

**RESOURCE FOR PARENTS AND TEACHERS OF  
STUDENTS WITH A.D.D.**

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*This project is dedicated to Tim Salonen and to the  
parents and teachers of children with Attention Deficit Disorder.*

## **ABSTRACT**

Inclusion and accommodation of special needs students has become a reality in public school systems. The need for qualified and trained personnel capable of program planning and modification for the success of these students is increasing. Parents are an essential part of a child's success. This resource covers topics that will assist teachers and parents to understand and manage children with Attention Deficit Disorder. Diagnosis, treatment alternatives, classroom and home management are some of the major topics covered.

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## **CHAPTER 1. INTRODUCTION & RATIONALE**

Children diagnosed with Attention Deficit Disorder (ADD) present challenging behaviours for parents and teachers. These behaviours can include inattention, impulsivity, immaturity, and aggression. Because of their inability to filter out extraneous stimuli, these children often don't cope well in the traditional classroom. At home the inordinate amount of attention they require can lead to problems with their siblings as well as their parents. Poor social skills, immaturity, and impulsivity make it difficult to make and maintain peer relationships. The child with Attention Deficit Disorder receives a great deal of negative interaction. Research done by Amen (1977) tells us that without intervention, the future for these children is quite dismal:

Almost one-third of students with Attention Deficit Disorder never finish high school. 40% of Attention Deficit Disorder teens and adults have problems with drugs or alcohol. Almost half of untreated hyperactive boys with ADD were arrested for a felony by the time they were sixteen. (p. 32)

These statistics are frightening for parents, children, teachers and society in general. If we could find a way to change these disturbing statistics, then we should do everything possible to effect change.

Freed and Parsons (1997) believe that it is not the disorder that produces delinquents but rather the mislabeling and shame with which it is associated. They say that there has been a disproportionate amount of research done on the deficiencies of children with ADD while very little has been focussed on their remarkable strengths.

The purpose of this project is to provide parents and teachers with insights into this disorder as well as furnish them with strategies that can lead to positive and

successful interactions with those affected. The end product will be a resource for parents and teachers which will contain ideas, resources and strategies to use at home and in the classroom.

### Project Description

The literature review in Chapter 2 will focus on answering the following questions:

- ✓ What is Attention Deficit Disorder?
- ✓ How is it diagnosed?
- ✓ How is assessment carried out?
- ✓ What are the current medical approaches?
- ✓ What are the treatment alternatives?
- ✓ What are the strengths and weaknesses of those affected?
- ✓ How does one deal with it within the family? At school?
- ✓ What successful strategies have been found to ensure that children with ADD learn to cope with their difficulties while learning and maintaining their self-esteem?
- ✓ Why are certain strategies unsuccessful?

I will use the research and my personal experience (as a parent of a child who has ADD and as a teacher who has worked with other children coping with this disorder) to compile a set of practical ideas for home and school. I will provide a rationale for these strategies so that those who use them will not only understand them but will also be able to explain their use. As parents, we often find ourselves in the role of advocate when our children have unique needs and/or styles of learning. As teachers who are bound so



firmly by curriculum, we also find ourselves in the role of advocate when a child's unique needs do not fit the definitions which allow for extra help or consideration.

An integral part of this project will be reference to available resources.

Interventions that have proved successful will be examined to determine why they are effective. Samples of various forms, information sheets, specific resources and assessment tools will be attached as appendices.

Permission to reprint certain material has been granted and these are included with other information in the appendices. The list is as follows:

- A. Talking to Children and Adolescents About ADHD: Suggestions for Parents (by permission of the Calgary Learning Centre)
- B. Application of Behaviour Management Principles (by permission of the Calgary Learning Centre)
- C. Guidelines for Successfully Parenting ADHD Children (by permission of the Neurology, Learning and Behavior Center)
- D. Family Problem-Solving and Family Problem Solving Worksheet (by permission of the Neurology, Learning and Behavior Center)
- E. Resource List
- F. Assessment Measures Sensitive to Attentional Skills
- G. Behaviour Evaluation Form

## CHAPTER 2. LITERATURE REVIEW

The purpose of this chapter is to acquaint the reader with the research which supports the need for specific programming and strategies for children with Attention Deficit Disorder. I will use samples from my own experience when appropriate to corroborate the research findings. The literature review will also attempt to define this disorder and its implications for learning and living. A number of current resources will also be examined. Throughout this paper the acronym ADD will be used in place of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder. Other researchers such as Moghadam (1988), Hallowell and Ratey (1994), and Freed and Parsons (1997) have adopted ADD as an acronym for both types of disorders because it refers to the same entity. Attention Deficit Disorder can exist with or without hyperactivity but the disorder itself is the same.

### What is Attention Deficit Disorder?

ADD is a complicated disorder that has been the subject of intense research for many years. The first recognition of ADD as a real disorder is credited to a British pediatrician, George Frederic Still, who in 1902 described children in his medical practice who were difficult to control. He believed it was the result of heredity or birth injury (Hallowell & Ratey, 1994). It wasn't until 1960 that research done by Stella Chess and other researchers that the notion of brain damage was put aside. Chess believed the symptoms were rooted in biology rather than environment. Goldstein and Goldstein (1994a) say, "Heredity is the single factor shown to be a common associate of children

with attention disorder” (p. 24). At this time, it is not known how the disorder is passed from parent to child.

During the seventies and eighties more research, some of which was done in Canada by Virginia Douglas, found four major traits which led to the naming of this syndrome as Attention Deficit Hyperactivity Disorder. These traits were: (1) deficits in attention and effort, (2) impulsivity, (3) problems in regulating one’s level of arousal, and (4) the need for immediate reinforcement (Hallowell & Ratey, 1994). In a 3-year period between 1977 and 1980, over 7,000 articles were published about this disorder (Moghadam, 1988). Barkley (1990) has included a detailed description of the history and research of this disorder in his book, Attention Deficit Hyperactivity Disorder. Presently the disorder is called Attention Deficit Disorder with or without hyperactivity.

The disorder involves a set of behaviours that impair a child’s ability to function in his/her environment (Bain 1991). Three main characteristics form the core of ADD: hyperactivity, impulsivity and inattentiveness (Bain, 1991). Measures of their severity and duration are used to determine whether or not a child has ADD. Another factor that must be considered is where these behaviours are observed. Are they only observed in one setting or several? If they are exhibited in a variety of environments then we can say that they are not triggered by specific environmental factors.

Although the above triad of behaviours form the core of this disorder, other characteristics and behaviours are also present in many children and adults who have ADD. Taken alone, these characteristics can describe many people who do not have ADD but coupled with impulsivity, hyperactivity and inattentiveness, they further compromise a child’s or adult’s progress in school and work. In his book “Attention Deficit Disorder:

Risk taking is another common characteristic among people who have ADD. It is a double-edged sword in the sense that taking risks impulsively can lead to problems, and the high incidence of people with ADD in the prison populations attests to this fact. On the other hand, some of our most successful entrepreneurs are risk takers. At home or school the child may engage in dangerous activities without considering the consequences. My son tied a rope around a bridge support and swung happily over the rocks until the knot gave way and he fell, nearly breaking his leg. He was eight at the time and this was just one more near-miss that contributed to my growing body of white hair. I have heard from parents about their children's fascination with fire. I have found spent matches under our basement steps and shudder to think of what might have occurred.

