“NOTHING WORKS!” A CASE STUDY USING COGNITIVE-BEHAVIORAL INTERVENTIONS TO ENGAGE PARENTS, EDUCATORS, AND CHILDREN IN THE MANAGEMENT OF ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

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Attention-deficit/hyperactivity disorder (ADHD) remains one of the most prevalent mental health diagnoses identified in school-age children. Affected children show an increased risk for school failure, social difficulties, and the development of psychiatric comorbidities. Despite the availability of evidence-based behavioral protocols for managing ADHD-related impairments, school psychologists often encounter difficulties involving teaching staff and parents in the sustained implementation of these interventions. Cognitive-behavioral therapy (CBT) can address treatment obstacles through emphasizing psychoeducation, the development of a collaborative treatment context, and the identification of thoughts and assumptions that maintain maladaptive behavior patterns. This article presents a case study of Alex, an 8-year-old child with ADHD. The school psychologist treating Alex supplemented standard contingency management training with parent-, teacher-, and child-focused CBT strategies. This case study outlines a central role for CBT in school-based ADHD management. © 2011 Wiley Periodicals, Inc.

Attention-deficit/hyperactivity disorder (ADHD), a behavioral disorder characterized by functional impairments in the areas of impulsivity, hyperactivity, and/or inattention, is one of the most frequently identified psychological disorders of school-age children and adolescents (Langberg, Froehlich, Loren, Martin, & Epstein, 2008). Current prevalence estimates suggest that as many as 3%–7% of children in the United States evidence clinically significant symptoms of the disorder (Stein et al., 2009). ADHD is widely regarded as a chronic and biologically based disorder characterized by specific deficits in executive functioning that persist into adulthood (Barkley, 1997a, 2006). Youth with ADHD are at greater risk for the development of comorbid psychiatric problems, including conduct problems, substance abuse, and mood disorders, and are also likely to evidence significant difficulties in the areas of academic performance and interpersonal skills (American Academy of Child and Adolescent Psychiatry [AACAP], 2007; Barkley, 2006).

Most current models of ADHD emphasize deficiencies in the executive functioning skills of behavioral inhibition and self-regulation (Barkley, 2006). As manifested in overt behaviors, these deficits are often expressed as marked impairment in abilities such as sustaining attention to academic tasks, resisting short-term interests for the sake of longer-term goals, generating intrinsic motivation, understanding consequences, planning, and the inhibiting excessive motor activity. For these reasons, children with ADHD are often in need of specific environmental supports to supplement their core cognitive deficits (Hinshaw, 2006).

Much research literature clearly demonstrates both the efficacy of behavioral interventions and the limitations of cognitive-behavioral interventions (CBT) in directly targeting central ADHD impairments (Abikoff, 1991; Kazdin, 1997; Pfiffner, Barkley, & DuPaul, 2006; Schultz, Storer, Watabe, Sadler, & Evans, 2011). The limited impact of CBT presumably reflects that problems with attention, motor restlessness, and impulse control—the core symptoms of ADHD—stem primarily

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from weakness in preverbal, neurologically based processes (Hinshaw, 2006). As such, these symptoms are not appropriate change targets for CBT interventions, which focus on identifying cognitive distortions and errors in information processing (Kendall & Braswell, 1993). The more effective, behaviorally based interventions for ADHD typically involve a combination of contingency management, academic accommodations, and collaborative home- and school-based behavior modification systems.

A particularly critical element of behavioral interventions is the active and consistent involvement of school staff and parents. Despite empirical support for these approaches, school psychologists frequently encounter resistance from school staff and caretakers in the implementation of behavioral protocols (Anastopoulos & Gerrard, 2003). When referring a child, parents and teachers are likely to have already made repeated efforts to address the child’s inattentive, hyperactive, and impulsive behaviors. At this juncture many parents and teachers feel highly frustrated, and this frustration in turn serves as a significant risk factor for cognitive misattributions, such as believing that the child is willfully defiant or that the problems are intractable. The child is also at risk for developing cognitive distortions about him- or herself and his or her relationships with adults and peers (Ostrander & Herman, 2006).

