Understanding and Responding to the Behavioural Issues of Students Diagnosed with Oppositional Defiant Disorder, Social Anxiety Disorder and/or Attention Deficit Hyperactivity Disorder in Early and Middle Years

Efstathios Petroulakis, Megan Morgan, Paulette LaFleur, Sherri Black

A Teacher’s Information & Strategy Guide
Overview

The *Public Schools Amendment Act*, Manitoba’s commitment to ensuring that all students receive appropriate educational programming, supporting both social and academic goals within the mainstream classroom, was enacted in 2005. This act, mandating inclusion in schools, created a paradigm shift in service delivery models across the province. Today, classrooms are comprised of heterogeneous student groupings, including an increased number of students with emotional behavioural disorders, special needs and exceptionalities. It is essential for teachers to understand students’ special needs and exceptionalities in order to provide effective inclusive learning environments. This includes building capacity, understanding and responding to those students who exhibit challenging behaviours, specifically those students who exhibit challenging behaviours related to psychiatric diagnoses. Three prevalent psychiatric disorders affecting students, families, schools and communities, are Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder and Social Anxiety Disorder. This resource intends to:

- Provide relevant information to teachers about all disorders.
- Provide effective instructional and behavioural strategies that address the needs of students diagnosed with one or more of these disorders.
- Differentiate strategies and best practices for students found within the universal, targeted, and intensive populations.
- Provide resources, templates, and a resource list for classroom teachers.
**Important Concepts**

*Universal Population* - Refers to effective universal intervention strategies supporting students working within the provincial curriculum (at grade-level range, with or without adaptations) who are benefiting from good classroom teaching and management, differentiate instruction and curricular adaptations for academic, social, emotional and behavioural development. The universal population makes up approximately 80 -90 % of your school population.

*Targeted Population* – Refers to effective targeted intervention strategies used to support students working within the provincial curriculum at or towards grade-level outcomes who require supports beyond differentiated instruction and curricular adaptations for academic, social, emotional and behavioural development.

*Intensive Population* – Refers to effective intensive intervention strategies for 1 – 5% of students – individualized programming and/or support. These strategies support students receiving Level II and Level III provincial categorical funding, in addition to or lieu of universal and intensive strategies.
## Table of Contents

I. Introduction p. 5

II. How to Use This Guide p. 6

III. Behaving and Learning p. 7

IV. Understanding Oppositional Defiant Disorder p. 11

V. Behavioural Strategies and Interventions ODD p. 15

VI. Understanding Attention Deficit Hyperactivity Disorder p. 23

VII. Understanding Social Anxiety Disorder p. 36

VIII. Behavioural Strategies and Interventions Social Anxiety Disorder p. 39

IX. Instructional Strategies for ODD, ADHD, & Social Anxiety Disorder p. 41

X. Beyond Instruction: Supports for Classroom Teachers, beyond the classroom p. 59

XI. List of Resources p. 70

XII. Appendix A – Templates & Exemplars p. 73
Introduction

According to Manitoba Education, Citizenship and Youth’s support document *Towards inclusion – from challenges to possibilities: Planning for behaviour* (2001), children experiencing behavioural challenges is the fastest growing special needs group not only in Manitoba schools, but also in many places across Canada. There continues to be concern regarding the rise in numbers of behavioural issues schools and classroom teachers are experiencing. One reason teachers may be experiencing an increase in challenging behaviours within the classroom, is the inclusion of students within the mainstream diagnosed with emotional behavioural disorders, such as Attention Deficit Disorder, Oppositional Defiant Disorder and Social Anxiety Disorder, only to name a few. Prior to inclusive education legislation, pull-out service delivery systems were quite common, with many students diagnosed with emotional behaviour disorders, removed from the classroom setting for a portion of the school day, or in some instances all day. Inclusive education legislation requires schools and teachers to take responsibility in creating inclusive, enabling classrooms and school environments for all learners, including those students diagnosed with emotional behavioural disorders.

It is widely held that growth and understanding occur best when the learning environment understands and respects the capabilities of all learners and provides the challenge and expectation to foster individual development. To create classrooms conducive to learning for all students, educators have a responsibility to challenge themselves within their professional practice, continuously striving to move forward and build professional capacity. This resource is intended to be an informative and guiding
tool for teachers who have students diagnosed with Oppositional Defiant Disorder and/or Social Anxiety Disorder in their classrooms. It is hoped teachers will use this resource to build capacity and create classrooms conducive to learning for all students, while at the same time, have the knowledge, tools and resources to address the needs of specific students, including those who require more intensive or targeted supports.

**How to Use this Guide**

This guide is divided into four initial sections: Learning and Behaving, Understanding Oppositional Defiant Disorder, Understanding Attention Deficit Disorder and Understanding Social Anxiety Disorder. The first section provides an overview of the continuum of positive behaviour supports and interventions for the universal population, the targeted population and the intensive populations generally found in all schools and classrooms (Sprick, R; Scott, T). The behaving and learning continuum provides an overview of specific and universal strategies for learners, including those with diagnosed psychiatric disorders. The next three sections provide comprehensive information about each disorder, including diagnosis, possible causes, treatment options, concurrence with other disorders and identify possible implications for the classroom.

Following the comprehensive diagnosis information, are sections providing effective instructional and behavioural strategies for early and/or middle years teachers who may have students with one or more of these emotional behavioural diagnoses in their classroom. Each suggested strategy will be marked with a green, amber, or red triangle, indicating universal, targeted or intensive population strategies, according to
the Learning and Behaving continuum. This is done in an effort to provide ease in finding the strategies appropriate for different situations. Templates for strategies are found in the appendix. A comprehensive resource list is provided at the end.

**Behaving and Learning: Universal, Targeted, and Intensive**

Best practices in teaching are designed to meet the needs of the universal student population. Best practices in teaching include, but are not limited to: differentiated instruction, differentiated assessment, good classroom management, continuous teaching of organizational skills, self-regulation, study and transition skills, classroom-based social skills instruction and positive, respectful relationship building. When used consistently, these practices address the needs of the universal population, students working at or close to grade level outcomes, comprising 80 - 90% of students (please see figure 1A). All students benefit from these practices, though in some cases, including those students with diagnosed emotional behavioural disorders, these strategies may not meet all student needs.

Students who require supports beyond best practices, including differentiated instruction and assessment and curricular adaptations for academic, social, emotional and behavioural development, are considered to fall within the targeted or amber population. These students may require more individualized attention and adaptations beyond differentiated instruction and supports. Many students diagnosed with ADHD, ODD and Social Anxiety Disorder may fall into this category, especially if students are diagnosed with one or more of these disorders. Figure 1A identifies effective targeted intervention strategies for 5 – 15% of the student population. Often, according to Randy
Sprick (2001), students can be moved from the targeted population back into the universal population, with effective, consistent targeted interventions. Students requiring more targeted interventions, but do not receive them, will likely move into the intensive population.

Students, whose needs are not met by differentiated or targeted interventions, fall into the intensive population, these students usually comprise on average 1 – 5% of your student population. These students require more intensive interventions and individualized programming to help support appropriate programming and student achievement and success (Figure 1A). These students have significant needs, usually requiring individual programming, Circle of Care/24-hour planning, and categorical provincial funding. Some, but not all students with psychiatric diagnoses, may fall into this category.

Students with diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, and/or Social Anxiety Disorder are found across all three domains, depending on the severity and symptoms of the students. Co-morbidity exists between these three psychiatric diagnoses. It is typical for ADHD symptoms to co-exist with other symptoms and disorders such as: Oppositional Defiant Disorder, Anxiety Disorder, Conduct Disorder, Bipolar Disorder, and Tourette’s Syndrome, just to mention a few. Some students diagnosed with these disorders will respond well and achieve success with differentiated instruction and assessment and adaptations; others will require targeted and/or intensive supports. As you will see, each student and each diagnosis can be different in presentation. Classroom settings provide contextual and confounding variables to each student, on any given day at any given moment. This is
why knowledge is power. Understanding the diagnoses, the classroom implications and
the implications of co-morbidity among these disorders will better enable teachers to
program appropriately for students within the inclusive school and classroom and to
create classroom environments that meet the needs of all students. Even when all
organizational procedures are clarified, classroom discipline addressed, and
teacher/student relationships are sound and positive (universal population), some
students with disabilities will need further accommodations (targeted population). For
example a student with ADHD may need a standing desk so that he or she may move
while working (Friend, 2009). A student with a learning disability or oppositional defiant
disorder may require an individualized reinforcement schedule where he or she earns
rewards for each 5 minutes of on-task behaviour. It is intended that this guide will allow
teachers to work smarter, not harder when addressing the often varying needs of all
students within the inclusive classroom environment.
Relationships are key: Students don’t care what you know, until they know that you care.
Understanding Oppositional Defiant Disorder

“You can’t change what you don’t understand”  
– B. Dylan

“Hope comes from understanding and understanding comes from empathy; but when teaching children with Oppositional Defiance Disorder, empathy does not come easily.”  
- Philip Hall

A. What is Oppositional Defiant Disorder?

The mental health professionals' handbook, The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR), classifies ODD as a disruptive behaviour disorder:

Oppositional defiant disorder (ODD) is a disorder found primarily in children and adolescents. It is characterized by negative, disobedient, or defiant behaviour that is worse than the normal "testing" behaviour most children display from time to time. Most children go through periods of being difficult, particularly during the period from 18 months to three years, and later during adolescence. These difficult periods are part of the normal developmental process.

