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School Based Interventions for School-Aged Children with Oppositional Defiant Disorder: A Systematic Review

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School Based Interventions for School-Aged Children with Oppositional Defiant Disorder:
A Systematic Review

By

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MSW Clinical Research Paper

Presented to the Faculty of the
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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

There are many barriers preventing children from getting mental health treatment. However, if more readily available, like in the school based programs, children can get the mental health treatment they need. The focus of this research study is effective treatment interventions for children and adolescents with oppositional defiant disorder in the school setting. A systematic literature review was conducted which reviewed 10 effective school based interventions for elementary and high school students who have been diagnosed with Oppositional Defiant Disorder. Three themes were identified as a successful intervention within the articles including positive praise interventions, a comprehensive approach using the individual, family and school in the intervention, and teacher consultation with mental health providers. Implications include relation to direct practice, where teachers can access the articles and use a variety of interventions on children with oppositional defiant disorder in the classroom setting.

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School Based Interventions for Oppositional Defiant Disorder

One major national discussion that is starting to be brought up is the increased need for mental health services. It is estimated that 20% of people in the United States meet the criteria for a mental disorder, but only 40% of those people receive services (Knapp & Foy, 2012). One population that this affects and that is at increased need for mental health services is children and adolescents. Less than one-third of children with mental health issues are seeking proper services, and children and adolescents who are receiving effective care are less than 10% (Weist & Evans, 2005). This is not just a recent problem. In 1996, 70% of children did not receive the mental health services they needed. Likewise, in 1990 only 15% of children who needed mental health services received treatment (Dwyer, 2002). Further, children are demonstrating more significant behavior disorders at an earlier age than ever before. Five percent of children suffer from a mental disorder that is considered to cause “extreme functional impairment” (Northey, Wells, Silverman, & Bailey, 2003). The families of these children need to seek out services and children need to receive interventions at earlier stages in life.

In the year 2000, the surgeon general declared the importance of mental health in children being essential for overall health, development and the ability to learn (Keller, 2014). However, there are still many barriers for children and adolescents to access the mental health treatment they need including stigma, little access to mental health in rural areas, primary care doctors taking on mental health roles, and cost. One of these barriers is the stigma associated with mental health. People put labels on others who are seen to have a mental health diagnosis and this scares the people needing treatment (Baruch, 2001). Another huge barrier to proper mental health treatment for children and adolescents is living in a rural area. Most of the time, these individuals do not receive the proper treatment due to travel, limited resources for referral

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and supervision of the agencies, and generalist practice challenges (Robinson et al., 2012).

Along with the disadvantage of living in rural areas there are too many primary care doctors taking on mental health professional roles. Fifty percent of all individuals receive mental health care through primary care professionals, and 75% of primary care visits among all individuals involve a mental health issue (Pratt et al., 2012). Primary care professionals have difficulty diagnosing mental health disorders in children, providing proper treatment, and have poor documentation skills, due to the lack of professional training on mental health (Robinson et al., 2012). Finally, cost prevents many from receiving mental health services. A majority of families who have children with a mental health disorder have limited financial resources to pay for the services needed. In most cases, when using a mental health agency individuals have to pay more for extra fees that insurance does not cover (Baruch, 2001). Ultimately, children with the mental health disorder who need treatment are suffering because their caretakers cannot afford the financial burden.

One way to reach out to children with mental health treatment is in the school setting. School based mental health has improved this accessibility for children and adolescents, it creates an environment where mental health concerns can be seen earlier in children, and it reduces stigma and allows for family support within the school setting. Since children and adolescents are required to go to school, mental health treatment is accessible for the students that have mental health diagnoses. Next, teachers can identify negative behaviors at an early age. After parents, teachers have the most contact with children, allowing for frequent observation. Observing behaviors of students can show underlying mental health concerns, which can lead to appropriate interventions and treatment on site (Cohen & Angeles, 2006). Further, in a school setting the stigma attached to mental health can be eliminated. When mental

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health services are more incorporated into the school setting, having to go to a clinic for treatment becomes eliminated by keeping the child in the building and reducing the stigma of getting outside help (Baruch, 2011). Finally, the school setting creates an environment for families to be involved in treatment. The teachers and mental health providers within the school have constant contact with parents throughout the year with signatures, meetings, and conferences. This contact with teachers and mental health providers opens the door for consistent intervention across all settings.

Treating mental health disorders in the school setting can be beneficial in regards to educating the most challenging of children. This includes children who have significant emotional and behavioral disorders. Research suggests that “15% of children experience severe emotional and behavioral difficulties” (Sarno Owens et al., 2005, p.262). Children with disruptive behavior have a tendency to bring much tension in the classroom setting by demonstrating refusal, aggression, and disruption to the other students who are learning in the classroom. A 2005 survey reported that “one half of regular education teachers have thought about quitting their job because of their experience working with a student with disruptive behavior problems” (Waschbusch, Graziano, Willoughby, & Pelham Jr., 2015, p.180). Not only does disruptive behavior have an impact on students and teachers, but it is estimated that the cost of educating a child with a disruptive behavior disorder is 18 times higher than students who do not display disruptive behavior (Waschbusch, Graziano, Willoughby, & Pehalm Jr., 2015). Therefore, intervening is crucial for treating disruptive behavior in the school setting.

There are many barriers preventing children from getting mental health treatment. However, if more readily available, like in the school based programs, children can get the mental health treatment they need. The focus of this research study will be treatment for children

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with oppositional defiant disorder in the school setting. A systematic literature review will be conducted to include effective school based interventions for elementary and high school students who have been diagnosed with Oppositional Defiant Disorder.

Literature Review

In the school setting there are special education classrooms that are used for varying educational needs and developmental levels for children and adolescents. One type of these special education classrooms is an emotional and behavioral disorder classroom, in which students are labeled in the school system as having emotional and behavior disorders (EBD). There are two categories in children and adolescents with EBD, internalizing and externalizing disorders (Miller & Cole, 1998). Externalizing disorders are outward forms of behavior, including aggression that disrupts the classroom, peers, and teachers. Internalizing disorders are inward forms of behavior such as depression and anxiety which also disrupt the individual, but do not disrupt the classroom dynamic (Miller & Cole, 1998).