The final characteristics described by Hartmann (1993) are easy frustration and impatience. The individual with ADD does not have the tolerance for detailed explanations. This is in keeping with Freed and Parsons's (1997) view that children and adults with ADD are global thinkers who want to see the whole picture rather than process small chunks of information.

Moghadam (1988) also includes inconsistency of behaviour as a characteristic of ADD. It is sometimes said that if a child with ADD does something right, it is held against him for the rest of his life. This inconsistency can lead to the belief that the child is lazy or manipulative. Goldstein and Goldstein (1994a) tell us that researchers are beginning to recognize ADD as a performance disorder rather than an inability. The inconsistency leads many people to view these children as simply not putting in enough

effort. Appropriate reinforcers presented correctly can help children with ADD perform more competently (Goldstein & Goldstein, 1994a).

Bain (1991) discusses associated problems that many children experience . Learning disabilities become more obvious in children with ADD when they are in school and are required to engage in activities such as reading and writing. Other non-verbal activities involving visual perception, visual-motor function, and the organization of visual information may also reveal disabilities. Estimates of children with ADD who qualify as learning disabled are as high as 10-20 percent (Sealand et al., 1995). Bain (1991) found evidence that the numbers may be even higher.

Conduct disorders and oppositional behaviour are seen frequently in children with ADD, as are mood and anxiety disorder. One-third to one-half of children who have conduct disorder also have ADD (Bain, 1991). These children are at risk for long-term problems such as substance abuse, juvenile delinquency, alcoholism, and sociopathy. Antisocial behaviour is seen in about 25 percent of hyperactive teenagers. "They get into more fights, are more often picked up by the police and involved in more petty crime than normal youngsters. However, they do not show significantly more alcoholism and drug addiction than their normal peers" (Minde, 1988, p. 6). Mood and anxiety disorders complicate the diagnosis of ADD because they can mimic the symptoms of ADD.

This disorder can occur in adults and children of any race, educational background, and intelligence. The incidence of ADD is often quoted as occurring in 3-5 percent of children, but this figure is not accurate because in recent years more girls have been diagnosed with ADD. At one time it was reported more with boys but closer scrutiny of girls who are experiencing difficulties at school has resulted in a change of

opinion. Winzer (1999) says, “Females are often unidentified, for they express the disorder through talking or being busier, which is more socially acceptable than the gross motor activity seen in boys” (p. 292). There does seem to be a higher percentage of boys who have hyperactivity. A study conducted by Wicks-Nelson and Israel (1991) estimates that hyperactivity occurs in 3 to 20 percent of all elementary school children, with a sex ratio of three or more boys with the disorder to every girl.

### How is it Diagnosed?

The American Psychiatric Association (1994) uses a list of criteria to define a person as having ADD. Of the 14 items on the list, 8 or more must be present and have started before the age of 7. They must also occur more frequently than in the average person of the same age. They also stipulate that the child must exhibit these behaviours in at least two settings, e.g., home, school, church, playground, work. To date this is the only ‘official’ criteria for diagnosing ADD. The publication is called the Diagnostic and Statistical Manual of Mental Disorders or DSM-IV and it is currently in its fourth edition. Despite the unfortunate nomenclature of mental disorders, the list has been helpful in diagnosing children with ADD and has served as a common language for professionals in their discussions of this disorder.

Many lists and inventories have been developed in an effort to clarify the criteria for diagnosis and intervention. They are generally behaviour rating scales such as the Conners Parent Symptom Questionnaire where the parent rates the child in terms of frequency of certain behaviours. The Swanson, Nolan and Pelham Rating Scale, the Achenbach Child Behaviour Checklist and the Home Situation Questionnaire are other examples of parent rating scales (Bain, 1991). The Achenbach Child Behaviour Checklist

has the added advantage of assessing other characteristics such as depression, anxiety, withdrawal and even conduct problems, all of which can co-exist with ADD or even be mistaken for ADD (Bain, 1991).

Other scales are used by teachers (e.g., Conners Teacher Rating Scale) in an effort to determine the frequency and severity of certain behaviours which may be exhibited in a classroom setting (Bain, 1991). There are several assessment tools that teachers can use which assess the three core characteristics of ADD. Aside from the Conners Scale, there is the Child Activity-Attention Profile, the ADDH Comprehensive Teacher Rating Scales, the School Situations Questionnaire and the Achenbach Teacher Report Form (Bain, 1991).

Interview tools commonly used include Diagnostic Interview for Children and Adolescents, Diagnostic Interview Schedule for Children, Schedule for Affective Disorders and Schizophrenia for Children, Interview Schedule for Children, and the Children Assessment Schedule (Sealander et al., 1995). As their names suggest, these tools rely on structured interviews.

Intelligence tests are not helpful in diagnosing ADD but they are useful in telling whether or not the child is working to his/her potential. If a child is performing well below his/her potential, further investigation is warranted. Dr. C. K. Conners, the developer of the Conners Parent Symptom Questionnaire and the Hyperactivity Scale, says the actual testing also allows for observation of the child in a structured intellectual exercise. The degree of frustration and the ability to stay on task in such a situation can provide valuable information when trying to diagnose a child's difficulties.

It is possible to measure attention and impulsivity with specific tests .Rather than being a diagnostic tool, these tests help identify areas of weakness. For example the Matching Familiar Figures Test assesses a child's impulsivity. The Continuous Performance Task test is an example of attention and vigilance. The Selective Reminding Test measures learning and memory . If the child has difficulty retrieving information, the problem may be one of attention or poor strategy (Bain, 1991). See Appendix F for an extensive list of assessment measures sensitive to attentional skills.

Because other conditions can co-occur with ADD and because approximately 10-25 percent of all children with ADD also have learning disabilities, it is important to determine whether or not other factors are present so that all issues compromising the child's learning can be identified. Wender (1987) has noted that "Hyperactive kids tend to be oppositional and have a greater than ordinary risk of being conduct-disordered and learning disabled" (p. 22).

Academic difficulties are common for children with ADD. Over half of the children with ADD who are taught in the regular classroom will fail at least one grade by the time they reach high school (Barclay et al., 1990; Brown & Borden, 1986; Minde et al., 1971; Zentall, 1993). Bain (1991) reports that the incidence of learning disabilities among children with ADD may be as high as 30-40 percent according to some researchers.

A complete medical examination by a pediatrician familiar with ADD should be part of the diagnostic procedure to ensure that the child is physically sound. Part of the physical exam may be conducted by a neurologist who can determine whether or not the presenting behaviours are due to central nervous dysfunction. Moghadam (1988) tells us



that although there are no specific and characteristic medical, neurological, or laboratory tests which can be used to give a reliable diagnosis, it is essential to have a complete medical examination. The parent and the child need to know that there are no physical reasons for the child's behaviour. A correct diagnosis is an impetus for addressing the child's difficulties through whatever combination of educational, medical, and emotional interventions the child and family may need. The parents and child must also understand the problems, diagnoses, and recommendations so that they will follow through with recommended treatment (Goldstein & Goldstein, 1994a).

The extent of the diagnostic procedure emphasises the need for a multidisciplinary approach to diagnosis and a multimodal approach to treatment of this complicated disorder. Because the cause and cure are unknown, the only logical course of action is an attempt to ameliorate the symptoms. Moghadam (1988) reports that many children will improve with maturation, but all of them "will suffer needlessly during their maturation, if they are not given the benefit of the presently available treatment"(p. 39). Hallowell and Ratey (1994) concur: "Most people who discover they have ADD, whether children or adults, have suffered a great deal of pain" (p. 215). Dr. U. Jain, who treats children and adults at Toronto's Clarke Institute of Psychiatry, says, "Let's not put too much emphasis on the diagnosis. The symptoms are more important. You have to look at each symptom, its intensity and how it is creating dysfunction in the child's life" (Hoffman, 1997, p. 49). Jain believes that there is no one treatment strategy that will apply to every child.