Children who have ODD are often disobedient. They are easily angered and may seem to be angry much of the time. Very young children with the disorder will throw temper tantrums that last for 30 minutes or longer, over seemingly trivial matters.

In addition, the child with ODD often starts arguments and will not give up. Winning the argument seems to be very important to a child with this disorder. Even if the youth knows that he or she will lose a privilege or otherwise be punished for continuing the tantrum or argument, he or she is unable to stop. Attempting to reason
with such a child often backfires because the child perceives rational discussion as a continuation of the argument.

Most children with ODD, however, do not perceive themselves as being argumentative or difficult. It is usual for such children to blame all their problems on others. Such children can also be perfectionists and have a strong sense of justice regarding violations of what they consider correct behaviour. They are impatient and intolerant of others. They are more likely to argue verbally with other children than to get into physical fights.

**B. Causes:**

The exact cause of ODD is not known, but it is believed that a combination of biological, genetic, and environmental factors may contribute to the condition.

- **Biological:** Some studies suggest that defects in or injuries to certain areas of the brain can lead to serious behavioural problems in children. In addition, ODD has been linked to abnormal amounts of special chemicals in the brain called neurotransmitters. Neurotransmitters help nerve cells in the brain communicate with each other. If these chemicals are out of balance or not working properly, messages may not make it through the brain correctly, leading to symptoms of ODD, and other mental illnesses. Further, many children and teens with ODD also have other mental illnesses, such as ADHD, learning disorders, depression, or an anxiety disorder, which may contribute to their behaviour problems.
• **Genetics**: Many children and teens with ODD have close family members with mental illnesses, including mood disorders, anxiety disorders, and personality disorders. This suggests that a vulnerability to develop ODD may be inherited. This pattern may, however, reflect behaviour learned from previous generations rather than the effects of a gene or genes for the disorder.

• **Environmental**: Factors such as a dysfunctional family life, a family history of mental illnesses and/or substance abuse and inconsistent discipline by parents may contribute to the development of behaviour disorders.

**C. Diagnosing Oppositional Defiant Disorder:**

According to the *DSM-IV-TR*, a diagnosis of ODD may be given to children who meet the following criteria, provided the behaviour occurs more frequently than usual compared to children of the same age and developmental level. A pattern of negative, hostile, and defiant behaviour lasting at least six months, during which four (or more) of the following are present. The child:

- often loses his or her temper
- frequently argues
- often disregards adults' requests or rules
- deliberately tries to provoke people
- frequently blames others for his or her mistakes or misbehaviour
- is often easily irritated by others
- is often angry and resentful
- is often spiteful
In order to make the diagnosis of oppositional defiant disorder, the behavioural disturbances must cause significant impairment in the child's social, academic or occupational functioning, and the behaviours must not occur exclusively during the course of a psychotic or mood disorder.

D. How Is Oppositional Defiant Disorder Treated?

Treatment for ODD is determined based on many factors, including the child's age, the severity of symptoms, and the child's ability to participate in and tolerate specific therapies. Treatment usually consists of a combination of the following:

- **Psychotherapy**: Psychotherapy (a type of counselling) is aimed at helping the child develop more effective ways to express and control anger. A type of therapy, called cognitive-behavioural therapy, aims to reshape the child's thinking (cognition) to improve behaviour. Family therapy may be used to help improve family interactions and communication among family members. A specialized therapy technique, called parent management training (PMT), teaches parents ways to positively alter their child's behaviour.

- **Medication**: While there is no medication formally approved to treat ODD, various drugs may be used to treat some of its distressing symptoms; as well as any other mental illnesses that may be present, such as ADHD or depression.
Behavioural Strategies for Children with Oppositional Defiance Disorder:

1. **Avoid all power struggles with this student.** They will get you nowhere.
   Decide which behaviours you are going to ignore. Most children with ODD are doing too many things you dislike to include all of them in a behaviour management plan; thus, target only a few important behaviours rather than try to fix everything.

2. **Avoid verbal exchanges.** State your position clearly and concisely and choose your battles wisely. Do not take the defiance personally. It is critical not to take what the student says personally. As soon as you defend yourself, your child, by the rules governing arguments, has the right to defend himself against your attack. In turn, you get to defend yourself, and he has now pushed your buttons and gained power. You do not have to defend yourself or try to convince him you are right. Do not lower yourself to the level of the oppositional child **remember**, you are the outlet and not the cause for the defiance- unless you are shouting, arguing or attempting to handle the student with sarcasm.

3. **Avoid making comments or bringing up situations that may be a source of argument for them.** Avoiding conflict is essential to de-escalate the situation. It is wise to change the subject if you suspect that the topic of discussion will result in an argument. When you must deliver a command to, confront, or discipline a student who is defiant or confrontational, be careful not to get 'hooked' into a discussion or argument with that student. If you find yourself being drawn into an exchange with the student (e.g., raising your voice, reprimanding the student), immediately use strategies to disengage yourself.


(e.g., by moving away from the student, repeating your request in a business-like tone of voice, imposing a pre-determined consequence for noncompliance). The following is a strategy to follow, should the student choose to escalate. Should the student choose to escalate, it is time to use two powerful words. These words are “regardless” and “nevertheless”. The use of these words clearly indicates you requests are not negotiable example, “nevertheless, this is how it is going to be…” Using these words repetitively (like a broken record), in a calm unemotional manner will serve to de-escalate the situation without allowing your child to draw you into the power struggle.

4. **Emphasize the positives in Teacher Requests.** When an instructor’s request has a positive 'spin', that teacher is less likely to trigger a power struggle and more likely to gain student compliance. Whenever possible, avoid using negative phrasing (e.g., "If you don't return to your seat, I can’t help you with your assignment"). Instead, restate requests in positive terms (e.g., "I will be over to help you on the assignment just as soon as you return to your seat.

5. **Positive Praise and Establishing Rapport:** Establish rapport with the student. If the student perceives you as reasonable and fair you will be able to work more effectively with him or her. Create rapport by communicating to the child that you feel they are capable and you know how hard they are trying. Establishing rapport involves making positive connections throughout the day that describes the student’s appropriate behaviour. Make positive connections with students by using some of these statements:

   i. You’re fun to be around because …
You’re really good at …

I Like it when you …

You did a good job when you…

You’re a good listener. I saw that you…

I’m glad you are in my class because…

I would like to get to know you better because…

I really liked your …

You helped when you…

These statements acknowledge the student’s behaviour, and shows them that you are noticing the positives that they are able to exhibit and your recognition of the student is not only occurring during periods of misbehaviour.

Providing positive immediate feedback following appropriate behaviour allows for students to easily associate the appropriate behaviour with the positive feedback. Positive praise allows the teacher to acknowledge the students for their efforts and allows the student to see themselves as capable of achieving positive behaviour. Example of Positive praise: smiling, giving compliments, giving specific feedback (e.g. telling the students what you like about his or her work), giving complimentary notes, and posting good work. Positive praise helps promote a positive self image for the child but the Oppositional Defiant student will need incentives or rewards to maintain his/her motivation. Token economies are often very effective when working with a student with ODD.
6. **Using Token Economies:** A student-specific token economy system includes a behavioural objective with corresponding symbols that reinforce the use of positive behaviour. Reinforcers can include things such as: check marks, happy faces, tickets, stickers on a chart, and poker chips.

Students will then use the tokens to keep track of the number of times they have performed their behavioural objectives. They can trade these tokens for positive consequences from a list. To allow for the student to be more involved and give them more ownership in the management of their behaviour, they can make their own list of positive consequences as agreed upon between the student and teacher.

Benefits of Token economies are:

i. Students receive lots of immediate, frequent feedback for appropriate behaviours

ii. Teachers can deliver the symbolic reinforcers quickly and effectively without disturbing the class.

iii. Teachers can reinforce several behaviour objectives or classroom rules at once.

iv. Students can learn organizational skills and responsibility by keeping track of and calculating their tokens.

7. **Implementing Student-Specific Negative Consequences:**

Most children with ODD do not perceive themselves as being argumentative or difficult. It is usual for such children to blame all their problems on others. Such children can also be perfectionists and have a strong sense of justice regarding
violations of what they consider correct behaviour. This is why implementing negative consequences can be so difficult and is often met with non-compliance and argumentative behaviour. Implement negative consequence using a system that is focused on and clearly addresses the behaviour. Specific strategies include:

i. Attacking the problem rather than the student. Students must understand that they are being disciplined for particular acts of misbehaviour and not because of who they are.

ii. Identify the consequences for particular rules and routines and have them posted in the classroom and even have them posted on the student’s desk. Follow through and use a planned consequence. Planning can increase a teacher’s ability to think quickly and act effectively. Be consistent and deliver the consequence in a thoughtful, clear, calm and predictable manner.

iii. Simply state the rule or agreement that the student did not follow and give only one planned consequence. Do not string consequences together.

iv. Use consequences of a short duration and give them immediately following the inappropriate behaviour.

v. Use logical Negative Consequences. Students are more likely to cooperate when they see the logical connection between what they do and what happens to them. See Reasonable and Logical Negative Consequences chart.

vi. Be quick. Do not engage in excuses or bargaining. Continuing the episode will lead to escalation and create a power struggle. Ensure that
more public, positive attention is directed towards academic work than misbehaviour.

vii. Give the student five to ten seconds to respond.

viii. Use social reinforcers such as words of praise or facial expressions (smiles) if the student complies.