When such cognitive misattributions arise, CBT can be used to increase the motivation of parents and teachers to engage in the committed work of implementing behavioral interventions (Kendall & Braswell, 1993). Parents and teachers can learn to identify their own unhelpful beliefs to become more accepting of both the child and of themselves (Anastopoulos, Rhoads, & Farley, 2006). Cognitive interventions can also help children with ADHD who may perceive themselves as “lazy” or “incompetent,” teaching them about the impact of the disorder on their performance and generating their interest in changing dysfunctional patterns (Hinshaw, 2006; Ramsay & Rostain, 2008).

**Essential Elements of CBT**

Cognitive-behavioral paradigms follow the model proposed by Aaron Beck (1964), which emphasizes the central role of thoughts and attributions in understanding an individual’s emotional and behavioral life. The core techniques of CBT involve helping clients to identify patterns of thinking that interfere with their optimal functioning. Thus, a teacher or parent who has the thought “nothing I do works with this child,” would be taught methods to identify negative self-talk, to challenge assumptions, and to generate more realistic and flexible approaches to evaluating situations. The CBT paradigm also includes an emphasis on education, positing that giving people information about their diagnosis encourages the development of independent problem-solving skills (Flanagan & Miller, 2010).

**Case Study**

This article presents a case study of “Alex,” an 8-year-old boy with symptoms of behavioral disinhibition and inattention. The school psychologist treating Alex used CBT strategies to design a treatment that included parent-, teacher-, and child-focused interventions.

**Presenting Complaint**

Alex was initially referred for an evaluation by his classroom teacher, “Ms. S,” who was concerned about his disruptive and inattentive behaviors, including frequently leaving his seat, distracting his peers, and making careless mistakes in his written work. While Ms. S described Alex as a “bright” and “likable” child, she also reported that much of her time was devoted to managing his classroom antics. She noted that his classmates were frustrated with his behaviors, and she
expressed the concern that he was increasingly socially isolated. For example, she recently observed several of his peers roll their eyes at him. On two recent occasions, Ms. S had Alex removed from her classroom due to his disruptiveness, and on both occasions her student assistant spent more than 30 minutes with him outside the class doing one-on-one assisted coursework. Ms. S requested assistance from the guidance center and the school psychologist in determining the cause of Alex’s behavior problems and in generating intervention strategies. Following this referral, Alex’s mother, “Ms. B,” was contacted, and she consented to having Alex participate in an evaluation.

**Evaluation Process**

The school psychologist evaluated Alex’s difficulties in the domains of academic, social, and home-based functioning. This evaluation involved interviews with his teacher, his mother, and him, as well as the completion of standardized rating scales, classroom observations, and a review of his history.

**Parent Interview.** Alex’s mother, Ms. B, was invited for an interview to discuss the current referral request and to review the available school-based services. While Ms. B voiced a number of significant concerns about Alex’s behaviors, she also expressed apprehension about Alex being “labeled” or placed in a “Special Ed” classroom as a result of the evaluation. Ms. B stated that she didn’t want Alex to be “blamed” for problems that could also be attributed to his teacher or to other students in the class. Thus, it was evident from the first meeting that Ms. B was anxious about having Alex evaluated and that she needed to have her concerns and negative beliefs about the process carefully and empathically addressed for the evaluation to move forward. Ms. B was educated about the full range of evaluation services available as well as about parental rights regarding special education services. She was assured as to the confidential nature of the process and that no intervention would take place without her consent.