#### What are the Treatment Alternatives?

Stimulant therapy. Stimulant therapy acts on neurotransmitters to stimulate the central nervous system. The most common drugs used in this form of treatment are

Ritalin (methylphenidate), Dexedrine (dextroamphetamine), Desoxyn (methamphetamine) and Cylert (pemoline). When a person with ADD takes these medications, the effect is an increased ability to focus and attend. Impulsive tendencies which often make it difficult for a child to maintain peer relationships are also inhibited. There is also evidence that stimulants can help to regulate mood swings which are common with this disorder (Hallowell & Ratey, 1988). Problems of aggression, noncompliance and other disruptive behaviours have also been reduced with this medication (Gomez & Cole, 1991; Keith, 1991). Minde (1987) noted that children taking Ritalin became less visibly active and could organize themselves better. Beugin (1990) found that the calming effect of these drugs helped children to be more receptive to behaviour management techniques. The child is not controlled by the drug but rather is able to control him/herself in situations that call for control (Bain, 1991). Teacher and parent attitudes toward the child become more positive in response to the child's more cooperative behaviour. Moghadam (1988) says that it is likely that the improvements in a child's behaviour as a result of medication and the subsequent boost to his/her self-esteem will actually decrease his/her risk of alcohol and drug abuse in later life. The majority of children treated with Ritalin respond positively (Black, 1992; DuPaul, Barkley, & McMurray, 1991; Gomez & Cole, 1991). Stimulant drugs do have some side effects which makes strict medical supervision requisite. Children can experience gastrointestinal problems such as decreased appetite or an uneasy feeling similar to nausea. These effects usually diminish after a short time. A more serious side effect is appetite suppression which can lead to weight loss. Bain (1991) notes that very few children lose significant weight because they usually adjust their eating schedules to

accommodate times when they are less hungry. Wender (1987) found that weight loss never occurred to a medically serious degree. I have found this to be true of my son, who eats very little during the day but eats throughout the evening. At 6 feet, 4 inches and 180 pounds, his growth has not been compromised by his ADD medication.

A small percentage of children (1-2 percent) have an allergy to Cylert (pemoline). Frequent blood work is needed to ensure that children do not develop allergies to this medication. Allergies to Ritalin and amphetamines are rare (Wender, 1987).

Insomnia and headaches are common complaints with stimulant drugs. Stopping the drug early in the evening will reduce the incidence of insomnia. Headaches can be an indication of a dosage problem and should be monitored carefully (Bain, 1991). Another side effect called 'rebound' sometimes occurs as well. Rebound is a worsening of behaviours as the effect of the medication wears off. As soon as the next dose of medication is taken, this effect disappears. My son needs quiet time after school; he usually spends time alone either on the Internet or listening to music. By the time we sit together for dinner, he is ready to chat with the family. Attempts to converse prior to this are met with annoyance and monosyllable answers.

An slight increase in blood pressure occurs with some children, but unless there is a family history of heart disease, this is generally not a big concern. It can account for a nervousness or "jittery" feeling that some children experience. Once again, dosage must be monitored and all children who are on medication should be monitored carefully by their parents/caregivers and by a physician. When a decision is made to try stimulant therapy, it should be with the understanding that there be a trial period under strict observation.

Less frequently reported side effects do occur as well. Some children develop motor and vocal tics or repetitive behaviours such as facial grimaces or twitching. There is no definitive research that shows whether stimulant drugs bring out more complex disorders such as Tourette's Syndrome or whether they exacerbate the behaviours that are already present (Bain, 1991). Caution should be used when there is an obvious presence of multiple tics in a child with or without a history of Tourette's Syndrome (Mogahadam, 1988). At the suggestion of our pediatrician, my son was examined by a geneticist who diagnosed him as having Tourette's Syndrome. His tics have become slightly more pronounced but they are still quite subtle. Since his behaviour and academic achievement have improved dramatically on medication, it was decided that he should continue.

There are two other serious side effects to Ritalin that are quite rare. Toxic psychosis, which includes delusions and hallucinations, have been seen occasionally. These symptoms disappeared when the medication was stopped (Goldstein & Goldstein, 1994a). Generalized tonic clonic seizures have occurred with very high dosages.

The Federal Drug Administration has approved Ritalin for use with children over the age of 6 and Dexedrine has been approved for children over the age of 3. These drugs are carefully monitored and require a new prescription each month (Goldstein & Goldstein 1994a).

Antidepressants. When stimulants are not effective or when there are contraindications for their use, antidepressants may be used. The most common ones used, particularly with adults or adolescents who show signs of depression, are Tofranil or Janimine (imipramine) and Norpramin or Pertofrane (desipamine). Their effects are longer lasting which helps to maintain a more consistent blood level. This reduces the

rebound effect sometimes seen in stimulant therapy. They are less likely to have the same negative side effects such as appetite suppression and worsening of tics as occurs in some cases with Ritalin.

There are other side effects with antidepressants. In addition to insomnia, decrease in appetite, and stomach pains, they may also produce a dry mouth, fatigue, sedation, mild constipation, increased excitability, headaches, and dizziness. In some cases they have been found to elevate blood pressure as well as change heart rate and rhythm. For this reason, their use is not recommended for young children (Bain, 1991).

There are other drawbacks to drug therapy which must also be considered. Without proper education, the child can be led to believe that drugs are a treatment which may cure the disorder or even that the drugs are controlling his behaviour. The child must understand that the ability to control his/her behaviour comes from within. The medication only helps make it possible for the child to use his own effort and ability. If this is not the understanding, then the child may feel incompetent. In homes where there is little structure, the effects of drugs may not be evident since structure and consistency are very important to the child with ADD (Souveny, 1995).

Medication for aggression. Catapres (clonidine), which is usually prescribed for Tourette's Syndrome, has been found to be effective for treating aggression. It is added to the stimulant medication so that aggression and impulsivity are treated together (Hallowell & Ratey, 1994).

Another category of drugs, called beta-blockers, has also been beneficial in treating aggression as well as anxiety and bodily tension. Taken with stimulant drugs they can be extremely effective. Beta-blockers serve to block the action of adrenaline which is

A Different Perception,” Hartmann (1993) discusses several of these characteristics. He describes a characteristic of chronic disorganization accompanied by snap decisions. He says that unlike ‘messy people’ who can usually find the things they need, the disorganized person with ADD typically cannot find what they need in their mess. My own son would work on an assignment, complete it finally after a great deal of time and effort and then promptly lose it before he got to school. Teachers would say his marks were low because this or that assignment was not done. I still bear the emotional scars of the battle to complete the assignment, and would at first react in horror and disbelief.

Hartmann (1993) also explains a characteristic that he calls “distortion of time sense”. He believes that individuals with ADD have an exaggerated sense of urgency when on task and an exaggerated sense of boredom when they feel they have nothing to do. The result of this perception is that they are impatient when things do not go quickly, and they tend to get into trouble because of the boredom. There is a high incidence of substance abuse among people who have ADD (Amen, 1977) which may be attributed to their need for instant gratification.