8. **Effective Time Out Procedures:** When students are continually disruptive and do not respond to the teachers directions to stop inappropriate behaviours, the teacher may need to remove them from their present environment. You should establish a set of procedures for using time-out in your classroom including:

   i. A hierarchy of planned consequences for misbehaviour that all students acknowledge and understand, with time-out as one of several alternatives for consequences for misbehaviour.

   ii. A range of time-out locations suited to your classroom, your pupils, and your personal classroom management plan.

   iii. A set of personal guidelines for deciding when to use time-out and what level of time-out to employ.

A proposed method for setting up time-out schedule with a classroom with a student or students with ODD is as follows:

1. **signal** indicating that time-out is imminent if the pupil doesn’t alter his/her behaviour.

2. A brief **verbalized explanation** of why the student is being given a time-out if the student does not alter behaviour after warning signal was given
3. The location in which time-out is taken: **Contingent observation** - requires the student to remain in a position to observe the group without participating or receiving reinforcement for a specified period.

**Exclusionary** - denies access to reinforcement by removing a student from an ongoing activity. **Seclusionary** - removes the student from the instructional setting as a means of denying access to reinforcement.

4. The duration of time-out - Brief (e.g., 1-5 minutes) timeouts are as effective as longer timeouts if the student hasn't been exposed to long timeouts first. Durations longer than 15 minutes should not be employed. A **nonverbal signal** indicating the beginning and end of time-out may be used if students have been taught to respond to it.

5. Requirements for release from time-out are:
   
   i. Completion of the specified duration of time-out.
   
   ii. Appropriate behaviour during time-out.
   
   iii. End of 15 minute maximum duration of time-out (implement alternate intervention if timeout has not been effective at this point)

**N.B.** Removal of students from a reinforcing environment, where they receive positive interactions from others has the most influence on the effectiveness of the TO procedure, not the amount of time spent in the TO area. The purpose of time out is to provide students with a cooling-off period where they can gain control.
6. **Post Time Out - Behaviours After:**

- Defenses Down, emotionally drained
- Physically exhausted, passive
- Calm, apologetic, remorseful or embarrassed (maybe)
- Ready to continue their day/Open to New Learning
- Remind the person that they are safe.
- Do not talk about consequences. Cook feels that it is the same as disciplining someone for having a heart attack or a diabetic shock;
- Allow the person to put the rage behind them, when the child is ready, use this time as a teaching opportunity

7. **Tips for Debriefing:**

- Encourage the student when they are down.(e.g. I know we can resolve this)
- Focus on helping each other ( “We” not “I”)
- If student becomes too emotional hook into thinking. (e.g. Ask for detail, clarify and paraphrase)
- Acknowledge feelings (e.g. I know that sometimes you feel picked on)
Give the student credit for their small victories. (E.g. I’m glad to see you stopped and thought before you…) 

Review the rules before returning to the classroom. Mirror and then pace the student.

Understanding Attention Deficit Disorder & Attention Deficit Hyperactivity Disorder

“Attention Deficit Disorder is not a disease, it’s part of the spectrum of children’s behaviour. The issue is to find the line where abnormality stops and normality begins, and the line moves according to who’s drawing it”

*Speed for Breakfast, 1995.*

According to Rief (1993), 3 to 10 percent of school aged children are diagnosed with ADD/ADHD. That means by grade three a class of thirty could potentially have three students who have been diagnosed with ADD OR ADHD disorders. The American Medical Association published scientific literature concerning ADHD and concluded that while there may be instances of over-diagnosis of the disorder, there is a greater problem of under-diagnosis. Therefore, these statistics are much lower than the reality. Moreover, in each class students who have not been diagnosed display different degrees of the characteristics of these disorders. From the beginning of the year, the classroom teacher must be armed with the preventative strategies as well as the reactive strategies in order to confidently make classroom management and academic decisions to have a successful year. Although, the child is not able to articulate what is causing him/her to behave that way, it is the teacher’s
professional responsibility to act like a detective and analyze the observations as he/she is thinking about what the behaviours are trying to tell him/her so the teacher can develop interventions to better support the child.

**A. What is Attention Deficit Hyperactivity Disorder?**

The National Institute of Mental Health defines Attention Deficit Hyperactivity Disorder as a neurological behavioural disorder that impairs the children’s ability to function in multiple settings, including home, school, and in relationships with peers. Children with ADHD show chronic and more severe symptoms of behaviours including inability to focus and inattentiveness, difficulty controlling themselves, and hyperactivity (over-activity) than the other children from the same age group. According to Rief (2005), a history of the symptoms must be evident (minimally 6 months) as well as academic and/or social impairments in order to be diagnosed with ADHD. The National Institute of Mental Health (1998) defines a procedure of assessments to screen and diagnose ADHD which involve parents, school and outside supports. The procedures are as follows:

- **i.** Parent and school fill out questionnaires, rating scales of core symptoms to establish a pattern of behaviours in various settings, age of onset, degree of symptoms and impairment.

- **ii.** School based assessments on academic, emotion and social performances,

- **iii.** Other diagnostics to assess child of other coexisting conditions

- **iv.** Communication assessments.
B. Causes

Genetic research has found at least two “candidate” genes associated with ADHD (Rief, 2005). Furthermore, Barkley (1998) found 80% of the students with ADHD are caused from heredity. Other factors have caused ADHD:

i. Prenatal, during or postnatal trauma or injury such as fetal exposure and/or cigarettes,

ii. Exposure to high level of lead,

iii. Some complications during pregnancy or birth, brain injury to the frontal lobe from a disease or trauma.

iv. Chemical Imbalances:

v. Environmental Factors such as living in dysfunction with limited management skills or structure versus chaos.

Research does not support the notion that diet, food, additives and sugar can cause ADHD.

C. Diagnosing Attention Deficit Hyperactivity Disorder

- **Professionals:** There are many different types of professionals who can evaluate for a diagnosis. Such professionals include psychiatrists, paediatricians, neurologists, psychologists, social workers, nurse practitioners, family practitioners and other licensed counselors or therapists (e.g. professional counselors, marriage and family therapists, etc. However, only certified medical professionals can prescribe medication for the disorder.
**Tools to diagnose:**

Doctors, mental health professionals, and other certified clinicians use a manual called The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, published by the American Psychiatric Association (APA, 2000) that sets the criteria for symptoms to assist in diagnosing the disability. The diagnosis of ADHD is made by gathering the information from different sources or settings and analyzing the findings to determine if the child has consistent and significant enough symptoms for having ADHD. ADHD symptoms may co-exist with other symptoms and disorders such as Oppositional Defiant Disorders, Anxiety Disorders, Conduct Disorders, Bi-Polar Disorder, Depression and Tourette’s Syndrome, to name a few.

The DSM-IV has identified and isolated three sub-types of ADHD based on the symptoms: *Inattentive type, Hyperactive type, and Combined type.*

1. **Inattentiveness:** According to NIMH the following are signs and symptoms individuals who may be diagnosed with inattention may display:

   - Be easily distracted, miss details, forget information or tasks, and frequently switch from one activity to another,
   - Have difficulty focusing on one task or thought,
   - Become bored with a task after only a few minutes, unless they are doing something enjoyable,
   - Have difficulty focusing attention on organizational strategies to learn something new
✓ Have trouble organizing, completing or submitting homework assignments,
✓ Have difficulty to work independently,
✓ Have inconsistent performance achievement in tests/assessments and assignments
✓ Disorganized such as often losing belongings or materials needed to complete tasks or activities (e.g., pencils, toys, assignments),
✓ Not seem to listen when spoken to or tunes out,
✓ Daydream, become easily confused, and move slowly,
✓ Have trouble processing information as quickly and accurately as others,
✓ Struggle to follow instructions.

Parents and teachers may miss children with these symptoms of the disorder. These children are often quiet and cooperative. They can camouflage themselves in the classroom by sitting still and seeming to do their work even though they are often not able to pay attention or follow directions as a result of their disability. Their inability to get work completed may seem to be rooted from lack of organizational skills rather than lack of attentiveness.

ii. **Hyperactivity**: Children who have symptoms of **hyperactivity** (ADHD) may:
✓ Fidget and squirm in their seats
✓ Finds nearby objects to play with/put in mouth. (Rief, 2005)
✓ Talk nonstop
✓ Dash around, touching or playing with anything and everything in sight
✓ Have trouble sitting still during dinner, roams around the classroom or the school, and story time
✓ Have difficulty doing quiet tasks or activities.
✓ Be constantly in motion. Often runs about or climbs excessively in situations in which it is inappropriate (AMA, 1998)

iii. **Impulsivity:** Children who have symptoms of impulsivity may:

✓ Be very impatient,
✓ Blurts out answers instead of waiting his/her turn,
✓ Have difficulty keeping conversation relevant to topic at hand, blurt out inappropriate comments, show their emotions without restraint, and act without regard for consequences,
✓ Have difficulty waiting for things they want or waiting their turns in games,
✓ Often interrupt conversations or others’ activities.
✓ Gets in trouble because he/she cannot stop and think before acting. (Rief, 2005)

These children are less likely to be missed. They take more of the parents’ and teacher’s time.
According to the NIMH, ADHD has three subtypes: predominantly hyperactive-impulsive, predominantly inattentive, combined hyperactive-impulsive inattentive.

i. **Predominantly hyperactive-impulsive**:
   - Most symptoms (six or more) are in the hyperactivity-impulsivity categories.
   - Fewer than six symptoms of inattention are present, although inattention may still be present to some degree.

ii. **Predominantly inattentive**:
   - The majority of symptoms (six or more) are in the inattention category and fewer than six symptoms of hyperactivity-impulsivity are present, although hyperactivity-impulsivity may still be present to some degree.
   - Children with this subtype are less likely to act out or have difficulties getting along with other children. They may sit quietly, but they are not paying attention to what they are doing. Therefore, the child may be overlooked, and parents and teachers may not notice that he or she has ADHD.

iii. **Combined hyperactive-impulsive and inattentive**
   - Six or more symptoms of inattention and six or more symptoms of hyperactivity-impulsivity are present.
   - Most children have the combined type of ADHD.

