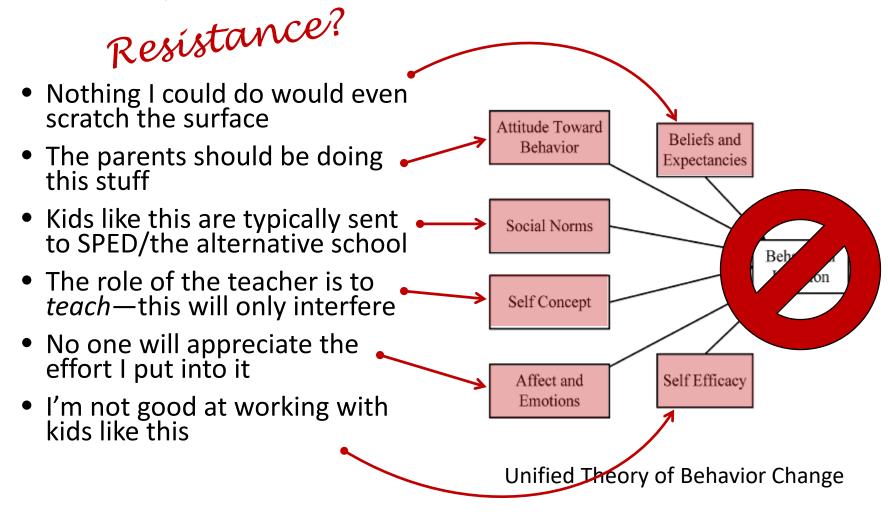
Pros of Helping a "Bad" Kid

- Change his trajectory and prevent worse things from happening
- Feel good about being effective/helping others



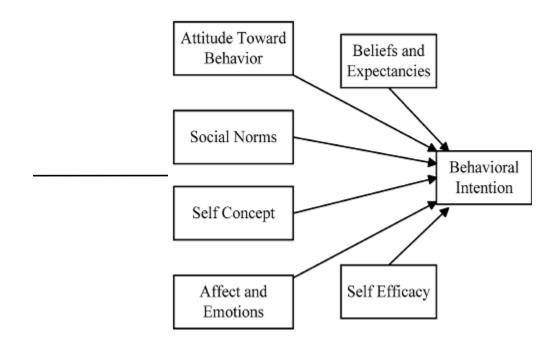
...that makes change unlikely.

(adapted from Olin et al., 2010)



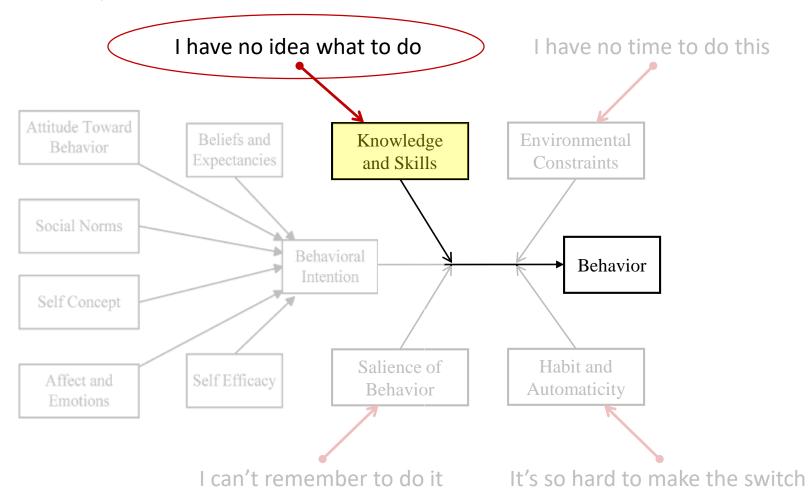
...that makes change unlikely.

(adapted from Olin et al., 2010)



...that makes change unlikely.

(adapted from Olin et al., 2010)



In Practice, We Have to be Flexible!

- On the next slides, we'll go through two additional case scenarios. Your goal is to plan modifications that are:
 - Realistic
 - Feasible
 - Acceptable
 - Consistent with the original intent of the intervention

Case Study – "Randall"

Randall is a 12-year old seventh grader who is danger of being suspended for inappropriate behavior. Randall's mother has been to parent training in the past and believes that working with you is unlikely to be helpful, but she's trying to convince the school that she is doing something. Randall's teachers describe him as "extremely immature" because he is often out of his seat and disrupting other students in the class. Randall's mom complains of similar impulsive behaviors at home, but mostly around blurting out rude comments to adults (sometimes strangers), which are extremely embarrassing. Randall had taken Ritalin in the past, and the medication did help, but since entering middle school he has complained about taking it every morning. When he prescription ran out earlier this school year, Randall's mother agreed to let him go without medications this year to see how he does.

Case Study – "Kamlyn"

Deandrea's daughter Kamlyn, a tenth grader, was struggling in most of her classes. Kamlyn had a history of being very resistant to her mother's attempts to help her with organization or homework, despite earning low grades since elementary school. After thinking about the problem for a while, Deandrea set up a homework plan that was rewarded with special privileges, such as visits to her cousin's house (who lives a block away). Two weeks after the start of the new homework plan, Deandrea met with the case worker and admitted that she gave up with the plan after only a few nights. Kamlyn was more resistant than Deandrea had anticipated, and on the first night Kamlyn refused to do any homework. After 30 minutes of pleading, Deandrea gave in and allowed Kamlyn to go to her cousin's house to avoid further arguing. The next night, the same thing happened again, but Deandrea decided that she would not give in again. After 45 minutes of arguing, Kamlyn seemed ready to do her homework, but when her mother was occupied with dinner, Kamlyn walked to her cousin's house.

Summary for Section IV

- The research suggests some basic connections between presentation types and interventions (e.g., inattention = organization)
- Unfortunately, as ADHD worsens (and comorbidities arise), already stressed families typically require the most treatment
- One of the biggest concerns that is not often assessed is parent/teacher motivation for change—in terms of intervention, this can be key
- Ultimately intervention success depends on the successful match between intervention demands and parent/teacher commitment

Resources???

• If you want the slides or any of the materials you see today, go to:

http://schoolpsychologytech.org

Click on "Resources"

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