Following directions is a challenge for those who have ADD. Hartmann (1993) proposes that the cause may be that the directions are not fully received and understood. There is research that suggests that people with ADD have difficulty processing auditory or verbal information (Freed & Parsons, 1997). Freed and Parsons (1997) and Hartmann (1993) discuss the problem of auditory processing in children with ADD. They believe that children with ADD hear the words but do not form the mental images that help retain words in our memories. Fortunately these skills can be acquired with patience and practice.

a hormone produced by the adrenal gland. Adrenaline causes a hyperarousal state readying the body to react quickly. People with ADD are often in a state of hyperarousal. Beta-blockers can ease tantrums, irritability, fidgeting, rocking, and impulsive behaviour of all sorts (Hallowell & Ratey, 1994).

Serotonin-active drugs are sometimes used as well. These include BuSpar, Prozac, Zoloft and Paxil. These drugs help to delay the brain activity that leads to impulsive, reckless responses. Again, these drugs would be used in combination with stimulants. These drugs are sometimes used when stimulants or antidepressants alone do not work or are not recommended because of age or health complications. For a table of primary symptoms, medications, and their mechanisms of action see Hallowell and Ratey (1994).

Behavioural interventions. Children with ADD often display aversive behaviours which can be difficult to cope with at home as well as in school. Aversive behaviours can include hitting, screaming, kicking people, walls and furniture, tantrums, whining, and biting. Such serious aversive behaviour must be managed for safety and the mental well-being of those involved. Behaviour management programs usually involve a set of set of rules and consequences. Adherence to the rules results in positive consequences and negative consequences follow violation of the rules. These programs can be designed by psychologists, parents, teachers, or others who are familiar with the techniques and principles of behaviour modification (Beugin, 1990).

It is helpful for families and schools to work together on behaviour management programs. Kelley (1990) advocated the use of school-home notes, a system of home-based reinforcement for modifying children's classroom behaviour. School-home notes provide parents with information about the child's behaviour in school so that parents are

involved in improving academic and behavioural problems. The success of this type of intervention program depends on whether or not the target behaviours can be objectively defined and if the consequences are real and immediate (Kelley, 1990). The behaviour evaluation form can be a simple form which is not time consuming for the teacher (see Appendix G). Kelley (1990) lists many advantages to this system. Several of the advantages revolve around shared responsibility for problem definition and solving. Parents and teachers support one another in a collaborative team approach. Beugin (1990) supports this system but cautions users that the lag time between behaviour and consequences may make the program ineffective in some cases.

It is essential that rules be simple and clear; ambiguous language can lead to unnecessary problems. It is preferable to have a written copy of the rules and consequences for compliance and noncompliance. It is unreasonable to try and change every negative behaviour at once. Parents and teachers need to prioritize the behaviours which need to change. This approach is more realistic and less stressful for the child as well as the teacher and parents. For example a child, may be allowed out of his/her desk during certain subjects and not in others or a child may leave his/her desk and go to a designated area of the classroom where other students are not disturbed. Rules need to be age-appropriate and fair if the program is to be successful (Beugin, 1990). Moghadam (1988) reports that sometimes the history of negative interaction between parent and child makes counselling a necessity before behaviour management can be attempted with any hope of success. He lists limitations to behaviour therapy which stem from their reliance on external controls rather than self-control.



Counselling. The child with ADD does not exist in isolation. The whole family is affected by this disorder which can be extremely stressful. The family is involved in the diagnosis process and in the development and execution of management strategies. Without family involvement and cooperation, these management strategies would not be effective. Often, however, the family does not benefit from the child's improved behaviour because some medication used in the treatment of this disorder can affect sleep. The child cannot take the medication within 4 hours of bedtime so parents may have to deal with aversive behaviour for much of the evening. Family conflict can hinder attempts at intervention. Counselling may be necessary to help a family overcome these conflicts. Dealing with ADD may be so difficult for a family that it can cause psychological difficulties such as depression or even marital problems. The goal of family therapy or counselling is to explore with a family their feelings and conflicts and to work towards managing their problems (Moghadam, 1988).

The choice of therapist depends on the needs of the family. It is possible to get family counselling from a psychiatrist, psychologist, social worker, or other therapists but it is important to choose a professional who is knowledgeable about ADD (Bain, 1991). This type of therapy is not a treatment for ADD but rather a way of ameliorating the overall environment for the family as well as the child with ADD. Family therapy is usually focussed around three goals: regaining control, accepting the diagnosis, and implications of ADD, and confronting anger (Bain, 1991).

In most cases a diagnosis is not made until the child reaches or nears school age. By this time the cycle of anger and defeat is well-entrenched. To regain control the parents need to break this cycle by looking at their style or styles of parenting to see if

they are contributing to the problem. Children with ADD often lack self-control and need consistency and structure to help them cope with their problems. A therapist can help parents to examine their parenting skills and form a plan of action to alleviate tensions. Research done by Steinberg, Darling, Mounts, and Dornbush (1994) has shown that children whose parents have an authoritative parenting style score higher on a variety of measures of social development, self-perception, mental health, general life competence, and achievement. Children from indulgent, authoritarian, and neglectful or abusive homes scored lower.

It is crucial that parents educate themselves about their child's disorder so that they understand the disorder and its implications. Regaining control leads to improved self-esteem for the parents and reassurance for the child that his/her parents will help him/her to control him/herself (Bain, 1991). Parenting classes may be a way of learning how to change ineffective parenting styles.

Sometimes accepting a diagnosis of ADD can be a relief for parents who have struggled with the knowledge that something was wrong. The uncertainty as to whether it be because of poor parenting or some other unknown causes anxiety and discomfort. Other parents are grief-stricken as they realize that their dreams for their child may never be realized. As grief from the loss of a loved one takes many shapes, so does grief about accepting that a child has a disorder. Parents need to find an outlet for their grief and each person is unique in their approach.

Education can be an extremely powerful way of dealing with grief. When parents take the time to thoroughly explore every facet of the disorder, they can find answers that may alleviate their sorrow, guilt, and worries. Education can come from resources such

as professionals, workshops, or books as well as from other parents. The success of support groups comes from the knowledge that other people can understand and be empathetic because of their own experiences. Education must be available for the child as well. It is vital that he/she understand the disorder that effects so much of his/her life (Bain, 1991).

It is not uncommon for family members to feel anger. The child with ADD often feels that he/she is the recipient of a great deal of negative interaction. Siblings may think that the child with ADD gets a disproportionate amount of attention at home or is an embarrassment at school or in the neighbourhood. They may feel resentful if parents expect more from them because the child with ADD demands so much time. They may suffer from repressing their feelings in their reluctance to cause more problems (Lee, 1993). Parents may blame one another for the child's behaviour or feel resentful if they perceive the burden of responsibility is not evenly shared. Family therapy can offer a safe place to express anger and explore its roots (Bain, 1991). It is important that all family members receive information about ADD so that they can accept and understand the disorder and all its implications.

Certain families have other complicating conditions that make coping even more difficult. Although it has not been successfully proven, there does seem to be a genetic basis for ADD (Bain, 1991; Hallowell & Ratey 1994; Hartmann, 1993; Minde, 1988). When a parent of a child with ADD also has the disorder, it can lead to guilt or blaming. Because the affected parent can identify with the child's difficulties, he/she may find it difficult to act with authority. If the parent has suffered because of his/her own disorder, he/she may have problems with his/her own emotional health and self-esteem.