**D. How is Attention Deficit Hyperactivity Disorder Treated?**

Once the child has been diagnosed, there are many different strategies used to help the child, the family and the school. Physicians, clinicians (mental health and
medical professionals), educators and divisional consultants as well as parents work collaboratively to develop a multimodal treatment plan to treat the child and support the family. It is important that all of the members of your treatment team communicate with each other on a regular basis for the multimodal approach to be successful. The interventions ought to be based on the age of the child with ADHD, the severity of symptoms and the needs of teacher, as well as all the members of the family. According to Rief (2005), a multimodal treatment program may include:

- Medical/pharmacological intervention monitored regularly by a medical team,
- Parent counselling/training to learn a set of skills to manage behaviour and structure the home environment,
- Family counselling to help other members of the family cope with the issues dealing with ADHD behaviours,
- Individual counselling to help the child to learn some social and emotional strategies in order to better self-regulate or to better problem solve situations.
- Social skills training such as waiting for a turn, listening and responding to conversations, read body language, etc.
- Educational supports to make environmental, behavioural, academic, instructional accommodations,
- ADHD coaching,
- Physical outlets such as individual sports that require the child to increase their ability to focus: swimming, martial arts, gymnastics and team sports such as soccer and basket ball that require less waiting time,
Peer tutoring.

Research has been conducted to review different approaches to the treatment of ADHD. Ervin (1996) concluded that when the treatment plan includes a combination of interventions such as pharmacological, behaviour management and cognitive behavioural intervention as well as parenting and educational interventions, the outcomes would be better than one isolated intervention. Other research indicates that stimulant medications are the best most effective intervention in isolation to better manage symptoms and to improve the child’s functionality. According to a report of the Surgeon General (Mental Health: A Report of the Surgeon General, 2003), “stimulants are highly effective for 75 to 90 percent of children with ADHD.”

**Medication:** While there is no cure for this disorder, medication will help in temporarily controlling some of the symptoms. According to Rief (2005), researchers suspect that the medications normalize the biochemistry in the parts of the brain that causes ADHD. They improve the nerve to nerve communication. Certified medical professionals can only prescribe medication for the disorder. First the professionals must establish the goal for taking medication. If the medication helps the children to improve their ability to learn as a result of being more attentive and less hyperactive, medication is a plausible first step and the educational outcome has been met. However, if the children with ADHD do not show any progress, but are better able to control the dysfunctional behaviour in the short term, has the medical intervention been effective? (Pelham et al. 1998). Pelham (1998), believes that there is no long term academic improvement for
medicating students. However, these authors conclude medication is less expensive than psychosocial interventions and for this reason; it may be a preferred intervention.

Implications of stimulant medication: The following factors can influence the child’s behaviour and academic performance:

1. **Short acting Formulas**
   - Start to work about twenty minutes from the time taken
   - Metabolize quickly and are effective for 3 to 4 hours
   - Generally require an additional dose to be provided at school
   - May require a third smaller dose in order for the child to function more successfully in the late afternoon

2. **Long-lasting formulas:**
   - Take longer to take effect
   - Last about six to eight hours for some medication, while others can last as long as ten to twelve hours
   - Provide a smoother, more sustained level of drug throughout the day
   - Minimize the peaks and trough in blood levels

Other medication factors to consider include:

**Rebound phenomenon:** the worsening of ADHD symptoms such as moodiness, irritability, less compliance, more activity as the medication wears off.
- **Half-life**: the rate different drugs break down, as it is eliminated through the body. For example, the half-life of Ritalin is between 2 to 3 hours. This means, 50% of the medication is left after 2 – 3 hours and 25% is left after another 2-3 hours. This is important for programming and scheduling of the school day, order of tasks, expectations and peak performance time for the student.

- **Peak effects**: related to half-life. For example, Ritalin’s peak life is usually 1.5 – 2 hours after being administered. The effects after that time are likely to diminish, as is the ability of the child to concentrate, focus and self-regulate.

- **Side-effects**: headaches, stomache, insomnia, reduction of appetite, irritability, and dizziness, all of which affect the student.

All of these factors must be considered for planning an effective program respecting the waves of symptoms as a result of the medication. Kollins, Barkley & DuPaul (2002)’s table for the clinical effects, contraindications, dosing information, peak effects, half life, and side effects of the stimulant medication. Please see **Table 1A** and **Table 1B** for Drugs, clinical effects, contraindications, dosing information, peak effects, half like, and side effects.

Anti-depressants are often prescribed for students with co-existing disorders such as Social Anxiety Disorder and Oppositional Defiant Disorder or as a second-line choice for students with ADHD. Antidepressant medications may be prescribed to
students with ADHD who do not respond to stimulant mediation or who cannot tolerate the side effects of stimulant mediations (Rief, 2005).

**Table 1A: The Stimulants: Drugs, clinical effects, contraindications, dosing information, peak effects, half life, and side effects.**

<table>
<thead>
<tr>
<th>Drug features</th>
<th>Methylphenidate</th>
<th>d-amphetamine</th>
<th>Pemoline</th>
<th>Mixed amphetamine salts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand name</td>
<td>Ritalin</td>
<td>Dexedrine</td>
<td>Cylert</td>
<td>Adderall</td>
</tr>
<tr>
<td>Areas Shown to be improved.</td>
<td>Short term academic performance, teacher parent behaviour ratings, aggression, social functioning</td>
<td>Short term academic performance, teacher and behaviour ratings.</td>
<td>Short term academic performance, teacher behaviour ratings, on task behaviour.</td>
<td>Short term academic performance, teacher and parent ratings, on task behaviour. As effective as Ritalin but more potent.</td>
</tr>
<tr>
<td>Contraindications to use.</td>
<td>Tics, Tourette’s disorder, glaucoma, marked anxiety or agitation, psychosis</td>
<td>Hypertension, hyperthyroidism, cardiovascular disease, tics, Tourette’s disorder</td>
<td>Hepatic (liver) problems, psychosis</td>
<td>Hypertension, hyperthyroidism, cardiovascular disease</td>
</tr>
<tr>
<td>Recommended starting/Maximum dose</td>
<td>5-10 mg twice a day/ max. 60 mg. daily</td>
<td>2.5-5mg. one or two times daily/max. 40 mg. daily</td>
<td>37.5 mg. once daily/max. 112.5 mg. daily</td>
<td>2.5 – 5 mg. once or twice daily/max. 60 mg. daily</td>
</tr>
<tr>
<td>Half-life</td>
<td>2-3 hours</td>
<td>6-7 hours</td>
<td>2-12 hours</td>
<td>Not determined; probably similar to d-amphetamine (Dexedrine)</td>
</tr>
<tr>
<td>Common Side Effects</td>
<td>Insomnia, decreased appetite, stomachaches, headaches, dizziness</td>
<td>Insomnia, decreased appetite, irritability, anxiousness, crying, Social Anxiety Disorder/unhappiness, nightmares</td>
<td>None substantially different from placebo</td>
<td>Insomnia, decreased appetite, but not significantly different from placebo at group level</td>
</tr>
</tbody>
</table>