Both externalizing and internalizing disorders affect children and adolescents in the school setting. One way this occurs is through peer relations. Children and adolescents with EBD have difficulties forming and maintaining friendships and are less satisfied with peer relationships. However, good peer relationships are shown to increase self-esteem in these individuals with EBD (Harrel, Mercer & DeRosier, 2008). If able to maintain positive relationships, the individual can start to see changes in their internalizing and externalizing disorders. Although children with EBD have difficulty in the school setting, there are ways to effectively manage their behavior. Effective planning and improvement for a child that falls under the EBD category is having daily experiences with reinforcement for positive behaviors

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and time set aside for social skill learning activity which should be accounted for in the individualized education plan (IEP) (Frey & Nichols, 2003).

Oppositional Defiant Disorder

Within the EBD label, there are a variety of mental health disorders that correlate with the school assessment. One term, identified in the research, is school refusal behavior. School refusal behavior is seen as “internalizing and externalizing behaviors including general and social anxiety, somatic complaints, depression, fear, social withdrawal, noncompliance, aggression, running away among others” (Kearney and Albano, 2004, p.148). Kearney and Albano (2004) go on to define school refusal behavior as “child-motivated refusal to attend school and/or difficulties remaining in classes for an entire day” (p.147). The school refusal behavior terms identifies a variety of disorders children in the school setting, with which children struggle, including Oppositional Defiant Disorder.

Children who have the EBD label in the school setting can have the externalizing mental health diagnosis of oppositional defiant disorder. According to the Diagnostic Statistical Manual of Mental Disorders (2013), Oppositional Defiant Disorder (ODD) can be described as “a pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months. . . and exhibited during interaction with at least one individual who is not a sibling” (p.462). For the ODD diagnosis to be credible the child’s behavior needs to be disrupting the current level of functioning and this disruptive behavior is shown across multiple settings, such as home, school and community (DSM 5, 2013).

ODD can also be found to be coinciding with Attention Deficit Hyperactivity Disorder (ADHD) and/or Conduct Disorder (CD). ADHD can be defined as “a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development”

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(DSM 5, 2013, p.59). Researchers discuss the importance of identifying the co-occurring diagnosis of ODD, and ADHD or CD. When a student presents as having both the ADHD and ODD diagnoses, it is important to understand that standing alone the two affect each other differently. For example, students that have the ADHD diagnosis alongside of the ODD diagnosis perform more poorly at tasks than the ODD diagnosis alone (Drabick, 2011).

Similarly, the ODD and CD diagnoses interact with each other as well. The DSM (2013) defines Conduct Disorder as “a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated” (p.469). Among these “violated societal rules” in CD are: aggression to people or animals, property destruction, stealing, and lying (DSM, 2013). Research discusses ODD as being a precursor and a risk factor to CD and antisocial behavior. Further, physical aggression and low socioeconomic status among children diagnosed with ODD are significant risk factors for CD. Recognizing these coexisting diagnoses is crucial when providing interventions to children who struggle with these mental health disorders. For purposes of research, this review will focus on Oppositional Defiant Disorder in children, but will recognize the other diagnoses that could play a role in a child’s behavior.

ODD within the School Setting

Children with the ODD diagnosis struggle in the school setting, but the school setting allows for early intervention and provides an opportunity for an all-around team treatment approach. “Between 10 and 12 percent of children experience moderately clinical problems during their school careers; many of these children are oppositionally defiant to authority and predisposed to conduct disorder in the absence of intervention” (Markward & Bride, 2001, p.73). When treating a child who has ODD, like many other diagnoses, early intervention is key.

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Although ODD is typically diagnosed at a later age, the school can provide an environment for early treatment approaches at the first sign of potential behavior problems. Often times if children with ODD go undiagnosed and untreated, the oppositional behavior in adolescence can lead to other disorders such as conduct disorder (Homem et al., 2014). The school provides an environment for early treatment approaches to begin within the preschool setting starting at age four. In some cases successful intervention can begin even earlier at 12 months of age up to 6 years old. Further, early intervention even in early elementary school years (k-2nd grade) can significantly decrease future behavioral disorders in later life (Markward & Bride, 2001).

Along with early intervention, school based interventions for children with ODD need to include a comprehensive approach where one includes all systems of the child, including family, school staff, and community service providers. Many times providers work on various treatment methods independently and are not using the same interventions across multiple settings. As is, little programming is created for school-age children that have ODD where the family is treated as a system and is involved in the treatment (Markward & Bride, 2001). However, if the child's mental health treatment provider can be responsible for bringing the interventions to the school setting and home setting, the child's behavior will improve (Kelly et al., 2010). Kelly et al., (2010) discuss this comprehensive reaching of systems as the "Response to Intervention (RtI) approach" (p.201). RtI allows for evidence based practice interventions to be shared across settings, providing consistency. This consistency in the home environment and the school environment allows for children to thrive and gain a sense of independence (Kelly et al., 2010). Not only is treatment important to establish across all settings, but diagnosing needs to be done comprehensively as well. It is noted in the DSM V Manual (2013) that it is "critical to assess children across all settings" when diagnosing ODD (p.463). A child with ODD will demonstrate

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oppositional behavior at home and at school. Providing intervention to one half of the environment will not fix the problem; therefore, providing supports in home as well as school will allow for a competent diagnosis.

Family Approach to School Based Intervention

In order for children to be successful within the school setting, the family needs to be involved with treatment. The school environment allows for families to be involved in treatment, mental health providers within the school to work within the school and home environments, and consistency across settings. According to Homem (2015) parenting is a major development in changing aggressive and oppositional behavior within the school setting. In order to be successful in the school environment, treatment on the home front is crucial. Many times schools do not include parents with the intervention that is being utilized with their child (Markward & Bride, 2001). However, the school is the environment where family centered approaches to interventions can be successful.