Single parents or those who are divorced may also find the responsibility of a child with ADD overwhelming on top of other daily problems of survival. The need for family therapy may be much greater in these situations. Children caught in these situations are at a greater risk for developing conduct disorders (Bain, 1991). Some social service agencies offer respite for families who simply need a rest or break in order to continue.

The child with ADD may need counselling to deal with emotional problems that can arise because of poor self-concept and low self-esteem. These can be addressed through discussion with a therapist who can help the child learn and practice approaches for dealing with these issues. Some therapists can help the child learn anger management strategies and even organization strategies to help with school work (Beugin, 1990). Indirect methods of providing therapy may need to be considered for children who have difficulty with the traditional “talk” method. Other methods might include music, art, play, and storytelling. Young children respond more easily when the atmosphere is play-oriented and free. The therapist tries to interpret the child’s problems and concerns by his behaviour (Winzer, 1999).

#### What Successful Strategies Have Been Found to Ensure that Children with Attention Deficit Disorder Learn to Cope with their Difficulties While Learning and Maintaining their Self-Esteem?

This section will examine techniques that have proven successful in working with individuals who have ADD. Learning to cope with this disorder is important because children who do not receive intervention are at a greater risk for social and emotional problems (Amen, 1977). Teachers also need to find ways that will help these children to

learn in a manner which does not compromise the other children in the classroom.

Successful strategies also help the child learn self-control which in turn takes some pressure from parents and teachers. When a child learns to control his behaviour he/she is better able to build his/her self-esteem.

Cognitive behaviour training. Children with Attention Deficit Disorder, like all children, exhibit a range of behaviours as well as degrees of intensities within these behaviours. Behaviours such as impulsiveness, aggression, disorganization, impatience, distractibility, and social incompetence have prompted the development of a whole educational movement called “psychoeducational training” or cognitive behaviour training. Children are seen as being deficient in interpersonal, prosocial, cognitive, and personal skills. The training involves the use of a combination of didactic, instructional, and audiovisual techniques. (Camp & Bash, 1985; Goldstein, 1988; Goldstein, Sprafkin, Gershaw, & Klein, 1980; Jackson & Monroe, 1983; Kelley, 1990; Kendall, 1988; McGinnis & Goldstein, 1991; Rosemond, 1990; Walker, Todis, Holmes, & Horton, 1988).

This intensive training is designed to teach desirable behaviours and involves development of metacognitive skills. The child is encouraged to “think aloud” so as to build awareness and set a purpose for his/her activity. Verbal mediation, or the use of language as an internal regulator, has been described as a way of problem-solving (Camp & Bash, 1985). The Think Aloud program developed by Camp and Bash (1985) is based on the belief that children can be trained in both cognitive and problem-solving through verbal mediation. Their program “Think Aloud: Increasing Social and Cognitive Skills- A Problem-Solving Program for Children” was initially created for use with young

aggressive boys but it has been proven effective with impulsive and hyperactive children. Children are taught to ask themselves four basic questions to ensure that they approach problems in a systematic manner:

1. *What am I supposed to do?*
2. *What are some plans?*
3. *How is my plan working?*
4. *How did I do?*

There are variations on this list of questions and some programs add the question, “What is the best plan?”. This type of cognitive behavioural therapy is also suggested as a means of family problem solving (Goldstein & Goldstein, 1994a). (See Appendix D for family problem-solving steps and worksheet.)

Teachers are required to allow students time to formulate their answers but also to model verbal mediation for the students. Some teacher preparation is required as effective use of the program necessitates a slight shift in traditional thinking. Teachers need to learn to emphasize process rather than products, to encourage and accept alternatives equally and to predict obstacles.

Walker et al. (1988) developed two other programs called ACCESS (Adolescent Curriculum for Communication and Effective Social Skills) and ACCEPTS (A Curriculum for Children’s Effective Peer and Teacher Skills). They are designed to improve the social competence of adolescents students. Walker et al. (1988) developed the theory that direct instruction could be appropriate for teaching social skills. Moghadam (1988) says that social skills training is often needed as a supplement to cognitive training because the child with ADD needs specific training in observational

skills, perspective taking, conversation, play skills, and relaxation. He sees social skills deficits as very troublesome for children because they often have trouble making friends.

Students are taught a standard procedure to help them analyze social situations, make choices, and adjust their behaviour to ensure certain social outcomes or consequences. The strategy is called 'Triple A' which refers to *assess, amend, and act*. Walker et al. (1988) report that "The Triple A Strategy has been one of the most consistently well-received components of the ACCESS program by both students and teachers and is an important factor underlying the high social validation ratings of the program by consumers" (p. x). These programs differ from behaviour modification in that children are helped to control their own behaviour. The disadvantage is that they involve a great deal of time to implement them correctly (Sealand et al., 1995).

Early research on children with learning disabilities showed that they need a "framework that defines limits and molds growth and development so that the finished product approximates desirable patterns of behaviour and achievement" (Painting, 1983, p. 113). Vail (1994) devotes a chapter of her book Emotion: The On/Off Switch for Learning to discussing the value and need for structure. In her words, "Some kids need LOTS of help with both internal and external structure; almost everyone needs some help" (p. 183). She lists 13 groups of the most needy individuals. Global thinkers and people with ADD are the top two groups. Vail's book offers tips and suggestions for parents and teachers to use with needy children.

Peer-mediated interventions. This type of intervention involves using the attention of other students for intervention purposes. There are three types of peer-mediated reinforcement and group contingencies.

- 1) Interdependent - the behaviour of the group determines whether or not the group receives reinforcement.
- 2) Independent - each member of the group's behaviour determines whether or not the individual receives reinforcement.
- 3) Dependent - reinforcement for the group is dependent on the behaviour of target members of the group.

The advantage of this type of intervention is that the students can observe each other's behaviour more closely and it is less time-consuming for the teacher (Sealander et al., 1995).

Cooperative learning. Cooperative learning is an example of how positive interdependence can stimulate learning. Johnson, Johnson, and Holubec (1986) describe the five basic elements of cooperative learning as follows:

- 1) Positive interdependence - it is essential that students, perceive that the group's success depends on positive relationships within the group.
- 2) Face-to-face interventions - the environment must be set up so that students can interact physically as well as verbally.
- 3) Individual accountability - each group member is responsible for learning the task in which the group is engaged. Each has a role and the group's success is dependent on the individual learning of all group members.
- 4) Collaborative skills- here students are taught the social skills needed for collaboration. They are further motivated to practice these new skills within their group.



- 5) Processing - students are given the time and techniques they need to evaluate their work.

Cooperative learning has been found to be effective in a wide range of outcomes. Of particular interest is its effectiveness in teaching problem-solving, social skills, and attitudes. One of its main outcomes is its ability to stimulate learning (Rolheiser-Bennett, 1989). Cooperative learning strategies have also been influential in developing such cooperative behaviours as empathy, reduced intergroup tension, reduced antisocial behaviour, and positive feelings towards others. It has also been shown to improve student self-esteem, increase on-task behaviour, and decrease disruptive behaviour of behaviourally disabled students (Joyce, Showers, & Rolheiser-Bennett, 1987). Johnson and Johnson (1989) found that 58 percent of 177 studies showed that cooperative learning yielded better interpersonal relations than competitive or individualistic approaches. The study also showed positive results for greater social support and improved self-esteem. Slavin (1990) examined cooperative learning experiments of 4 weeks or more and also found positive results. Eight-four percent of the 32 studies yielded a significant result in favour of cooperative learning.