Ms. B described Alex as an overactive toddler who was “always on the go,” and who “started to walk without first learning to crawl!” Ms. B went on to report a history of behavior management problems, including resistance to completing homework, which now were most evident with regard to completing homework. She reported that Alex frequently either denied having any homework or claimed he lost his assignments. She described frequent battles over homework and admitted to yelling at him about his forgetfulness, lack of follow-through, and distractibility. Ms. B noted that Alex needed multiple reminders to complete even simple daily tasks, such as putting on his clothes. Ms. B admitted that Alex’s classroom behaviors had been problematic since preschool. During the first grade, Ms. B was called by Alex’s teacher at least twice a week to request that she pick Alex up early due to his disruptiveness. Despite Alex’s significant history of behavior problems, he had never previously been referred for a psychological evaluation nor had he received mental health or psychiatric services of any kind.

Due to the referral concerns about Alex’s difficulties with behavioral control and attention, a preliminary screening for ADHD was performed (DuPaul & Stoner, 2004). This screening included having Ms. B complete the National Initiative for Children’s Healthcare Quality (NICHQ) Vanderbilt Assessment Scale, a 43-item measure based on the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) diagnostic criteria for ADHD (American Academy of Pediatrics [AAP], 2002a). The results of this screening confirmed several of the behavioral patterns previously reported. Ms. B’s ratings indicated that Alex exhibited eight DSM-IV symptoms of inattention and six symptoms of hyperactivity-impulsivity. On the Parent Rating Scale of the Behavior Assessment System for Children, Second Edition (BASC-II; Reynolds & Kamphaus, 2004), Ms. B’s responses showed significant elevations on the subscales of Attention Problems (T Score = 71, 96th Percentile)
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and Hyperactivity (T Score = 70, 95th Percentile). Additionally, Ms. B’s rated Alex in the “at-risk” range in the area of depression (T Score = 62, 88th percentile).

Teacher Interview. In a clinical interview, Ms. S stated that Alex was having difficulty controlling his behavior throughout the school day. He was particularly prone to disruptiveness during independent work periods and creative writing. Ms. S noted that, although Alex was able to demonstrate an understanding of concepts when assessed one on one, he was not performing to his potential in most subjects. Alex typically did not complete school- or home-based assignments, and the work assignments he did complete had numerous careless errors and omissions. Also, Ms. S observed that Alex frequently sought out attention from his peers by resorting to comical and “class clown”–type behaviors.

On the NICHQ Vanderbilt Assessment Scale-Teacher Informant (AAP, 2002a), Ms. S endorsed six DSM-IV symptoms of inattention and eight symptoms of hyperactivity-impulsivity. Ms. S reported that she had noticed these behaviors since the beginning of the school year and that they were significantly interfering with Alex’s peer relationships and classroom performance. Ms. S also completed the Teacher Rating Scale of the BASC-II (Reynolds & Kamphaus, 2004), where she again rated Alex as having significant symptoms of Hyperactivity (T Score = 70, 95th Percentile) and Inattention (T Score = 72, 98th percentile), with no other clinical score elevations.

Child Observations and Interview. Alex was observed in three settings on separate days. Each observation was approximately 15 minutes and used the Student Observation System of the BASC-II (Reynolds & Kamphaus, 2004). The classroom observations confirmed that Alex engaged in a high level of motor activity (e.g., fidgeting, standing beside his desk), impulsivity (e.g., blurting out answers to questions), and inattention (e.g., staring out the window, disorganization of materials) during academic subjects. These behaviors were associated with frequent verbal reprimands from his teacher. Alex’s seat was near the back of the room, and he faced away from the area where Ms. S most frequently addressed the class. In writing class, Alex produced a three-line product as compared with the two paragraphs completed by most of his peers.

During an interview, Alex was personable and talkative. He was often out of his seat, fidgeting with available toys, and repeatedly cracking his knuckles. Alex demonstrated some awareness of his difficulties, stating that Ms. S frequently told him to “pay attention” and that he often “[got] in trouble for talking too much.” He added that he preferred to “look at clouds” rather than do work. Alex tended to minimize how disruptive his own behavior was to his learning and to the functioning of Ms. S’s class, stating that Ms. S “[didn’t] know how to have fun.” At one point Alex became tearful when describing that “sometimes [other] kids don’t want to play with me at school.” In addition, he reported a recent instance of conflict with his mother during which she threatened to “send him to another country” because he was “very bad.” Despite his sad affect, when questioned directly, Alex denied symptoms of a depressed mood and denied thoughts of suicidality.