**Table 1B: The Antidepressant: Drugs, clinical effects, contraindications, dosing Information, peak effects, half-life, and side effects.**
<table>
<thead>
<tr>
<th>Drug feature</th>
<th>Tricyclic Antidepressants</th>
<th>Selective Serotonin Reuptake inhibitors</th>
<th>Other antidepressant compounds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Representative Drugs: Generic names/Brand names</strong></td>
<td>Imipramine/Tofranil (IMI)</td>
<td>Fluoxetine/Prozac (FLU)</td>
<td>Bupropion/Wellbutrin:</td>
</tr>
<tr>
<td></td>
<td>Desipramine/Norpramin (DMI)</td>
<td>Sertraline/Zoloft (SER)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Venlafaxine/Effexor (VEN)</td>
<td></td>
</tr>
<tr>
<td><strong>Areas shown to be improved</strong></td>
<td>Parent, teacher, clinician ratings</td>
<td>Clinician, teacher ratings, laboratory measures of impulsivity, IQ</td>
<td>Parent, teacher, clinician behaviour ratings, cognitive performance, laboratory measures of impulsivity</td>
</tr>
<tr>
<td><strong>Contraindications to use</strong></td>
<td>Concurrent use of monoamine oxidase inhibitors (MAOIs)</td>
<td>Concurrent use of monoamine oxidase inhibitors (MAOIs)</td>
<td>Concurrent use of monoamine oxidase inhibitors (MAOIs), seizure disorder, bulimia, or anorexia nervosa</td>
</tr>
<tr>
<td><strong>Recommended starting/Maximum dose</strong></td>
<td>IMI: 25 mg once daily/75 mg daily</td>
<td>PRO: 27 mg/day*</td>
<td>1-3 mg/kg twice daily (35-100 mg)/250-300 daily</td>
</tr>
<tr>
<td></td>
<td>DMI: 25-100 mg once daily/150 mg</td>
<td>SER: 25 mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>VEN: 60 mg/day*</td>
<td></td>
</tr>
<tr>
<td><strong>Duration of action/Peak effects</strong></td>
<td>Unknown</td>
<td>Unknown</td>
<td>Effects noted within 2 weeks for some variables</td>
</tr>
<tr>
<td><strong>Half-Life</strong></td>
<td>IMI: 10-20 hours</td>
<td>FLU: 24-96 hours</td>
<td>8-14 hours</td>
</tr>
<tr>
<td></td>
<td>DMI: 12-75 hours</td>
<td>SER: 26 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AMY: 20-35 hours</td>
<td>VEN: 3-11 hours</td>
<td></td>
</tr>
<tr>
<td><strong>Common side effects</strong></td>
<td>Cardiac changes (arrhythmia, blood pressure changes), blurred vision, dry mouth, constipation**</td>
<td>Nausea, insomnia, diarrhea**, increases in hyperactivity, feeling spacey, facial rash</td>
<td>Drowsiness, nausea, skin problems</td>
</tr>
</tbody>
</table>

*Recommended doses from PDR or other problems. Doses not established for use with children with ADHD.

**Side effects not shown to occur significantly more frequently than placebo and not established in controlled studies with children with ADHD.
Understanding Social Anxiety Disorder

*Don’t tell me you believe “all kids can learn.” Tell me what you’re doing about the kids who aren’t learning* – Richard DuFour

A. What is Social Anxiety Disorder

According to the *National Institute of Mental Health* website (2010):

> “Social Phobia, or Social Anxiety Disorder, is an anxiety disorder characterized by overwhelming anxiety and excessive self-consciousness in everyday social situations. Social phobia can be limited to only one type of situation — such as a fear of speaking in formal or informal situations, or eating or drinking in front of others — or, in its most severe form, may be so broad that a person experiences symptoms almost anytime they are around other people.”

It is important to understand that Social Anxiety Disorder can be managed by the student and the teacher in an environment that is proactive in putting strategies into place in order to maximize the learning opportunities for the student.

B. Who does SOCIAL ANXIETY DISORDER affect?

Anxiety is the most prevalent mental health problem in children. According to the US Surgeon General’s report on mental health, 13% of children and adolescents suffer from anxiety disorders, which is 1 in 8 children aged 9 to 17. SOCIAL ANXIETY DISORDER is the most common anxiety disorder in teenagers, and is associated with significant impairment in functioning and long-term negative outcomes such as depression and alcohol use. Unfortunately, many adolescents
with social anxiety go undetected and without appropriate treatment. That is why it is important to be able to identify the symptoms and put intervention efforts into place.

C. Diagnosing Social Anxiety Disorder:

Symptoms of Social Anxiety Disorder include:

- Intense fear of social and performance situations
- Avoids social situations or endures them with intense distress
- Fears unstructured interactions with peers, initiating conversations, performing in front of others, inviting others to get together, talking on the telephone, and eating in front of others.
- Appear isolated and on the fringes of the group
- May sit alone in the library or cafeteria, hang back.
- Concern about negative evaluation, humiliation or embarrassment
- Difficulty with public speaking, reading aloud, being called on in class or gym class.
- Anticipation of a social event may provoke a panic attack.

Diagnosis of SOCIAL ANXIECY DISORDER is done by a medical doctor; however data collected by the classroom teacher, occupational therapists, counselors and resource teacher can be helpful for said diagnosis to occur.

Concurrence with other conditions (Co-morbid) a diagnosis of SOCIAL ANXIETY DISORDER is often co-morbid with a diagnosis of ASD, which is defined by the DSM-IV as:
Autism, which affects thought, perception and attention, is not just one disorder with a well defined set of symptoms; autism is a broad spectrum of disorders that ranges from mild to severe. In addition, the behaviour usually occurs across many different situations and is consistently inappropriate for their age.

In the diagnostic manual used to classify disabilities, the DSM-IV (American Psychiatric Association, 1994), “autistic disorder” is listed as a category under the heading of “Pervasive Developmental Disorders.” A diagnosis of autistic disorder is made when an individual displays 6 or more of 12 symptoms listed across three major areas: social interaction, communication, and behaviour. When children display similar behaviours but do not meet the criteria for autistic disorder, they may receive a diagnosis of Pervasive Developmental Disorder-NOS (PDD not otherwise specified).

**D. How is SOCIAL ANXIETY DISORDER Treated?**

In the article entitled “Keys to Helping Socially Anxious Teenagers: For School Personnel and Parents”, Carrie Masia, Ph.D. indicates that the use of Cognitive Behaviour Therapy (CBT) as a method of treating SOCIAL ANXIETY DISORDER. CBT uses practical strategies directed at changing the factors that maintain anxiety such as negative thoughts or expectations, physical symptoms, avoidance, and reactions of adults to an anxious child. Children learn to think more realistically about fears to confront the feared social situations. Training in social skills is often an excellent approach, such as initiating conversations and inviting others.
Behavioural Strategies for Children with Social Anxiety Disorder

✓ Gradual desensitization through small group activities
✓ Do not force the student into situations that are potentially embarrassing or highly anxiety provoking situations (e.g. reading or speaking out loud in class).
✓ Encourage student’s participation in small group projects using multi-media presentations in order to reduce amount of speaking
✓ Ask a friend/popular classmates to buddy with the student prior to giving a paired assignment so there is not a trigger for anxious symptoms.
✓ Encourage relaxation techniques such as deep breathing and visualization (e.g. MP3 player with meditative exercises and relaxing music on it to use during non-instructional time as sensory tool)
✓ Teach student decision making skills by encouraging the use of a journal to help the student track what is going on inside of them and to help them understand what they need to do. For example: “Identifying If There Is a Problem” from the Companion Exercise Forms for Teach Me Language: A language manual for children with autism, Asperger’s syndrome and related developmental disorders (1997) or the “HA, HA, SO strategy“ (HA- help, assert yourself, HA-humor, avoid, SO-self-talk, own it) could be used as a tool for the student.
✓ Look for opportunities to build student’s trust and confidence—even small increments of time set aside for the student to know that they have a person who they can trust and go to if they are feeling out of control.
✓ Reassure the student that he/she is not alone in feeling embarrassed or anxious—for example explain that all of us have times when we feel anxious and that is to
be expected. (one activity is called “How do you see me?” could be used where students are asked to draw their teacher with 5 adjectives under the picture, then on the other side they can draw themselves with 5 adjectives, these can then be share in small groups as an activity that promotes understanding and helps build rapport with class members.

- Explore a student’s interest and encourage them to get involved with extra-curricular activities (e.g. Book Club).

- Planned ignoring-for example if the student is perseverating on a subject or a phrase, if you can plan on ignoring it for a while so as not to reinforce the anxiety then, when you have a chance to talk to the student privately and calmly, the actual concern can be addressed with the student.

- Positive praise and establishing rapport-for example if you give positive praise to a student for working in class, then you can reinforce that desired behaviour. Furthermore, when you establish a rapport with a student then they will feel more comfortable with you and less anxious, hence reducing the symptoms of SOCIAL ANXIETY DISORDER.

- Avoiding power struggles

- Creating classroom responsibilities and opportunities to practice generosity and kindness

- Behavioural reinforcement: Reward System

- Creating a Behaviour Intervention Plan(this would not always be needed)
Effective Instructional & Behavioural Strategies that meet the Needs of students diagnosed with

ODD, ADHD & SOCIAL ANXIETY DISORDER

The following strategies and approaches are beneficial for the whole class as well as pivotal for the student diagnosed with a psychiatric disorder or combination of disorders. “Differentiated Instruction” means a method of instruction or assessment that alters the presentation of the curriculum for the purpose of responding to the learning diversity, interest and strengths of students. (Amendment to the Public Schools Act: Appropriate Educational Programming Regulation.)

1. Pace and delivery of instruction should consider students’ needs.
   - **Multiple Intelligence Quiz** for example “Eight Kinds of Smart”. This is a great tool to use to provide students and teachers with information about students’ strengths and learning styles. (See Appendix A). Doing this quiz at the beginning of the year with all students provides students knowledge about their own learning styles and strengths and provides teachers with profile of learning strengths and needs. Using “Eight Kinds of Smart” can be used as part of classroom profiling.
   - **Classroom Profiling** using **Class Review Recording Forms** (Brownlie, King 200), to provide a visual, organization view of the classroom. Class recording forms provide the teacher or team of teachers with a multi-purpose, easy to use template for class profiles. Profiles can be used to determine class goals,
identify individual concerns, strengths, weaknesses, and to appropriately and efficiently know how to program effectively for each classroom grouping. (See Appendix A).