Teachers must be willing to take substantial training in order to implement this program in their classroom. Training schedules usually include initial training followed by follow up sessions. There is quite a time commitment, but the results seem to be worth the effort.

In my child's experience, the 2 years that he spent with a teacher who employed co-operative learning techniques were the most positive of his academic life. During this time his self-esteem and confidence increased to such a degree that he was given the

Merit Award for his grade. This award is given to the student who consistently works well academically and demonstrates a good attitude.

Humour. In their book “Right-Brained Children in a Left-Brained World: Unlocking the Potential of Your ADD Child”, Freed and Parsons (1997) advocate liberal use of humour. Their experience has shown that “Right-brained, gifted and ADD children tend to have a sophisticated sense of humour, ‘getting’ the puns and jokes that go over the heads of other children” (p. 93). Humour, however, will only work if the student-teacher relationship is secure. Painting (1983) tells us that a child is more apt to behave in ways that will earn him recognition and acceptance from adults with whom he has a positive relationship. Humour can be the way of unleashing the “pools of affect and energy that characterize real learning” (Vail, 1987, p. 15).

Learning styles. Learning styles refer to the use of perceptual strengths when learning. Some learners acquire new knowledge through auditory channels, preferring to hear a lesson, joke, name, number, or formula. Others are visual learners who need to see new information on a blackboard, in a book, or on an information sheet. Still others are tactual learners who retain new information if they can somehow involve their hands in the learning process. They may need to make notes, underline, or highlight in order to process and retain new material. Another type of learner needs to involve his/her whole body in some sort of movement. These are the kinesthetic learners. Freed and Parsons (1997) suggest that all teachers be required to take classes on differing learning styles. They also believe that children should be placed with teachers who either have a corresponding learning style or has an understanding of other learning styles and can effectively teach to them. “Right-brained children will almost always excel with an

instructor who expects good work from them and who has tolerance - even admiration - of their uniqueness” (Freed & Parsons, 1997, p. 164). Freed and Parsons (1997) believe that children with ADD are right-brained thinkers.

Vail (1987) states that a ‘smart kid’s’ school problems can be the result of a mismatch between learning styles and the methods and resources used in the curriculum. The student is often given the identification of being learning disabled when this occurs. She suggests the use of the term ‘learning difference’ because it offers hope that with adjustments to teaching methods and resources the child can learn in a regular classroom. Because learning differences are persistent through life she feels it is important to investigate these learning systems thoroughly.

Educational management. There are numerous studies about how best to meet the educational needs of a child with ADD. In reality, a combination of several techniques is usually in order because ADD children, like their unaffected peers, are individuals with unique abilities, characteristics and backgrounds. There is no single set of characteristics of ADD that identify every child who has this disorder and the severity of the behaviours differ from child to child as well. If the diagnosis has not been made until the child enters the regular school system, then it is likely that the child has already been subjected to a good deal of negative interaction. The child’s self-esteem may have already suffered as a result of this negativity. It has been my experience that a child’s self-esteem is quickly and easily undermined but rebuilding that self-esteem takes a great deal of time and effort.

In “Attention Deficit Disorder: A Different Perception”, Hartmann (1993) lists a variety of systems which may be useful in the classroom. He suggests:

- ✎ Create a weekly performance template and check it daily. This is similar to school-home notes (Kelley ,1990). It is a quick way to record a child's performance in school. It serves to support a team approach between home and school and it helps the child to stay on task and learn to control his/her own behaviour.
- ✎ Encourage special projects for credit. Special projects allow a child to use his/her own creativity and interests to earn credit. Using research done on multiple intelligence by Howard Gardner (1993), Freed and Parsons (1997) also advocate the use of projects. "In our view, most productive human work takes place when individuals are engaged in meaningful and relatively complex projects, which take place over time, are engaging and motivational, and lead to the development of understanding and skill"(Gardner, 1993; cited in Freed & Parsons, 1997, p.172). A research report entitled, "Facilitating Teacher's Professional Learning: An Evaluation Study of the Southern Alberta Professional Development Consortium" (Butt et al., 1995) found that certain strategies were highly motivating for students. Among these strategies was the organization of projects that resulted in the creation of products.
- ✎ Emphasize doing rather than simply listening. Hartmann (1993) describes programs for 'gifted children' that are based on experiential learning. He suggests that children with ADD who have a high need for stimulation may do better in smaller, experience-based learning environments.
- ✎ Ensure that the emphasis is on the positive characteristics of a child who has ADD rather than on the disorder. Stressing the disorder diminishes a child's self-worth

and is not constructive. Some positive characteristics of children with ADD are their ability to monitor their environment, noticing minute details and an amazing ability to concentrate when they are interested in a task. They are capable of changing strategies quickly and working energetically. They are visual thinkers who can create wonderful images in their heads. Risk taking is part of their nature and they are bold in their attempts at problem solving (Hartmann, 1993).

✍ Children with ADD seem to cope better when their environment is structured and predictable. Fowler (1993), author of “Maybe You Know My Kid”, offers suggestions for educational interventions that have proven successful. She cautions that they are only guidelines and the child’s unique needs, personality, strengths, and weaknesses need to be considered when choosing the appropriate intervention techniques. Some children will require intensive levels of intervention because their behaviour severely impairs their opportunities for learning. Behaviour management strategies such as those discussed earlier might be necessary for these individuals.

✍ Try to place the child with a teacher who is knowledgeable about ADD or is willing to learn. A teacher who understands a child’s struggles will be more willing to work with parents and more willing to make changes in order to meet the child’s needs. Painting (1983) says,

Environmental conditions must maximize success and minimize excessive premature pressure. As inner controls, emotional strength, and relevant skills increase, the child’s need for external structure decreases, and he will be able to handle the pressures of daily living more successfully. (p.113)

✍ Teachers who cultivate a safe environment and have a supportive, warm attitude will have more success with children who have ADD. Butt et al. (1995) report that several factors have a powerful direct positive correlation with increased student achievement. Some of the most compelling factors include:

- a) student self-concept and self-esteem
- b) teacher warmth, enthusiasm, and degree of organization
- c) a sense of community
- d) a safe orderly working environment

Cruikshank, Morse, and Johns (1980) also consider affective education to be very important: “It is essential that the teacher demonstrate proper attitudes and clarify the essence of acceptance” (p. 29).

✍ Adjustments to the curriculum may be necessary for the child to achieve success. Because children with ADD are prone to restlessness and boredom if they are required to do repetitive tasks, it may be necessary to reduce the number of practice tasks if the child shows mastery of a concept. Other changes might include presenting a variety of tasks such as brief lectures followed by hands-activities, role plays or group activities.

Hallowell and Ratey (1994) state:

There is no easy solution for the management of ADD in the classroom, or at home for that matter. After all is said and done, the effectiveness of any treatment for this disorder at school depends upon the knowledge and the persistence of the school and the individual teacher. (p. 254)

Hartmann (1993) suggests that children with ADD often need a different structure in which to learn. This learning environment or structure may be a combination of smaller classes, shorter segments of instruction, visual aids, instruction in visualization, enforced quiet times and lots of hands-on experiential learning.