This team approach can start with the formation of an Individualized Education Plan (IEP). In 1975 Public Law 94-142 was established and the IEP was born. The IEP gives an education plan that is specific to that child that receives special education including the children with externalizing disorders such as ODD. The IEP document provides compliance, services and guidelines for children who have physical, mental, and learning disabilities in the school setting and provides them with adequate educational opportunities. "There is no document more significant to districts, agencies, administrators, teachers, parent and educational advocates, and students." (Smith, 1990, p 6). With the IEP signatures and meetings are scheduled at least yearly to meet the needs of the children. In school-based intervention the IEP is the start of the involvement with the parents. Further, mental health providers in the school can be contacted

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prior to, during, or after these meetings and conferences occur, allowing for easy access to mental health treatment. At this point, the mental health treatment can be accessed across all settings, home and school, to provide a consistent treatment approach.

Treatment Approaches to Oppositional Defiant Disorder

Family centered school based interventions for treating children with oppositional defiant disorder should include social-learning family interventions (SLFI). According to Markward and Bride (2001) SLFI approaches are the most successful when treating children with externalizing behavioral disorders. Markward and Bride (2001) go on to discuss 4 steps for families to treat non-compliant children with the SLFI approach by first, “watching the child’s play rather than direct it” and then “engaging in the activities”. The second step is for parents to “reinforce positive behavior in social situations.” The third step is for parents to “state commands simply.” The final step is for parents to “learn to use time-outs for noncompliant behavior.” (p.76).

Two different SLFI approaches that can be successful family centered school based interventions within the school setting are Incredible Years training, and Tuesday’s Child training. Incredible Years training seeks to prevent children with behavioral disorders, such as ODD, to continue on as disruptive in late elementary and within adolescence. Incredible Years implements this intervention by using interactional parenting models to enhance a child’s well-being. These interactional parenting models can be learned through role play, videos, and group parenting sessions (Homem, 2014). Further, the school can adapt these models and utilize them in the classroom setting as well, to be consistent in treatment. A study done using Incredible Years training on Portuguese families in the school setting yielded positive results on parent/teacher-child interactions and improved the child’s oppositional behavior (Homem, 2014).

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A second SLFI approach that can be modeled as a family centered intervention within the school setting is the Tuesday's Child approach. Tuesday's Child approach emphasizes the importance of family centered practice in five ways (Markward & Bride, 2001 p.78-79). First, there are structured ways in teaching parents how to effectively intervene with their oppositional child, thus making the parent feel empowered. The second way is assessing with a mental health professional and using individualized treatment methods to meet the individualized need of the child in the home and school settings. The third way family centered practice is emphasized is that the families meet at the school for treatment, which allows school staff and practitioners to reach the family and child at a safe environment. Fourth, the social work systems approach is being utilized. The parents, services, and school are looked at as systems that need to be adjusted, providing a consistent structure for the child. Fifth, within the systems method, a team approach is being yielded, where the different service providers are able to discuss interventions with each other. The Tuesday's Child approach may create the tools necessary for the parent and school to be successful in creating a positive environment for the child to grow and cope positively.

Another form of intervention that can be used within the school setting is understanding the temperament qualities of students with ODD to further assess the student's strengths and weaknesses. Joyce and Oakland (2005) discuss that when looking at a temperament dimension there is a strong side, and an "underdeveloped" side which leads to negative behaviors. They propose that when a teacher or professional has an understanding of their strong attributes they can successfully use those attributes when working with those children. When looking at the extroverted-introverted styles, a child with ODD has extraverted qualities. The strengths of extraverted qualities include "enjoying group discussions, a wide range of topic interests, and a

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preference for verbal responses” (p.127). Another temperament trait identified is the practical-imaginative style. Children with ODD are practical in that they “have rigid attitudes, narrow focus on present issues, and failure to consider long-term consequences for behaviors” (p.128). It is noted that for students with a practical orientation, such as children with ODD, providing very specific rules in every situation and discussing the consequence of each rule can be beneficial in changing defiant behavior. A third temperament to be discussed is the thinking-feeling style. Joyce and Oakland (2005) discuss children with ODD to have a Thinking style due to “blunt verbal interactions and initiate debate in provoking or responding to conflict” (p.129). Children with ODD often fail to seek harmony and closure, and would rather confront conflict, demonstrating the Thinking preference. Lastly Joyce and Oakland (2005) discuss the organized-flexible style. In this temperament children with ODD demonstrate a flexible temperament style whose weakness is organizational skills and compliance. Children with ODD are more apt to display minimal self-control and little compliance to the classroom structure. This can be demonstrated in the behavior of “losing their temper, blame others for misfortunes, argue, defy rules, and neglect to follow procedures” (p.129). If the temperament styles of a child with ODD are identified, the teacher, professional and parent would be able to plan interventions accordingly. Knowing the temperament of a child allows those to pursue the child’s strengths and build those strengths through positive interventions.

In order for a child diagnosed with ODD to be successful within the school setting, all systems need to be involved for a comprehensive treatment approach. It is unclear how these interventions and other interventions are being used within the school setting. This study looks to explore treatment models that can be used within the school setting for children to answer the

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question: What school based interventions are effective in school settings for students who are diagnosed with Oppositional Defiant Disorder?

Conceptual Framework

Social work has a responsibility to provide best practice and use that in their work with clients. This research will look at best practice interventions for children who have oppositional defiant disorder. The purpose of the research is for school teachers and school staff to use interventions for children with oppositional defiant disorder in the school setting.

One theory that guided this research was the socio-ecological systems theory. The socio-ecological perspective provides the framework to help change the dysfunction in relationship between the person and their environment. Specifically within the school environment, the ecological perspective provides a framework for evaluating the child's relationship with the school, and the interactions of school, home, and other environments that impact the child.