- **Environment : Dunn and Dunn fits here**

2. **Establish rules and routines:**

- Being immediate, clear and consistent, implement consequences that are reasonable. Have rules and routines posted in the classroom with appropriate visuals; provide individual visual schedules for students where needed. Research show that the brain recalls pictures faster and with more accuracy than it recalls words. (Sprenger 1998; Politano and Paquin 2000).

- Allow student to *set goals*, as Richard Stiggins says: “students can reach any target they know about and that holds still for them” (Davies, 2000). Use Cooperative Learning groups to reduce the anxiety of wondering who he/she will be working with during class, also smaller groups of students is helpful learning environment.

3. **Co-operative Learning:**

- Co-teaching as a service delivery option is one way that students in inclusive schools may receive services (Friend, 2009). Co-teaching provides a dramatically reduced teacher/student ratio, allowing teachers to better address the class as a whole, as well as individual student needs within the classroom.
4. **Success for All Learners:**

Note that these strategies are available in French and English and are used in an English and French classrooms.


ii. **Acquiring Strategies**: Integrating & Processing Learning: Do Your LAPS, Il faut bien epier, Q.A.R., Explanation Planner Frame, Pland’explication, Compare and Contrast, Fact-Based Article Analysis

iii. **Applying Strategies**: Word Map, Concept Overview, Sommaire des concepts, Learning Logs

5. **Response Ability Pathways** – or simply **RAP**:

Response Abilities Pathways is a strength-based, proactive approach to working with children and youth in crisis. The approach reflects extensive research done by a variety of well-respected experts on resiliency and youth, positive school wide behaviour approaches, and attachment. RAP, as it known, takes an ‘act, don’t react’ approach to reaching out and connecting to children and youth while in crisis. In my professional practice as an educator working with at-risk youth and many children with psychiatric disorders such as ODD, PDD, ADHD and Attachment disorders, I have found this approach to be exceptionally effective, humbling, and rewarding. *(Please see Appendix A).*
6. **MAPS: Multi-Action Planning System:** Planning for individual students using a team approach. A way to align parent and school goals. Developed by Marsh Forest and Judith Snow, MAPS is a collaborative problem-solving process that helps develop a feeling of ‘working together’ to meet a student’s needs (Brownlie et al, 2000). Teachers, parents, and students participate in the process and focus on a mutually agreed upon plan. Order of events: 1. *Who will attend the meeting?* Anyone who can provide meaningful information about the student may attend. 2. *Who will facilitate the MAPS meeting?* Usually an outside person with facilitation experience. The facilitator does not participate in the brainstorming or planning, but leads discussion, clarifies, and records. 3. *What needs to happen before the meeting?* Prior preparation is key to a successful MAPS meeting. Provide time, place, determine invitee list and send out appropriate preparatory questions. 4. *How should the meeting be set up?* And 5. *How should the meeting unfold?* MAPS meetings focus on specific objectives and then gather and record information about dreams, concerns, strengths and needs of the child. Once this information is gathered, the group sets priorities for planning and creates a plan. Once the plan is set, a follow-up meeting is planned. MAPS require quite a bit of time, but are extremely effective and inspiring – providing a useful tool for students, parents, & teachers. (Brownlie et al. 2000).

7. **PATH - Planning Alternative Tomorrow’s with Hope:** The PATH process can be a very powerful, creative and useful planning tool for students, families, and school teams. It is very similar to MAPS, but more like an action plan – with
support people, actions and goals defined. The PATH process was developed by Jack Pearpoint, John O’Brien and Marsha Forest beginning in 1991. Doing a PATH requires two trained facilitators, one for leading the discussion, and one for recording/drawing. Visual representations are an important part of the PATH process. Below is the format of a PATH. The PATH is drawn on a large piece of

**Figure of PATH Process**

1. The Dream
2. Positive & Possible Goals
3. Now
4. Enrol
5. Keep Strong
6. Six months from now
7. 1st Steps

**Example of a Completed PATH.**
8. **Soft Landings:** Soft landings are check-in routines, usually occurring first thing in the morning and/or right after lunch. Soft landings create routine and opportunity for check-in, temperature checks, and de-sensitization opportunities. Soft landings can be implemented as a transitional routine, and are easily established across age and grade levels. Soft landings are exceptionally effective for targeted and intensive students diagnosed with ADHD, ODD, and SAD. They are meant as a transition routine into the regular school day. *For example:* a grade 3 student, Sam, is walked into the school each day by his foster dad. Foster Dad and Sam are met by the classroom teacher and Paraprofessional. The teacher has a brief chat with dad to see how the evening and morning went – a temperature check. The teacher, Paraprofessional and Sam then proceed to the Blue Room (quite or calming space). There Sam has a visual check-list, a poster of the Incredible 5-Point Scale, and a large visual calendar on the wall. Sam places his coat and back pack in their appropriate space, he then identifies where on the 5-Point Scale he feels he is in that moment. If Sam is a 1, the morning proceeds, with the morning calendar. If Sam is a 3 or higher, the Paraprofessional and Sam proceed with finding ways (using calming strategies) to help Sam bring himself to a 1. Once at a one, the calendar is done, the visual checklist completed, and both proceed to the classroom. Eventually, Sam will do his soft landing within the classroom setting.

9. **Quiet Spaces & Calming Areas:** Calming areas and quiet spaces can be located within the classroom setting or in a separate space. Calming spaces can be used for the universal population. At times, calming spaces, located outside
of the classroom are geared toward targeted or intensive students. Within a classroom an example of a calming space could be a bean bag chair, stuffed animal, sensory headphones, thera putty, and a visual timer. There could also be social stories, or a specific social story in the area. One strategy is to introduce the idea and rules of use to the whole class, using a story, or visuals. Students can practice using the space. It is usually helpful if the space can be removed from the most active spaces within the classroom. If an alternate setting is required for a calming or quiet space, calming and soothing lighting, non-locking doors, and calming tools appropriate for the child or age group should be in the room. The room should have minimal objects in it – should be warm and welcoming. Excellent tools for calming rooms include Thera bands, Thera putty, bean bag chairs, stuffed animals, visual timers, The Incredible 5-Point Scale, and books such as *My book Full of Feelings – How to Control and React to the Size of your Emotions*, by Jaffe & Gardner and *When My Worries Get Too Big! A relaxation Book for Children who Live with Anxiety* by Buron. (See Resource List).

**10. Class Reviews/Classroom Profiling:** An effective means for teachers to have an organized view of their classroom. Class Review Recording Forms (Brownlie, 2000), were created as recording tools for class review meetings. This tool allows for the facilitation of meetings and planning for teachers around creating inclusive classrooms, based upon the needs of each classroom grouping. This is an effective tool across all grade levels. The tool can be used in a variety of meaningful ways, outside of the team approach as well. The class review
recording form allows the teacher to create a profile of the class as a whole. The form creates an inclusive picture and facilitates an inclusive thought process by focusing on the classroom as a whole, identifying strengths, needs, and goals as well, as identifying individual students needs within the context of the classroom. *(See Appendix A and Resource list)*.

11. **Restitution:** Restitution is an in class teaching technique that was developed by Linda __________. The techniques used in restitution are aimed at eliminating unwanted classroom behaviours and are designed to quickly and unobtrusively correct student misbehaviours. Restitution allows for both the student and the teacher to fulfill their main needs.

12. **Dunn and Dunn’s Learning Strengths and Styles:** By 1990, Dunn and Dunn designed a model to include 21 multi-dimensional elements of learning styles and learning strengths that impact on the student’s performance as well as his/her reaction to the learning experiences. The elements have been classified into five main categories:

   I. **Immediate environment**:

      i. sound (some children cannot block out sound and prefer to work in a quiet area while some prefer background sound or soft music),
      
      ii. light (brightly illuminated or subdued lighting, or natural light),

      iii. temperature (cold, cool, or warm)

      iv. furniture/seating formal classroom style or relaxed design). Some learners prefer silence while others can learn with soft music or background noise.
II. Own emotionality (motivation, persistence, responsibility [conformity versus nonconformity], and need for either externally imposed structure or the opportunity to do things their own way),

III. Sociological preferences (learning alone, in a pair, in a small group, as part of a team, or with either an authoritative or collegial adult; and wanting a variety as opposed to patterns and routines),

IV. Physiological characteristics (perceptual strengths, time-of-day energy levels, and need for intake and/or mobility while learning); and

V. Processing inclinations (analytic: right/left, step by step learning, global: create an overview of information, and impulsive/reflective).

Dunn and Dunn’s learning style model ought to be used along with Gardner’s multiple Intelligences approach of the learning process to get a more complete profile of
the students’ strengths and their learning needs. These models integrate the four sensory modalities.

- The auditory: You learn by listening.
- The visual: You learn by seeing text (reading) or by seeing real or mental pictures.
- The tactual: You learn by using your hands and feet.
- The kinesthetic: You learn by using your whole body and/or by involving yourself as a person.

These two approaches respond to the instructional preferences or strengths, information process style, and cognitive personality style. These will help educators to better plan for the diversified learning styles by identifying the students’ learning styles, planning and implementing curricular programming while accommodating to the individual’s learning styles and needs.

*E.g. Environmental modifications to decrease misbehaviour & to prevent over-stimulation*
Balls on the feet of the chairs to reduce noise.