Diagnostic Findings and Case Conceptualization

Both Alex’s teacher and his mother reported that Alex exhibited chronic and clinically significant symptoms of inattention and hyperactivity-impulsivity. His mother reported that Alex had exhibited these behaviors since he was a toddler and that his prior teachers had also struggled to manage his disruptive tendencies. Alex’s behavioral dysregulation was evident in classroom observations, and both Alex and his teacher were worried about his ability to form and sustain peer friendships. In addition to his difficulties with self-control at home and in the classroom, Alex reported feelings of sadness and a diminished self-esteem as he increasingly experienced himself as someone who was bothersome to his mother, teachers, and peers. Alex’s mother described him as
at risk for depression. The initial conceptualization was that Alex was a child with ADHD, Combined Type, with subthreshold depressive symptoms that were secondary to his primary behavioral impairments. It was expected that, if Alex were to experience improvements in his behavior, his relationships with both adults and peers might improve. Finally, as Alex’s performance on academic tasks was within the appropriate range when assessed directly, there was no immediate indication that a learning disability was underlying his behavior problems.

**Treatment Plan**

The treatment goals included (a) providing cognitive and behavioral interventions to improve Alex’s behavior and academic participation and (2) addressing his inattentive and noncompliant behaviors at home. A program was designed to provide both Ms. S and Ms. B with individualized training in behaviorally based interventions for ADHD. In addition to parent and teacher training in behavioral interventions, Ms. S and Ms. B would be introduced to the CBT framework as a tool to address their negative beliefs about Alex’s behaviors. Alex would also participate in CBT-based counseling sessions to teach him about his diagnosis of ADHD, to address his sad affect and worries about peer rejection, and to optimize his motivation to participate in behavioral interventions.

**Course of Treatment**

*Initial Feedback Session.* Following the initial assessment, a feedback session was held with Ms. B. To the surprise of the school psychologist, Ms. B readily accepted the conclusion that Alex had ADHD. She reported that the evaluation process greatly increased her awareness of Alex’s longstanding behavioral patterns and that she had done some research online and determined that Alex met the criteria for ADHD. Thus, even from the first feedback session, Ms. B was more responsive and engaged with the school psychologist than she was in the initial interview. The psychologist reviewed the findings of the evaluation with Ms. B in detail. In keeping with a CBT focus on education, Ms. B was given literature about ADHD and a comprehensive list of support groups and Internet resources (AAP, 2002b). An overview of ADHD as a neurobiological disorder was presented with general recommendations for “multimodal” treatment (e.g., school accommodations, parent training, possible psychopharmacological treatment) (Swanson et al., 2002). Alex’s symptoms were normalized within a disability framework, allowing blame to be shifted away from Alex, his mother, and his teacher. Due to these cognitive changes, Ms. B was now ready to discuss treatment planning, and she expressed an interest in learning more about the services the school could provide.

Midway through the feedback session, Ms. S was invited to join and learn the results of the evaluation. This portion of the feedback session introduced the basic framework of behaviorally based treatment for ADHD. Both Ms. S and Ms. B expressed an interest in learning and implementing these strategies. Ms. B also indicated that she wanted to contact Alex’s pediatrician to discuss the evaluation and his recommendations regarding treatment.

*Behaviorally Based Parent and Teacher Training.* For the behavior modification training, components of empirically developed behavior modification programs were adapted to target Alex’s school and home difficulties (Anastopoulos et al., 2006; Barkley, 1997b; DuPaul & Stoner, 2004). Both Ms. S and Ms. B met with the psychologist individually for this training, and the school psychologist also coached Ms. S directly during two classroom lessons. The training used behavior management approaches that are antecedent focused (e.g., environmental and classroom changes) and that shape behavior through consequences (e.g., selective attention, reprimands) (Pfiffner et al., 2006).