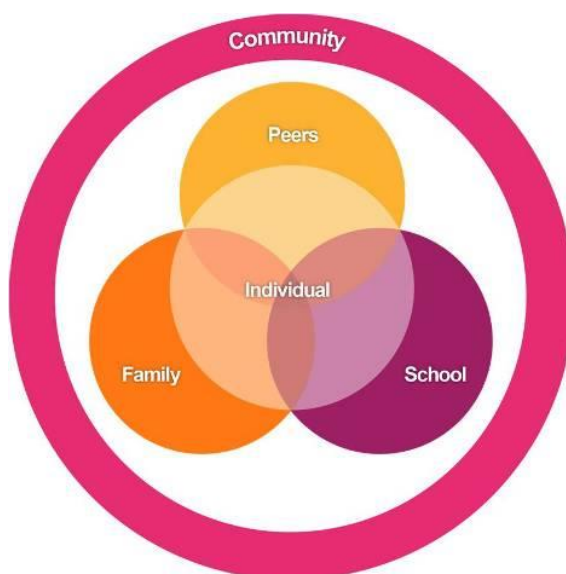
Another theory that guided this research was evidence based practice theory. Evidence based practice invokes the notion that interventions used by Social Workers when working with client populations should have scientific support for their use. Further in the school setting, evidence based practice provides the school staff a level of competency while using an intervention on a child.

Socio-Ecological Framework

This study will acquire an ecological conceptual framework for integrating teacher-child interventions for children who have oppositional defiant disorder. Socio-Ecological concepts provide a framework that by helping the individual, one needs to help the environments around the individual. More specifically when working with a child in the school setting who has ODD

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the individual is impacted by school, family, and peers. This reciprocal relationship is shown in the figure below.



<https://www.kidsmatter.edu.au/primary/about-kidsmatter-primary/kidsmatter-primary-evidence-base>

The figure demonstrates that within the community of the individual, the individual is impacted by family, school and peers. The professional, while using an intervention with the student who has ODD, has to have the mindset that all of these environments will have an impact on the student, and has to keep these environments within the scope of practice. In the socio-ecological framework “social workers should concentrate on helping to change dysfunctional relationships between people and their environments” (Gitterman & Germain, 2013, p.2). Further, school staff and professionals need to take this approach as well and incorporate the framework to best intervene with the student who has ODD.

Evidence Based Practice

This study will also invoke the evidence based practice (EBP) framework. Within social work, EBP is used to demonstrate competency within their field of practice. “EPB is a five-step process used to select, deliver and evaluate individual and social interventions aimed at preventing client problems and social conditions” (Jenson & Howard, 2013, p.1). Jenson and

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Howard (2013) explain the steps as: Step one, converting practice information needs into answerable questions; step two, locating evidence to answer questions; step three and four, appraising and applying evidence to practice and policy decisions; and step five, evaluating the process. This research demonstrates the EBP framework, by using those steps through the research to find the best evidence based research specifically focused on students who have ODD. Professionals and school staff need to encompass an EBP framework in order to provide best practice to their students and clients.

Professional Lens

Within the school setting there is a disconnect between teachers, school staff, and administrators on ways to provide interventions for children who have behavior disorders that are challenging to work with. Many school staff are trained in a variety of approaches for a broad range of students, but there is a lack of training with specific, hard-to-engage populations, such as children who struggle with Oppositional Defiant Disorder. Importantly, this is not about blaming the school staff, as they have a large role in educating our students while being responsible for a large number of students for eight hours per day. By allowing this research to guide practice within the school setting, school teachers, administrators and professionals within the school setting will be more confident when providing interventions to children who are diagnosed with Oppositional Defiant Disorder and children who are oppositional in general. This is another tool teachers will be able to grab from their tool box to positively intervene with those hard-to-reach children.

Method

In this study, I conducted a systematic review. The goal was to collect, analyze, and provide information from the review in a format that would be useful for others as they make

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decisions about which intervention approaches to use and how best to implement those approaches within the school setting.

Literature Search

Selection criteria: A systematic search was conducted for all school based interventions used for students who have oppositional defiant disorder published between 1992 and 2016.

Only studies in English were reviewed. First, key search terms were taken from a review of the literature and were used in combination with each other to narrow the search results. The terms “oppositional defiant disorder”, “intervention”, and “schools” were used simultaneously to retrieve relevant publications.

Studies that implemented interventions for students in a classroom setting from preschool to high school were used. Selection of the literature included studies that identified the intervention and the effectiveness of the intervention. Further studies that demonstrated assessment, intervention and evaluations of school based interventions for students with oppositional defiant disorder were included in the studies that were assessed. After reviewing studies, the reference lists of the included studies were reviewed to find other appropriate studies as well.

Studies that did not include the school environment and studies that were evaluating symptoms of ODD in the school environment were excluded. Studies that contained the title of “defiant child” and did not label the “defiant child” as “oppositional defiant disorder” were also excluded. Fig. 1 provides detailed information regarding reasons for publication exclusion.