Home management. Homework is frequently at the centre of conflict as parents try to encourage their children to complete the work sent home by teachers. Children with ADD may have difficulty staying on task and completing their required school work so they often have uncompleted class work to do as well as regular homework. Rosemond (1990) says that parents need to take the role of consultant rather than participant when dealing with ‘ homework hassles’. He advises parents to provide encouragement and support but not to add to the child’s distraction by their constant presence. The more responsibility a parent assumes for homework, the less responsibility the child will develop. Rosemond (1990) offers several helpful strategies in his book, “Ending the Homework Hassles: Understanding, Preventing, and Solving School Performance Problems”. As a support group facilitator and parent, I know that homework can be extremely stressful. It is difficult for parents to let go but in order to foster responsibility, autonomy, perseverance, time management, initiative, self-reliance and resourcefulness, we must learn to do just that (Rosemond, 1990). There is a difference between helping a child when there is a need and hovering around the child ensuring that work is done.

There are many suggestions for home management that revolve around consistency and structure. Parker (1988) developed a whole workbook for families and teachers. He cautioned, however, that “There are no ‘new improved’ quick fix methods of child rearing that will consistently be effective in managing the behaviour of these

children” (p. 22). Parker lists four conditions that must be met in order to manage misbehaviour:

1. An understanding of the reasons why children misbehave.
2. An awareness of the common mistakes that parents tend to make in managing their child’s misbehaviour.
3. The learning of specific tools that are useful in the home to correct misbehaviour.
4. The correct application of these tools on the specific misbehaviour of the child.

(p. 26)

Management tools include having the right attitude, using positive reinforcement, using assertive communication, using time-out, giving choices and using token programs (Parker, 1988). It is important to understand that no matter how hard families and teachers try to use these tools consistently, there will be times when they will simply not succeed because of unpredictable variables such as sickness and fatigue. Parents need to be realistic in their expectations for themselves and their children.

Anger management. Aggression is a serious behaviour that is sometimes seen in children with ADD. The potential for harming other people in the environment makes it a concern that must be addressed. Children need to feel safe in their environments. Cognitive skill and social skill training programs as described above have been somewhat effective in dealing with aggressive behaviour. Children who do not respond to these programs and who exhibit severe aggressive behaviour may need to be educated in special settings.

Hallowell and Ratey (1994) explain the aggression exhibited by some children with ADD as being caused by their intensity and impulsivity. The normal inhibitors that



usually help with self-control seem to be absent in these children. They believe that intense people experience feelings more fiercely and impulses more deeply. When these individuals have difficulty making and keeping friends because of their behaviour, it can lead to aggression. The conflict created by their seeming disregard for consequences and authority leads to intense situations which in turn can lead to aggression.

In an effort to understand and explain the sequence and progression of aggression, Hallowell and Ratey (1994) use a chart called the “Anatomy of Aggression” (p. 273). It is their belief that ADD leads to an initial distortion of the child’s perception of a situation. This misperception leads to poor evaluation of the situation and inappropriate reaction. When intensity and impulsivity are added to this scenario, it is easy to see how the child might react with aggression.

Behavioural approaches are the preferred intervention for students with such behavioural disorders. Some forms of behavioural interventions are best used in segregated settings. Ideally, the goal is to return the child to the regular classroom when the undesired behaviour diminishes. Despite the push for inclusion, a segregated class is sometimes the least restrictive environment for a child who is already at risk socially and academically (Winzer, 1999).

Winzer (1999) includes a lengthy debate regarding the placement of students with serious behavioural disorders in her book, “Children With Exceptionalities in Canadian Classrooms”. She provides a comprehensive review of the current literature on this topic. The arguments against inclusion far outweigh those that support inclusion. Winzer (1999) states that children with mild behaviour disorders can manage in the regular classroom if teachers have support, appropriate programming, and individualization. Children

exhibiting violent behaviours, however, can pose a serious safety problem and she feels that there placement in a regular classroom is still highly debated.

The next chapter is a collection of strategies for the classroom. Rationale for their use is provided so that teachers and parents can understand their application. The strategies have been collected from a number of sources and I have added personal experiences when applicable.

### CHAPTER 3. STRATEGIES FOR THE CLASSROOM

- ✎ Testing can be stressful for any student but students with ADD often do better on verbal tests than on written tests because they can concentrate on what they are saying rather than trying to get their thoughts down on paper in a given time period. A student with ADD and Tourette's Syndrome can be at a real disadvantage in a testing situation as stress can aggravate the tics that are a symptom of this disorder. Whenever possible, time limits should be waived and alternate forms of testing should be considered (Conners, 1994). Children with ADD take longer to retrieve information; this puts them at a distinct disadvantage in timed test situations (Freed & Parsons, 1997).
- ✎ Children with ADD frequently have difficulty with handwriting. There are a number of considerations in this event. If the child is capable of using a word processor, he should be allowed to do so whenever possible. If this is not possible in the classroom, the child can either dictate lengthy assignments into a tape recorder or to a scribe. Children should be encouraged to work on this skill in less stressful situations. Poor handwriting should never be penalized when content is the priority (Conners, 1994).
- ✎ Preferential seating will help avoid problems for the child and make special instruction easier for the teacher. The child who is easily distracted needs to be placed in the front and to the side of the classroom. This eliminates some distractions and the child is more easily accessible to the teacher. Sometimes teachers arrange to deliver a signal to the child when the child needs to be

reminded to focus or get back on task. Other advantages may arise from efforts to unobtrusively help the child manage his/her behaviour by being close to the child when he/she is losing control. It is not necessary to physically touch the child but standing near the child or the child's desk may help the child to think about his/her actions (Conners, 1994).

Circle time is a popular way of delivering a lesson to young children. This may be troublesome for a child with ADD because of his/her impulsivity and distractibility. A half circle arrangement may work better because the teacher can keep all the students in view. Placing the child with ADD directly opposite the teacher will make eye contact much easier. Seat a child with ADD next to someone who won't provoke or encourage misbehaviour.

Small groups often work better for children with ADD who do better socially, academically, and behaviourally when working in smaller numbers. Research has shown that children with ADD perform better when there is a low student-teacher ratio (Freed & Parsons, 1997) but when this is not possible small groups may be a workable alternative.

- ✎ Break down assignments into manageable chunks so that the child who struggles with organization has a better chance of completing the assignment. Mark and record each segment of the assignment before pieces are accidentally lost. By monitoring their work and giving frequent feedback, the child is able to stay on track and see progress. This can encourage the child who might otherwise become frustrated (Hallowell & Ratey, 1992).

- ✎ Time frames may need to be adjusted to ensure completion of all aspects of the assignment. Instead of giving a date for the final assignment give shorter time frames for each segment. For example - 2 days for the introduction, 5 days for the body, and 3 days for the conclusion would be easier for the child with ADD to manage than a 2-week due date (Conners, 1994; Hallowell & Ratey, 1992).
- ✎ The disorganization that plagues so many children with ADD becomes a real issue in school. Aside from assignments, the student is responsible for remembering the material he/she needs for each class as well as for homework. There are a number of organizational strategies that can be used depending on the child's age. The aim of these strategies should be to make the child as independent as possible. My son carries everything he needs for his classes despite the fact that his book bag probably weighs 40 pounds. He has carried this load since junior high because he does not want to forget or lose anything. It is certainly not the most efficient system, but he has found it himself and it works for him.

Other more efficient methods include making sure the child has a second set of textbooks at home to alleviate the worry of forgetting books. When possible colour coding binders with textbooks can be helpful. A highly visible list of assignments and due dates will help all students without singling out the child with ADD.