The first part of the training provided Ms. S and Ms. B with an overview of “functional behavioral assessment,” the process of identifying environmental variables that preceded or followed Alex’s
misbehaviors. The possible functions of Alex’s disruptive behaviors in obtaining attention and/or avoiding work were explained, and an example was provided in Alex’s removal from class during lessons (e.g., escaping from work) and subsequent one-on-one tutoring from the student teacher (e.g., obtaining attention). Both Ms. S and Ms. B were encouraged to provide him with more consistent supervision to improve his follow-through on difficult tasks and to prevent his disruptive behaviors.

Next, the training reviewed ways to improve Alex’s attention by using frequent and targeted prompting. Regular use of verbal and nonverbal cues to keep Alex on task was emphasized (e.g., making eye contact, tapping his shoulder). Both Ms. S and Ms. B were coached in giving effective commands (e.g., breaking a task into small component parts, having him repeat directions). A simple but powerful environmental change was implemented by moving Alex to the front of the class, allowing for more prompting during lessons. Accommodations to improve his ability to stay on task included decreasing work requirements to emphasize accuracy over quantity, using colorful and varied visual materials, and ensuring that Alex was organized with necessary materials handy before lessons were initiated.

Following from this, both Ms. S and Ms. B were taught about the importance of positive attention in shaping behavior. They were asked to be mindful of the times when Alex was behaving well and to provide him with frequent, immediate, and consistent encouragement during these intervals. “Active ignoring” of minor misbehaviors was introduced as an additional consequence-based tool to diminish misbehaviors through an absence of reinforcement (Barkley, 1997b). With Ms. B, an emphasis was placed on “positive attending skills,” and she was asked to spend 15 minutes daily playing with Alex without offering directives or making negative comments (Webster-Stratton, 1994).

The final behavioral intervention involved the use of token systems and reward incentives for increasing Alex’s motivation. Both Ms. S and Ms. B were coached to target a small number of specific behaviors and to allow for both immediate and longer-term rewards. For example, a token system was set up to target Alex’s writing performance, listing five writing goals for each session. As Alex completed target behaviors during lessons, Ms. S would check off boxes next to the list writing goals. A school-based reward menu allowed Alex to get immediate reinforcement for completing at least three of the tasks. Additionally, a daily take-home note was established for Ms. S to report to his mother about his school-day performance. A home-based reinforcement menu was designed to reward him on days when his note reported that he achieved acceptable performance levels.

Parent- and Teacher-Focused Cognitive-Behavioral Interventions. Ms. S and Ms. B were introduced to the cognitive model and the relationship between attributions about a child’s behaviors and subsequent emotional and behavioral responses. They were taught to identify automatic self-statements regarding Alex’s behaviors and were introduced to the CBT tools of “cognitive restructuring” and disputation. For Ms. S, who was initially resistant to using a rewards program, the following thoughts were observed: “I don’t have the time to do all this for one child,” “other children will tease him,” and “I’ve tried these before and they don’t work.” Ms. S was first taught to categorize these “cognitive distortions” as fortune-telling (predicting a negative outcome) and magnification (focusing on the time requirements of a token economy and minimizing the time already spent on Alex). These thoughts were then collaboratively challenged: How much time will this actually take, and what are the costs and benefits of trying this approach? Ms. S was reassured that research does not support the development of social stigma around the use of token systems (Pfiffner et al., 2006). The idea that using a token economy is time-intensive was challenged by pointing out that, although token economies take time to set up, they require only a few minutes a day of follow-up and are faded out when behaviors improve. Finally, with regard to the belief that “behavior report cards don’t work,” it was acknowledged that many reward systems are not optimally successful due to
Table 1
Dysfunctional Thought Record for Ms. B