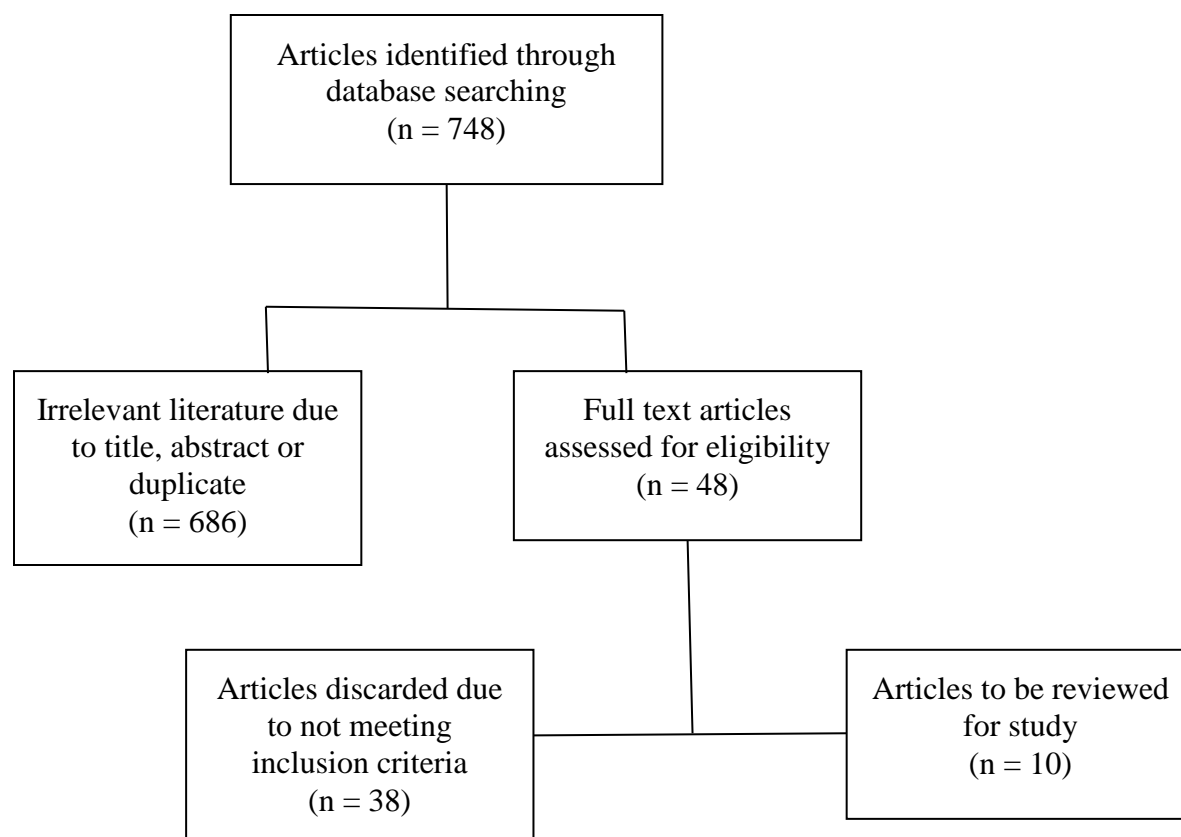


Fig 1. Flow chart of systematic review results

Search Strategy: Many different search strategies were used to identify school based interventions for students with Oppositional Defiant Disorder. Using the terms listed above, a search was performed of the following electronic databases: ERIC, Social Work Abstracts, Soc Index, and Psych Net. In all of the databases, the key words were used with different combinations. The abstracts of all relevant articles were screened for inclusion eligibility. When the abstracts met the inclusion criteria, the publication was retrieved and reviewed. The search resulted in a total of 734 initial studies. (Figure 1). After reviewing the title and abstract of the studies, 686 articles were discarded that did not meet criteria. A full review was then done of the remaining 48, and if the articles did not meet the inclusion criteria they were eliminated, leaving 10 included studied articles to be reviewed.

Findings

After reviewing, and finding information on ten articles, a summary of articles is presented, as well as themes of the research findings. Table 1 shows the different articles, and the demographics of the article. Of the ten articles, eight were research articles and two were theoretical articles. The table also represents the five countries that the various intervention strategies took place in. Although many of the articles discussed symptoms of other co-existing mental health disorders, for purposes of my specific research the summary of the articles, I will focus on Oppositional Defiant Disorder.

Research Articles

1. Perspectives on oppositional defiant disorder, conduct disorder, and psychopathic features

In this theoretical article, authors discussed theory related to ODD, Conduct Disorder, and ADHD, as well as their interactions with each other. The article discusses the most effective interventions for ODD as being cognitive behavioral strategies and targeting the child across all settings: individual child, home with the parent or parents, and in the school setting. Researchers discuss Parent Management Training “PMT” as being an effective early intervention approach to treating ODD. More specifically the PMT they discuss are Parent Child Interaction Training and the Incredible Years treatment program. Further, researchers found that treating the negative affect symptoms of ODD early on can inhibit the progression of the disruptive behavior (Loeber, Burke, & Pardini, 2008).

2. Source-Specific Oppositional Defiant Disorder: Comorbidity and Risk Factors in Referred Elementary Schoolboys

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A set of researchers discuss the symptoms of ODD in children in this basic research study. This study was not an intervention study, but the need to carefully assess ODD symptoms to provide best treatment practices. Facilitators of the study had teachers and parents fill out measures including: child symptom inventory, child sensation seeking scale, task achievement tests, the parent's report, family environment scale, child behavior checklist, and a diagnostic interview using the DSM-IV. Results conclude that when you combine the teacher and parent ratings of a child, there were high ratings of social problems, sensation seeking, and maternal use of control. This demonstrates that when an assessment is done on a child with ODD, more accuracy is presented when more systems of the child are reporting the symptoms. Researchers discussed implications, as boys who demonstrate ODD symptoms in multiple settings are likely to experience impairment in multiple domains, based on multiple sources of information (Drabick, Gadow, & Loney, 2007).

3. Temperament Differences Among Children with Conduct Disorder and Oppositional Defiant Disorder

Authors in this basic research study review temperament differences in children with CD and ODD. The article discusses using interventions in the school setting concurrent with personality styles and temperament of the child. Researchers conducted a study using the student styles questionnaire, which determined a preference across four temperament qualities: Extroversion-Introversion, Practical-Imaginative, Thinking-Feeling, and Organized-Flexible. Data were then coded and analyzed. Findings suggest that children with ODD have practical styles which demonstrates that teaching methods using hands-on experiences and using all senses will be more successful for children with ODD. Another finding that was significant was that children with ODD prefer Thinking styles instead of Feeling styles. This is consistent that

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children with ODD demonstrate conduct problems consistent with the weaknesses of a stronger thinking style. This includes children with ODD interpreting interactions in a hostile way which escalates defiant and arguing behaviors. Researchers suggest that children would benefit from teaching strategies that include behavioral intervention programs that use strengths including social skill training programs created to improve listening skills and sensitivity (Joyce & Oakland, 2005).