Exercise breaks to help for everyone through completing weight bearing yoga poses. www.yoga4kids.org/

Token board to provide frequent and immediate feedback.

activities that provide a break for the students.
13. **Gardner’s Multiple Intelligence Theory:** This theory is based on the notion that intelligence is a multi-dimensional phenomenon that is present at multiple levels of our brain/mind/body/spirit. According to this theory, students possess a minimum of eight intelligences in addition to others that have not yet been tested. To plan for our students, educators should include experiences from the eight intelligences in order to meet the diverse needs in their classrooms.

14. **Reading Recovery:** Reading Recovery is an individualized literacy program for the lowest achieving first graders delivered by specially trained teachers to implement daily 30 minute lessons. This program is to accelerate the child’s learning with the goal of closing the child’s learning gaps to catch up to the grade level expectation for the end of the year in reading and writing. Each lesson follows a strict procedure:

   - Reading a familiar book,
   - Working with letters and/or words using magnetic letters,
   - Reading yesterday’s new book as the teacher is taking a running record,
   - Writing a story, assembling a cut-up story, and
   - Reading a new book.

15. **Guided Reading:** According to Fountas and Pinnel, Guided Reading is an instructional strategy for the teacher to work with a small group of children on differentiated instruction to learn more effective strategies to process meaning and the text in order to read increasingly more difficult text. The guided reading lesson can follow a similar structure to reading component of Reading Recovery:

Cooperative Learning: Cooperative learning is an instructional strategy of having students work together in groups to learn or reinforce concepts as they are accomplishing a common goal. This instructional strategy helps develop leadership skills, to learn from each other, to build a network among all the students in the class. Each member is responsible for the outcome of the common goal. This strategy engages the learners, channels their “talk” and builds excitement and friendships, encourages appreciation for uniqueness, promotes problem solving and social skill under the direction of an adult. However, according to Johnson and Johnson, cooperative learning is only successful when it has the 5 essential elements:

1. Positive interdependence: Each member must depend on each other to reach the group goal.

2. Face-to-face interaction: The group members must use social and supportive skills such as praising, encouraging, and helping each other.

3. Individual accountability: Accountability is created through the structures of the groups, the roles, teacher/student interviews, and peer assessments.

4. Social skills: Explicit teaching assists in developing leadership skills, the ability to compromise, reach a consensus, decision making, and trust-building.

Group processing: The group reflects on the experiences as they are debriefing on their feelings, difficulties and successes
<table>
<thead>
<tr>
<th>Cooperative Group Role</th>
<th>Cards LEADER</th>
<th>RECORDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Makes sure that every voice is heard</td>
<td>Compiles group members’ ideas on collaborative graphic organizer</td>
</tr>
<tr>
<td>2.</td>
<td>Focuses work around the learning task</td>
<td>Writes on the board for the whole class to see during the presentation</td>
</tr>
</tbody>
</table>

**Sound bites:**
- Let’s hear from _____ next.”
- “That’s interesting, but let’s get back to our task.”
- “I think I heard you say________; is that right?”
- “How would you like me to write this?”

<table>
<thead>
<tr>
<th>TIME KEEPER</th>
<th>PRESENTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Presents the group’s finished work to the class</td>
</tr>
<tr>
<td>2.</td>
<td>Encourages the group to stay on task</td>
</tr>
<tr>
<td>3.</td>
<td>Announces when time is halfway through</td>
</tr>
<tr>
<td>3.</td>
<td>Announces when time is nearly up.</td>
</tr>
</tbody>
</table>

**Sound bite:**
- "We only have five minutes left. Let’s see if we can wrap up by then.”
- “How would you like this to sound?”

<table>
<thead>
<tr>
<th>ERRAND MONITOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.  Briefly leaves the group to get supplies</td>
</tr>
<tr>
<td>2.  Request help from the teacher when group members agree that they do not have the resources to solve the problem.</td>
</tr>
</tbody>
</table>

**Sound bites:**
- “Do you think it’s time to ask the teacher for help?”
- “I’ll get an extra graphic organizer from the shelf.”
17. *Gradual Release of Responsibility (Pearson and Gallagher, 1993) model of explicit instruction*: The gradual release of responsibility model can be used to plan the learning and instructional experiences in all subject matters where the learning responsibility gradually shifts from educators to the students. This model has also been the educators’ solution to the logistics of differentiating. Through assessments and interviews the teacher decides where to place the child in the model based on the amount of support he/she needs to succeed and to further his/her understanding.

**Demonstration:** The teacher demonstrates the strategy or the concept as he/she talks through the process. The students’ role is to listen to the lesson quietly.

**Shared demonstration:** The teacher leads the learning and the student participate in the learning (ie. Shared writing, shared reading, etc.

**Guided practice:** The teacher and a small group of students are practicing the strategy and skills. The teacher and the students engage in conversations about their learning.

**Independent:** The students are practicing the strategy or skill independently.
18. **Mathematics/Numeracy Instruction:** Children with diagnoses such as ADHD, ODD and/or diagnosed with learning disabilities experience often experience difficulties with Mathematics programming as a result of having to go through multiple processes. It is exceptionally important to use differentiated instruction for mathematics related tasks and instruction. Many difficulties are related to the students’ lack of attention and organizational skills or working memory. Things to consider:

   a. **Memory weaknesses:** Many children with these diagnoses experience weaknesses in holding short term information long enough to be able to go through the steps in a problem. Long term memory issues arise when the children struggle with retrieving previously learned processes and math vocabulary. Implications of memory issues include learning of math facts, recalling math facts quickly and accurately, processing multi-step problems (forgetting the steps and where they are in the steps and recalling rules, procedures, algorithms, teacher instruction, and directions.

   b. **Attention Weakness:** Many students have difficulty noticing when processing operations signs change, paying attention to details such as decimal points, and sustaining attention long enough to complete tasks.

   c. **Perceptual/Visual-Motor/Fine-Motor/Spatial-Organization Weakness:** Many students have difficulty copying problems from
the board, aligning numbers or decimal points accurately, writing within the lines, writing within the minimum amount of space and time, remembering the directional sequence of solving math problems (moving right to left, regrouping).

d. **Language weaknesses:** understanding the abstract terms in mathematics, solving word problems, and understanding and following directions.

e. **Self-Monitoring/Self-Management weakness:** Being aware of time and time-management in pacing, realizing when something does not make sense or close to the estimate, resolving the problem with tenacity by trying another strategy, and being able to check for errors and self correct.

**Differentiated Math strategies and interventions:**

- Provide a variety of manipulatives to help visualize the work and the math problems.
- Introducing concepts by demonstrating and using real life examples.
- Relating concepts with what the children know already (4’s-quarters in a dollar, legs on a table, sandwich cut up into four),
- Projecting images on transparencies, smart board and/or power point.
- Modelling the use of drawings, diagrams and labels in problem solving.
- Using mnemonics **Dead Monsters Smell Bad** for learning the steps for long division (divide, multiply, subtract, bring down).
- Having multiplication math facts, charts, and tables available as a reference.
- Allowing use of calculators to check answers.
- Teach strategies such as counting forwards or backwards with their fingers, using doubles or known facts to figure out unknown facts, using the concept of 10, etc.
- Learning a variety of rhymes, songs, chants, raps to learn math facts.
- Having students practice one sequence of multiplication x2s, x3s,..using multisensory instructions.
- Practice and review facts in frequent, brief sessions a few times per day.
- Having students look for patterns in addition, subtraction, multiplication.
- Using Touch math to strategically visualizing a numeracy strip from 0 to 9 to accurately compute without having to use fingers.
- Provide additional class time to finish work or tests.
- Grade by number of correct problems.
- Provide frequent feedback for accuracy.
- List steps or procedures to complete multi-step problems.
- Cut up a page of problems into strips and give the student one strip at a time.
- Let child decide which problems he/she will solve first, second, etc.
- Provide models and a rubric for success.
- Keep sample math problems on the board as a reference.
- Provide frequent review of skills.
Beyond Instruction: Supports for Classroom Teachers, beyond the classroom.

Targeted and Intensive students often require collaborative supports from a variety of sources. Behaviour Intervention plans, providing proactive and reactive strategy plans are a positive and proactive means of supporting the student, bringing consistency and predictability for all parties. Behaviour Intervention plans; Adapted Education Plans and Individual Education Plans are usually written by student services personnel within the school, such as Resource teachers, Special Education teachers, and school counsellors, through a collaborative process with family, the students, teachers and any clinicians or outside agencies involved with the students.

19. Behaviour Intervention Plan:

When your general classroom discipline plan is not effective with a student, you’ll need to establish an individualized behaviour plan for him or her. Such a plan is designed to adapt the elements of your regular classroom discipline plan to meet the unique needs of a particular student.

An individualized behaviour plan can help teach the student to behave responsibly and help you to develop the positive relationship with the student that may have been out of reach.

See the sample Behaviour Intervention Plan for a further understanding of the components of the BIP and what is required in each section. The provided toolbox
offers tips and suggestions on how to write positive student goals and objectives which will also support the writing of the IEP.