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Automatic Thoughts</th>
<th>Emotion</th>
<th>Alternative Ways of Thinking/Dispute</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/1</td>
<td>Alex told me he has no homework today</td>
<td>He shouldn’t lie to me about his homework! I shouldn’t have to monitor his homework assignments! He’ll never be independent!</td>
<td>Anger</td>
<td>It isn’t helpful to think he shouldn’t lie. Kids lie about homework sometimes, particularly if it is hard for them. Alex has ADHD, and it makes sense that he needs extra help following through and organizing himself to do homework. I’m glad that I’m available to help him. Alex is in second grade. It’s normal for him to need help, even more so because he has ADHD. This doesn’t mean he’ll never be independent!</td>
</tr>
</tbody>
</table>

problem with their design or implementation. The psychologist emphasized that the “devil is very much in the details with reward systems,” and the strengths of the system designed for Alex was reiterated.

Ms. B was also taught to catch automatic negative thoughts about Alex (e.g., “he is so lazy!”). With empathy, she was reassured that many parents of children with ADHD have similar responses. Common “cognitive sets” were reviewed, such as “selective abstraction,” focusing on what the child does wrong and ignoring positive behaviors, “overgeneralization,” assuming that nothing that the parent tries will be helpful, and “should statements,” making unrealistic statements about what a child “ought to be able to do” that discount the child’s disability and developmental level. Ms. B was instructed in the use of a Dysfunctional Thought Record (Beck, 1995) and was given tools to challenge “unhelpful thoughts” (see Table 1). The education she had received about ADHD, as well as a review of normal child development (e.g., second graders often resist doing homework and even lie about it), were of assistance in helping Ms. B generate more balanced interpretations of Alex’s behaviors (see Bloomquist, 1996, for further discussion of using education about child development to develop cognitive disputes). Like Ms. S, Ms. B initially showed resistance to the use of a token economy (e.g., “he shouldn’t need a prize to do things any normal kid does!”). She was reminded, however, that ADHD is associated with deficits in intrinsic motivation and that Alex would likely need more external motivators for performance. Ms. B was able to challenge her automatic thoughts through this understanding. Finally, while Ms. B had originally expressed a number of strong negative beliefs about “special education,” she was able to use the thought record to challenge her assumptions and reported that she was now more open to requesting school supports if needed in the future.

Child-Focused Cognitive Behavioral Interventions. The school psychologist met with Alex for eight individual cognitive-behaviorally focused counseling sessions. The goals of Alex’s counseling sessions were as follows: to provide him with psychoeducation about ADHD, to help him identify negative evaluations of himself related to his impairments, to help him develop a more positive self-image, and to help him understand the changes being implemented at home and at school.

In the beginning of individual treatment, Alex was given positive coping examples of other children who had overcome similar problems with the purpose of normalizing his experience (he was also told that as many as one in eight children report similar problems). Famous individuals with disabilities were discussed, particularly as to how they had overcome personal obstacles. These
discussions helped Alex to “reframe” his prior negative self-evaluations. He was encouraged to change his label of himself from being a “bad kid” to being a good and normal kid who “happens to have some difficulty with a few specific behaviors.” This intervention targeted a number of cognitive distortions, including “all-or-nothing thinking” and “labeling” (e.g., rating himself as completely “bad” based on a limited number of problem behaviors).

The individual counseling sessions used humor and role plays to develop Alex’s social perspective-taking abilities and cognitive flexibility. Furthermore, Alex was taught about the ways in which the adults in his environment were going to work with him in a team effort to help him feel more successful at school, further helping him to change his self-appraisal of being a “bad kid” whom no one wanted to help. Before implementing the home and school behavior programs, Alex met with the psychologist, his teacher, and his mother to rehearse the writing token economy and the daily home report card. This experience was positive for everyone, and it provided an opportunity for the establishment of a collaborative working alliance around his behavioral problems.