4. Preventing Disruptive Behavior in Elementary Schoolchildren: Impact of a Universal Classroom-Based Intervention

Researchers in this randomized controlled trial evaluated an intervention called the Good Behavior Game on a school setting in second and third grade classrooms. The Good Behavior Game is as follows: Teachers review rules of the classroom and rules of the game. Teachers then assign teams with equal numbers of disruptive and non disruptive children. Each team receives cards, which is put on the child's desk. A card is taken away if a rule is violated. Teams are rewarded for most cards on the desk. The game is played in three stages. The first stage lasts 2 months and is 3 times a week for 10 minutes. The second stage, the expansion stage, happens for 3 months and occurs 3 times a week for 1 hour a time. Teachers expand the settings where the game is played. The third stage is the generalization phase where teachers promote prosocial behavior outside of the Good Behavior Game explaining how the rules are applicable in other settings. The same three phases were then used the next year. Throughout the process teachers were supported by "coaches" consistently throughout the process. Results demonstrated that the Good Behavior Game showed preventive effects in children with ODD, Conduct and Attention Deficit problems (Van Lier, Muthen, Van der Sar, & Crijnen, 2004).

5. Classroom Rule Violations in Elementary School Students With Callous-Unemotional Traits

Researchers reviewed callous-unemotional traits in children with disruptive behavior disorders such as ODD, CD and ADHD; they conducted a randomized controlled trial using Behavior Education Support and Treatment (BEST) school intervention project. BEST is an intervention using behavioral strategies delivered at universal, targeted and clinical levels. Researchers used BEST as school wide behavioral programming, which developed a set of student behavior rules that were defined and implemented in a standardized manner throughout classrooms and schools. Programming was done in the schools for 35 weeks. In early October of the school year intervention began. Intervention started with teachers' discussion of rule violations (RV). Students were told if they broke a rule from following directions, raising hand, taking turns, respecting self and others, staying in assigned seat, using materials and possessions appropriately, and working quietly. Children were reinforced for rule following behavior with a daily positive note sent home and weekly Friday afternoon fun activities. More positive praise tactics were used when children presented positive behavior; teachers would give attention and reward with special privileges. Teachers would downplay and ignore negative behavior of the child. After intervention, results demonstrated that CU traits were associated with elevated rule violations at the start of the school year, but rule violations significantly declined towards the end of the year (Waschbusch, Graziano, Willoughby & William Pelham Jr., 2015).

6. A pilot study of a school-based prevention and early intervention program to reduce oppositional defiant disorder/conduct disorder

Researchers conducted a pilot study done in the classroom setting using incredible years and the fast track project to create a universal approach to treating children with ODD. The

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program psychologist trained teachers and parents in individual and group sessions on behavior management techniques. Training included “psychoeducation involving conduct problems, positive reinforcement, limit setting/punishment, parent-child relationship building and problem solving skills” (p.182). Classroom observation was then conducted throughout the 5-week period with regular consultation. Classroom observation included a functional analysis behavior assessment, which the psychologist used along with parent and teacher questionnaires to create a behavior management plan for the child. At the end of the program a review session with the child’s teacher was held to discuss progress and further recommendations. Results showed that the universal intervention led to a decrease in ODD/CD symptoms and an increase in prosocial skills. Further, the teacher run classroom interventions included positive feedback from teachers and school staff. It allowed for a common, consistent language including effective communication, problem solving and emotional regulation strategies within the school environment (Winther, Carlsson & Vance 2012).

7. School-Based Mental Health Programming for Children With Inattentive and Disruptive Behavior Problems: First-Year Treatment Outcome

In this pilot study, researchers implemented an intervention using the Youth Experiencing Success in School (Y.E.S.S) program which includes the daily report card procedure, parenting sessions, and teacher consults to elementary school children with ADHD and disruptive or defiant symptoms. This treatment took a comprehensive approach to treating children by supporting the home, teachers and the child in mental health supports. Treatment lasted a year and was completed with 30 children. Target behaviors were identified through assessments conducted by researchers with parent/teacher interviews, parent/teacher rating scales, and an unstructured observation of the child in the classroom. That data helped determine criteria for

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success on the individual Daily Report Card (DRC). During the intervention, the teacher provided feedback to the child regarding the identified target behaviors on the DRC along with praise for achieving the goal, and the DRC was delivered to the parents. The parents were then recommended to use a reward/consequence system depending on the child's performance. Results indicated success, where children showed a reduction in hyperactive, impulsive, oppositional, and aggressive behavior as reported by parents. There was also an increase in attention in the classroom setting, and improved peer relationships for this sample (Owens, Richerson, Beilstein, Crane, Murphy, & Vancouver, 2005).

8. Students' Evidence-Based Practice Intervention for Children With Oppositional Defiant Disorder

Researchers in this pilot study used graduate social work students and had the social work students apply practice techniques to their social work education. There were four phases used throughout the study. The first phase was to prepare social work students to work with children in the school setting which included creating goals, creating intervention modules, developing assessment and evaluation measures, and creating a manual for intervention. The second phase was training social work students to use the intervention and evaluate the results. Their training included a child intervention course where students studied CBT, group intervention and ODD. After two months, students started conducting group work with children. Students specialized in working with children led 8 groups of 51 children who had ODD throughout a 12-week session in social skills groups. In these groups, children learned self-control skills, which included techniques like drawing, sculpturing, self-report, and observation of themselves for 75 minutes, once a week. A significant decrease in behavior problems was found after the 12-week session.

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Phases 3 and 4 were conducted the second year, which included training more students to lead social skill groups in the school setting, for a larger number of children identified (Ronen, 2005).