20. Individualized Education Plans: (see Appendix)

A collaborative team consisting of classroom teacher(s), resource teacher, the school administrator, other supporting staff in the school or division, parent(s) or guardian(s) and when appropriate community agencies develop Individual Education Plan (IEPs) for students with moderate or severe behavioural disorders. An Individual Educational Plan is a global term referring to a written document developed and implemented by a team, outlining a plan to address the individual learning needs of students. An IEP is:

- Collaborative
- Comprised of seven essential components
- Addresses needs beyond those that can be addressed through differentiation
- A “work in progress” reviewed at intervals throughout the school year

IEP’s describe:

- Students identification and background information
- Current levels of performance, reflecting team consensus on the student’s abilities and needs
- Student specific outcomes
- Performance objectives
- Methods, materials and strategies
- Names of team members who will implement the IEP and the location where it will be implemented
- Plans for evaluation and review with dates for meetings to examine student progress

21. Guidance and Counselling

School is not just about enhancing children’s academic skills. School is also about equipping children with the social skills they need to find a niche within the broader society. The Guidance counsellor can work directly with students diagnosed with oppositional defiant disorder, or ADHD or any other students struggling to regulate their anger response and work together on a variety of exercises and activities that will provide strategies for recognizing their frustration and reacting accordingly (Hall 2003). Guidance counsellors and student services personnel may also go into classrooms do proactive service delivery, using tools like *Learning about Anger* worksheets (Appendix A) (Hall, 2003). For targeted and intensive students, one to one work enables the student to begin to understand what anger is, what the antecedents/causes of the anger are, and how to react accordingly. School counsellors may also support students, proactively and within the targeted and intensive populations, in creating positive peer relationships by providing opportunities for students to learn how to interact with one another. For example, a guidance counsellor can work with a group of students along with identified students, such as though diagnosed with Oppositional Defiance Disorder to participate in safe, structured and co-operative small group activities. Social stories and role playing prior to interactive situations can be beneficial.
Other student services approaches include comprehensive guidance and
counselling programs and services, to support students. These are sometimes
systematically planned to meet the needs of all students and are infused into the daily
activities of schools.

- Comprehensive guidance and counselling programs and services support
  student learning in areas of personal/social, educational and career
development.
- Comprehensive guidance and counselling programs and services are
  inclusive; they respond to the unique and special needs of all students from
  kindergarten to Grade 12.
- Comprehensive guidance and counselling programs and services provide a
  range of guidance/counselling services from a developmental/preventive focus
to a responsive/remedial focus
- Four types of services are provided: counselling, prevention, guidance
  education, and consultation (see diagram below).
- School Division Plans, Student Services Plans, and School Plans include
  guidance and counselling services and programs. Plans for a comprehensive
guidance and counselling program include provisions for regular, systematic
identification of needs and priorities, specification of expected outcomes,
descriptions of activities, and identification of success indicators. Guidance
programs and services should be evaluated on a regular basis. The provision
of comprehensive guidance and counselling programs and services is the shared responsibility of all staff. A team approach should be employed, wherein all staff members have specified roles to play. School counsellors play a key role in planning and implementing programs and services.
22. **Social Skills Training:** Social skills instruction and training can be done within the universal population, proactively in classrooms, with the targeted population with teachers, resource teachers and/or counsellors. An example of effective social skills training for those diagnosed with psychiatric disorders, including oppositional defiant disorder, may include the following steps:

a. *Instruction:* During the instruction step modeling is frequently used to help explain the skill. Children in particular learn best when by watching a skill being modeled. Modeling is even more effective when the people shown performing the skill are of the same gender and of a similar age as the child. (Hall 2003).

b. *Behaviour Rehearsal:* The guidance counsellor, teacher or resource teacher outlines the rules that should be followed and have specific moments where rules may be broken or students will react to certain negative behaviours with scripted response. This allows the student to practice how to follow the rules and how not following the rules affects the group. (Hall, 2003).

c. *Reinforcement and feedback:* During the role plays praise and feedback can be via the coach/trainer. During implementation it is crucial that children continue to get reinforcement for their efforts in using skills and feedback on their performance. Self monitoring is also very important because it keeps the children aware of the skill and actively monitoring their social environment for the most appropriate times to implement the
skill. (Hall, 2003). Children will self-monitor and report their performance back to the coach who provides positive praise and feedback.

23. Accessing the School Psychologist:

The school Psychologist has multiple responsibilities. The psychologist does classroom observations, synthesizes the results and presents the findings to the school team. When the assessment supports categorizing a child as being emotionally disturbed, the school psychologist is apt to be the person who gathers findings from other team members and creates an evaluation summary (Hall, 2003). The school psychologist sets up procedures for routinely collecting data to monitor learning and behaving. The school psychologist is the mental health professional on the team. In this role he or she shares information and communicates with health professionals in the private sector, at times assisting the family with physician appointments, supporting the child and family with diagnostic information and implementation of changes both at home and at school, and can often be the interpreter of information from physician, to family, to the school environment (Hall, 2003).

In addition, most school psychologists provide the some or all of the following services:

i. Consultation: Collaborate with teachers, parents, and administrators to find effective solutions to learning and behaviour problems. Help others understand child development and how it affects learning and behaviour. Strengthen working relationships between teachers, parents, and service providers in the community.

ii. Evaluation: Evaluate eligibility for special services within the school system and
community at large. Assess academic skills and aptitude for learning in an effort to establish best practices in teaching, reflective of the student’s needs. Help to determine social-emotional development and mental health status and evaluate learning environments to ensure they are appropriate and reflective of need.

iii. Intervention: Provide psychological counselling to help resolve interpersonal or family problems that interfere with school performance. Work directly with children and their families to help resolve problems in adjustment and learning and provide training in social skills and anger management.

24. Accessing Occupational Therapists:

The profession of occupational therapy is concerned with a person’s ability to participate in desired daily life activities or “occupations”. Occupational therapists complete assessments and work with other members of the school-based team to help determine what is needed for a student to receive a free appropriate public education in the least restrictive environment. Occupational Therapists may do the following for students diagnosed with certain psychiatric disorders: observe a student engaging in activities and provide strategies to facilitate the student’s participation; reduce barriers that limit a student’s participation within the school environment; utilize assistive technologies to support student specific needs; suggest methods for appropriate alternate assessments; help identify long-term goals; and help plan relevant instructional activities, provide tools and strategies, and provide input for ongoing classroom implementation.

25. Accessing a Speech and Language Therapist: Speech and Language Pathologists and Therapists assess speech, language and communication skills and
investigate possible reasons for any speech difficulties. It is not uncommon for students diagnosed with psychiatric disorders, such as those discussed within this guide, to experience difficulties with communication. Speech and Language therapists lease with parents and other professionals on the child’s strengths and weaknesses to determine effects on learning experiences and implications for curriculum. Speech and Language Therapists provide interventions to support all aspects of speech and language, including attention, listening, ways in which children understand and use language and the sounds they can produce. Speech and Language Therapists discuss activities to support speech, language and communication development at home and within the school community. Speech and Language practitioners are excellent in joint planning and contributions to Individual Educational Planning goals and student outcomes.

26. Creating a Positive Home School Connection: One of the most important pieces for student success, especially with students who have been diagnosed with a psychiatric disorder if a positive relationship between home and school.

Effective School to Home Systems needs to include:

- Student and parental input into the behaviour plan from the outset, so they can help to select positively stated objectives.
- One or two attainable objectives to increase the chances of early success
- Daily quantitative feedback about students performances
- Immediate and frequent feedback because some students have difficulty with delayed reinforcement.
An effective Daily School to Home Program procedure can be established using the Daily Scorecard to Success from Dawn Reithaug’s (1998) *Orchestrating Positive and Practical Behaviour plans*:

**iv.** The school based team, parents and the student choose three measurable and observable classroom behaviours the students needs to improve and one behaviour the student is successful in achieving, this way the students starts off with some success.

**v.** The student writes the four behaviours on the scorecard.

**vi.** The school team informs the parents and the student of the rating scale used to evaluate each classroom’s behaviour.

**vii.** Teachers need to provide immediate feedback at the end of each class period and award the number of points.

**viii.** Parents and the students establish Home Based Positive Consequences and placed them on an Incentive schedule. Points are assigned to each incentive.

**ix.** If the student exceeds the amount of points needed to get the first level of incentives, these points are banked to put towards the second level of incentives which contains more substantial positive consequences (see the Incentive schedule). Naturally the student will experience difficulties and exhibit poor behaviours this allows for those really great days to pay off even more, keeping the child motivated to work towards a larger reward/incentive.

**x.** The point system is connected to home by having the parents sign and
comment on their child’s behaviour on the Daily Scorecard. This way they can share in their child’s successes but also have immediate feedback on difficult days and address the child’s behaviour quickly and positively.

Celebration Book:

A very effective method of school to home communication is the use of a communication book that is sent back and forth between school and home. The book should be viewed as a positive pro-active means of supporting the student. The communication should be as positive as possible and emphasize positive behaviours across the school environment. (Canters, 1992). The book should not contain info on negative behaviours unless the child was successful in turning a negative situation around using positive strategies. At the school level decide who will write in the book. Keep communications short and to the point. Bullets are easier than paragraphs.
References and Resources


American Academy of Child and Adolescent Psychiatry – Children with Oppositional Defiant Disorder.
http://aacap.org.wwwname=children+with+oppositional+disorder&section=Facts+for+Families


Dunn, K. & Dunn, R. The environmental design. Available at www.learningstyles.net


Success for All Learners: A Handbook on Differentiating Instruction ((1996) Manitoba Education & Training.


Winnipeg Manitoba: Manitoba Education, Citizenship and Youth.

Appendix A

Templates & Exemplars

Joseph Tart/EHP