Assessment of Progress

During the course of the initial intervention, the school psychologist continued to make classroom observations, and both Ms. B and Ms. S were asked to complete updated ADHD rating scales on a weekly basis. After the first 2 weeks of the intervention, Ms. S’s ratings of Alex’s symptoms were no longer in the clinically significant range. Ms. B continued to rate Alex as having significant symptoms of ADHD, but her severity indicators decreased. She also reported decreased depressive symptoms. In the third week, Alex again started to exhibit moderate symptoms on classroom measures. This was taken as an opportunity to do some “fine-tuning” of the behavior modification techniques by working with Ms. S in the classroom. The daily report cards were modified to keep them novel and interesting, and a new list of reward choices was generated at home and at school. With these adjustments, Alex’s symptoms again returned to the mild range, and both Ms. S and Ms. B reported excitement at Alex’s improved behavioral control and performance.

With behavioral treatment of ADHD, ongoing monitoring is central to preventing the reemergence of impairing symptoms (Perrin, Stein, Amler, & Blondis, 2001). With this in mind, a team meeting was scheduled for 2 months following the evaluation. During this meeting, Ms. B reported feeling some annoyance about needing to continue the behavior program, and she admitted to being inconsistent with her follow-through. Ms. S also expressed some frustration at the level of sustained effort needed to keep Alex’s symptoms under control in the classroom. These difficulties were reframed by reviewing the chronic course of ADHD and the need for long-term environmental changes to help children with the disorder achieve success. Ms. B and Ms. S were asked to reflect on Alex’s progress to date, and both reported that there were substantial improvements in his behavior. Thus, although he still met criteria for the diagnosis of ADHD, his symptoms were now in the mild range. He was producing writing products of acceptable length with some consistency, and his tendency to disrupt the class was now limited to the occasional episode. Alex had less opportunity to become distracted and was more easily engaged in tasks due to Ms. S’s classroom management strategies. Despite some inconsistency with the implementation of his behavior plan at home, Alex was now bringing in completed homework assignments most days of the week, and Ms. S noted that she had witnessed fewer peer conflicts. At the end of this meeting, both Ms. B and Ms. S expressed a commitment to continue with the behavioral intervention, and Ms. B agreed to formally request accommodations under Section 504 to ensure that Alex would receive continued behavioral management and work accommodations when he started third grade.
Treatment Implications

While a combination of pharmacological and behaviorally based interventions are common front-line recommendations for ADHD symptom management, for many families, there are multiple barriers—including parental resistance—to accessing services within school settings (Bussing, Zima, Gary, & Garvan, 2003). Furthermore, due to their academic underperformance, children with untreated ADHD are at significantly greater risk for being placed in special education settings that fail to target core domains of impairment (Bussing, Zima, Perwien, Belin, & Widawski, 1998). Alex’s mother’s initial concern was that her son would be placed in a specialized setting where his academic potential would not be optimally fostered. A combination of psychoeducation and cognitive interventions led Alex’s mother to be interested in having her son evaluated by the school-based team. Subsequently, a coordinated multimodal intervention (school and home) was designed that allowed Alex to remain in his general education classroom.

This case also demonstrates a place for CBT in the treatment of children with ADHD. Although research has clearly shown the limitations of CBT in addressing core symptoms of the disorder (Abikoff, 1991), parent and teacher cognitions play a key role in their motivation and commitment to behavioral strategies. In addition, cognitive techniques can address the child’s attendant problems with self-image and self-esteem, and provide a context in which to address comorbid symptoms of depression or anxiety (March et al., 2004). Cognitive interventions can further be used to engage the child in a discussion of the ways that their symptoms impact their emotional and interpersonal life and to develop children’s resilience and positive coping.

Finally, this case highlights the critical role that school psychologists can play in the treatment of ADHD. School psychologists can observe the child in multiple settings and have ready access to collateral diagnostic materials that are often unavailable to clinicians outside of schools. School psychologists are also ideally situated to build working relationships with the important adults in the child’s world and to provide the support needed to optimize the child’s long-term functioning.

REFERENCES