9. Reducing Disruptive Behavior in General Education Classrooms: The Use of Self-Management Strategies

In this article, a case study approach was used to evaluate an intervention. Researchers used self-management strategies to decrease disruptive behavior in the classroom setting. This article identifies as self-management strategies as “actions in which an individual takes to change or maintain his or her own behavior” (p.291). Researchers conducted a case study and followed three students across school settings and used the intervention. Children and teachers together created a rating scale on behavior that the student presented in the classroom setting. The student and teacher reviewed the process and how each behavior was given a score, and the score would be totaled up for a final behavior score. Students were given verbal praise for positive behavior, and token reinforcement for positive scores. Starting, teachers used five minute intervals to evaluate behaviors based on rules; teachers then showed the total scores immediately. This continued for second and third five-minute intervals. After 15 minutes, teachers gave feedback to students and discussed why they were given ratings. Student also gave themselves a self-evaluation. They rated themselves using the same scale as teacher. They were given points if rating scales matched the teachers. Students continued to rate themselves; teachers would then only rate 75% of the time, which decreased to 50% and then to 25%, and finally to 0%. Teachers would then do surprise matching where the student did not know teachers were evaluating them: on average every 6 days. This implementation allowed immediate feedback to children by letting them look at their ratings to understand the negative behavior and then find reason to change the

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negative behavior. Disruptive behavior decreased in all three children across school settings

(Hoff & Dupaul, 2016).

10. Improving Treatment Outcome for Oppositional Defiant Disorder in Young Children

Researchers discuss in this theoretical article using Behavioral Parental Training (BPT) to improve treatment outcomes in children with ODD, and to expand training to the school setting. Specific to the training is increasing target positive behaviors with positive reinforcers like verbal praise, affection and tangible rewards. Parents are then taught monitoring skills to distinguish between positive and negative behaviors, and respond quickly to them. Researchers then find this approach being generalized to the school setting with Daily Report Card, and parents giving appropriate consequences for school behavior. Researchers discuss children with ODD have a decrease in defiant behaviors if the BPT is used in the school setting as well as home setting. (MacKenzie, 2007).

Table 1: Research Articles

<i>Author</i>	<i>N</i>	<i>Country</i>	<i>Article Type</i>	<i>Intervention Theme</i>
Loeber, Burke, Pardini (2008)	N/A	United States	Theoretical	PP, CA
Drabick, Gadow, Loney (2007)	248	United States	Basic Research	CA
Joyce & Oakland (2005)	40	United States	Basic Research	PP
van Lier, Muthen, Van der Sar & Crijnen (2004)	744	Netherlands	Randomized Controlled Trial	PP
Waschbusch, Graziano, Willoughby & William Pelham Jr., 2015	648	Canada	Randomized Controlled Trial	PP, CA
Winther, Carlsson & Vance 2012	240	Australia	Pilot Study	PP, CA, TC
Owens, Richerson, Beilstein, Crane, Murphy, & Vancouver, 2005	42	United States	Pilot Study	PP, CA, TC
Ronen, 2005	51	Israel	Pilot Study	TC
Hoff & Dupaul, 2016	3	United States	Case Study	PP, CA, TC
MacKenzie, 2007	N/A	United States	Theoretical	PP, CA

Note: Interventions are in three categories, representing the themes. PP = Positive Praise Intervention; CA = Comprehensive Approach Intervention; TC = Teacher Consultation Intervention; N/A = not applicable

Themes

Throughout the review of the ten articles I was able to find many similarities in the interventions that decreased defiance and aggression and increased positive behavior in children and adolescents with Oppositional Defiant Disorder. In turn, three common themes were found within the research: positive praise interventions, a comprehensive approach, and teachers in consultation with Mental Health professionals.

Theme one: positive praise interventions. Throughout the ten articles a common theme was positive praise interventions. Specifically, terms used within the literature were “verbal praise,” “positive feedback,” “response for positive behavior.” Within the ten articles reviewed, eight used positive praise interventions within the intervention technique (Loeber, Burke, Pardini 2008; Joyce & Oakland 2005; van Lier, Muthen, Van der Sar & Crijnen 2004; Waschbusch, Graziano, Willoughby & William Pelham Jr., 2015; Winther, Carlsson & Vance 2012; Owens, Richerson, Beilstein, Crane, Murphy, & Vancouver, 2005; Hoff & Dupaul, 2016; MacKenzie, 2007). Positive praise was associated with a decrease in defiant and disruptive behavior throughout the articles. Some specific interventions that used positive praise techniques include incredible years, Y.E.S.S program, and Self-Management Strategies.

Theme two: comprehensive approach: individual, family, school. A comprehensive, universal approach was found in many of the articles that contributed to a successful intervention result. This theme, when used takes individual, family, and school approaches to provide consistent treatment interventions across all levels. Seven articles used a comprehensive treatment intervention approach. Within the seven articles two articles were theoretical, discussing the positive effects of comprehensive treatment (Loeber, Burke, Pardini, 2008; MacKenzie, 2007). Five articles provided specific interventions using a comprehensive approach

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to treatment by providing treatment in the individual setting, family setting and the school setting (Drabick, Gadow, Loney 2007; Waschbusch, Graziano, Willoughby & William Pelham Jr., 2015; Winther, Carlsson & Vance 2012; Owens, Richerson, Beilstein, Crane, Murphy, & Vancouver, 2005; Hoff & Dupaul, 2016). The articles that used this approach demonstrated a positive response in decreasing defiant and disruptive symptoms in the children with ODD. Specifically, some examples of the interventions that used a comprehensive approach within the research include Y.E.S.S program, Daily Report Card, and Parent Monitoring Technique.

Theme three: teachers in consultation with mental health professionals. Throughout the articles there was consistency with teachers wanting support from mental health professionals. Teacher consultation in the articles was identified as having a set time for teachers to consult about the interventions, a time to ask questions, and discuss what was working for the intervention and what about the intervention could be improved. Ultimately the teachers were provided with feedback on effective classroom strategies for children with ODD. Four articles displayed the interventions that used teacher consultation (Winther, Carlsson & Vance 2012; Owens, Richerson, Beilstein, Crane, Murphy, & Vancouver, 2005; Ronen, 2005; Hoff & Dupaul, 2016) Further within these interventions teachers identified feeling successful at implementing the interventions in their classrooms and were able to manage behavior successfully. Some examples where this theme was found was in the Y.E.S.S program, Self-Management Strategies, and the Daily Report Card approach.

Discussion

Interpretations of Findings

Many teachers and school staff struggle with finding strategies to work with children who are defiant in the school setting. The purpose of the research was to find interventions within the

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school setting that is successful when working with children with ODD in hopes to aid school staff with relevant, evidence-based research. Throughout the articles, the three themes identified (positive praise, comprehensive approach, teacher consultation) can be used to guide intervention strategies, which can be incorporated in the school setting with children and adolescents who struggle with ODD or have symptoms consistent with defiant behavior. Using positive praise can enhance a student's sense of self, as well as enhance the relationship between teacher and student (Markward & Bride, 2001). Second, using a comprehensive approach to the intervention allows the intervention to be consistent across all settings (Markward & Bride 2001). This strengthens the teacher-parent relationship, the child-parent relationship, and the teacher-child relationship. Further, consistency holds the child accountable for behavior, and can decrease the behavior symptoms (Owens, et al., 2005). Last, teacher consultation creates teacher development within the school setting and allows the teacher to have immediate feedback on the implementation of the intervention (Winther, Carlsson & Vance 2012). Further this can also enhance the teacher's confidence with knowledge surrounding intervention to allow for more success with children who struggle with disruptive behavior and defiance.

Relations of Finding to literature

The comprehensive approach to treating students with ODD was discussed in the literature review. Kelly et al., (2010) discuss the importance of establishing treatment in both home and school, and allowing the treatment to be consistent. They discuss that the child's behavior will improve if treatment is being provided across all settings. Two interventions that use this approach are the Tuesday's Child approach and the Incredible Years intervention (Markward & Bride, 2001; Homem 2014). Both encourage treatment across the individual, family and school setting in order to see success in the children.

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Another theme that was discussed in the literature is the positive praise approach. In the literature “positive praise” was not used specifically, but was discussed in “positive reinforcement” terms. Frey and Nichols (2003) discuss children with ODD having a low self-esteem. They discussed that the forming of positive relationships will help increase the self-esteem and self-worth of the student. Further, they suggest that positive reinforcement and positive praise sets an environment to establish positive healthy relationships.

Strengths and Limitations

Throughout the research process there were many strengths and limitations related to my research. One strength is that this research directly applies to practice. Teachers in the classroom setting that work with students who have ODD struggle with finding effective interventions. This review allows teachers to see a variety of interventions that they can use in their setting. Another strength this research uses is that the themes that were discussed are approaches that can be used in the school setting. The identified themes allow teachers, mental health staff, or school staff to use one or all three of the themes in their intervention with students who have ODD. For example, a teacher could implement positive praise and a comprehensive approach without following a specific intervention, which could still lead to a successful approach with the student. Teachers could implement this unique programming and evaluate if their programs are meeting the needs of the children and families.

Along with strengths there were limitations to my research as well. One limitation was that there were only ten studies that met criteria. There were very few articles that gave specific interventions to use in the school setting. Ideally more articles would also make the research findings more valid and reliable. Another limitation is the comprehensive approach theme. It is evident in the literature and in the present research that a comprehensive approach to working

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with students with ODD is the most successful. However, it can be difficult to get all parties on board (home, school, individual) in order to effectively implement the intervention. In school based mental health, it can be difficult to reach families to provide the comprehensive service. This is a barrier for using the comprehensive intervention approach. Further, it was hard to find articles that were limited to just Oppositional Defiant Disorder. Many of the interventions included ADHD and Conduct Disorder which this project did not discuss.

Implications

Practice. The research can be used in direct practice to schools. Schools are able to access interventions specific to students who struggle with ODD, and implement the intervention. As discussed, many teachers struggle with their students who are oppositional. This research can be used when teachers struggle. Further, the theme of teacher consultation demonstrates the need for teachers to consult with the mental health providers in the school regularly. In the research teachers felt confident, and enjoyed the feedback and consultation by having the access to the mental health resource. Another practice implication is the comorbidity ODD has with other disorders as ADHD and Conduct Disorder. As discussed research has shown that those disorders are often concurrent. Interventions that are cognizant of all three disorders are necessary in practice.

Policy. Mental health in the school setting needs to be supported. The successful interventions that the research showed used mental health agencies within the school setting. Currently, in Minnesota, there are mental health policies in place for the school setting. But this needs to continue to expand. Currently, the children that can be treated by mental health agencies are children and adolescents that qualify for Medical Assistance or Medicaid. For mental health professionals in the school setting working for agencies, students who have private insurance

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have to go untreated for their mental health disorders. Mental health is continuing to grow, and teachers need to be informed of the mental health needs of their students, especially those on private insurance who cannot be reached by mental health providers. Further they need to be able to provide interventions in the classroom setting for the students who have mental health disorders. More communication between mental health providers and teachers needs to be in place to allow teachers to be able to learn from mental health providers about the needs and the interventions that are appropriate for the student's mental health disorders.

Research. More research needs to be done on defiant behaviors within the school setting. As stated previously there is little research on ODD interventions within the school setting. Teachers continually struggle with this population of students, and having more interventions available would only enhance the teachers' ability to teach in their classroom setting. Other research that could be looked at is the ODD diagnosis and how it correlates with other disorders as interventions. This research focused on ODD interventions specifically. Many students that have mental health disorders have dual-diagnoses with other disorders. More research to see if there are specific interventions on students with multiple diagnoses would also be helpful in the school setting.

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