- ✎ Hallowell and Ratey (1992) suggest sitting with the child and discussing what they need to get their work done. "They [the children] are often too embarrassed to volunteer the information because it can be rather eccentric" (p. 255).

In Grade 7, my son's teacher presented the students with a list of their marks for each assignment in each subject. She then asked the students to write whether or not they had the marks they should have and if not why. It was interesting to see the comments that my son wrote. He felt his marks had suffered in Social Studies because the class did a lot of group work. He found it hard to concentrate when so much was happening around him. His teacher simply made sure that when group work was required, my son's group worked in the hall rather than the classroom. It was such a simple change and because several children were involved, he was not singled out in any way. His marks gradually improved with the new arrangement.



Structure and routine are important to the child with ADD. When a person lacks an internal system for structure, their external environment needs to provide structure so that they can function adequately. Young children will benefit from reviewing class rules, schedules, instructions, and format. Older children can be helped if rules, schedules, and directions are posted or given to them so that they can refer to them when needed. It is reassuring to know what is expected and to prepare yourself mentally for what is needed. If the schedule varies for some reason, a child should be forewarned so that they are prepared for the change. Young children often have problems with transitions so teachers must prepare them in advance by giving them some kind of warning signal. When a child needs to work independently, offer to help the child make his/her own schedule.

Painting (1983) explains the need for structure this way:

Environmental conditions must maximize success and minimize excessive premature pressure. As inner controls, emotional strength, and relevant skills increase, the child's need for external structure decreases, and he will be able to handle the pressures of daily living more successfully. (p. 113)

In her book "Emotion: The On/Off Switch for Learning," Vail (1994) provides an excellent and comprehensive discussion of structure. She includes a section called "Ten Tips for Moms, Dads, Nannies, Grannies, Grandfathers, Teachers and Other concerned Adults". Vail (1994) looks at structure as it relates to all ages, from very young children to adolescence.

- ✎ Consistency goes hand in hand with organization and structure. Children with ADD need clear limits and they learn self-control when teachers are consistent in enforcing these limits. Classroom rules should be few but meaningful and highly visible. Frequent reminders may be necessary to prevent problems from arising. Management strategies of any kind are only successful when applied systematically and consistently. Students need to know what to expect of their teacher and what is expected of them. They also need to be aware of the consequences of their success or failure (Winzer, 1999).
- ✎ Learning is emotional as well as cognitive. A child needs to find happiness in learning. Children who have ADD often experience a great deal of negative interaction from their peers, family, and teachers. Learning can be frustrating and failure can be commonplace. Because their performance and behaviour is inconsistent, they are often thought of as lazy when they fail to complete required work or if they can attend to their work one day but not the next. For this reason it

is important to pay special attention to how emotions are involved in the learning process. Vail (1994) calls emotion, ‘the on/off switch for learning’. She suggests that emotion and intellect fuse through:

- a) prompting motivation
- b) sparking curiosity
- c) nourishing intellect, talent and power
- d) encouraging connections
- e) assessing growth
- f) accepting special considerations (Vail, 1994, p. 7).

She offers excellent suggestions for achieving these goals at home and at school.

Cruikshank et al. (1980) concur with Vail. They consider affective education to be very important: “It is essential that the teacher demonstrate proper attitudes and clarify the essence of acceptance” (p. 29). When looking at factors that have a powerful positive correlation with increased achievement, teacher warmth, teacher positive image of students’ ability to learn and student self-concept and self-esteem are found to be very important (Butt et al., 1995).

- ✍ If impulsive behaviour is a problem, allow an older child to leave class a few minutes early so that there is less opportunity to misbehave. Crowded hallways and lockers are an invitation for trouble. This also serves to keep the child on task when getting material for the next class or packing his/her book bag. If he/she is not distracted by the activity and noise of a crowded hallway, he/she may be able to concentrate on the task of getting what is needed from the locker.





When one considers how difficult it is for children with ADD to start a task , stay focussed and then prepare for the next task, it makes good sense to lengthen the lesson. Students can stay interested for long periods if the material is interesting, multi-sensory and relevant. The schedule in our local high school is four 80-minute blocks a day. I was apprehensive at first but soon found that my son preferred this schedule and commented frequently about how much work he could get done in class. Longer lessons allows for a variety of teaching strategies as well as a variety of learning opportunities.

A recent study (Butt et al., 1995) which looked at research on experiential and innovative teaching found that other forms of teaching aside from teacher-centred and direct teaching could result in increased student learning.


In the last fifteen years other forms of teaching (more related to motivational, child-centred and experiential means of maximizing the quality of student engagement) have been shown to result in significant increases in student learning in all domains.” (p. 12)

Butt et al. (1995) note several key strategies used to motivate students to learn experientially. They include:

- a) Having students role play and engage in simulations
- b) Organizing projects that result in the creation of products
- c) Playing games with students for review
- d) Relating subject matter to current events and students’ lives
- b) Assigning students to case studies
- c) Using thought provoking questions

- d) Inviting guest speakers from the community
- e) Showing videos and films
- i) Organizing co-operative learning activities and peer teaching
- j) Providing hands-on experiences
- k) Giving students more choice and control
- l) Giving students time to dialogue with peers and relate their own experiences
- m) Doing experiments and projects which involve hands on activities
- n) Having students design and conduct their own projects and experiments

They believe that these strategies make learning “personal, social, active, experiential, concrete, emotional as well as cognitive, and reflective” (Butt et al., 1995, p. 10). The above techniques are beneficial to all students, but for the child with atypical learning needs, this type of environment can help the child stay motivated. Children with atypical learning styles need teachers who are willing to use a variety of materials and teaching methods. Teachers may need to consult a specialist to help them plan for such a child (Vail, 1987).

 Homework must be meaningful and relevant as well. Too often children with ADD are assigned the regular homework in addition to the work that was not completed in class. Freed and Parsons (1997) emphasize that homework should be a tool for reinforcing concepts and keeping the ‘spark’ ignited outside of the classroom. Long-term projects and research can alleviate the child’s resistance to homework. For many years we experienced tears of anger and frustration around the issue of homework which at the time was repetitious work that my son

detested. When we understood his disorder we advocated for less repetition and negotiated for other homework. Once he started to work on projects and research, he no longer resisted the homework.

✍ Teachers and parents need to work closely together to support one another and to help the child with ADD succeed. Communication is the key to understanding and cooperation. Empathy is needed for the parents who suffers vicariously when their children struggle and it is needed for the teacher who tries to meet the needs of all the students with limited resources, external pressures and limited time. School-home notes are a way of keeping the lines of communication open and also a way for parents to be involved in any management techniques being employed in the classroom. A useful resource for parents and teachers is: “School-Home Notes: Promoting Children’s Classroom Success” by Mary Lou Kelley (1990).


✍ When giving directions make eye contact with the child who has ADD. Reward eye contact and attention with acknowledgement. Even a smile or nod will let the child know that you are happy to see that they are ready to listen. When possible, avoid giving directions to whole groups. If this is not possible, have the child repeat all or some of the directions to ensure that the child understands what is expected. It may be necessary to provide the student who has ADD with written directions as well as oral directions. Because of their distractibility it can be difficult to remember a set of directions. Providing written directions will alleviate the need to explain and re-explain the directions for a task. Short-term memory problems need to be accommodated in the interest of time. On the other hand, they also need to be strengthened. Modelling activities while giving

directions, helps the child to learn visually and also helps them to recall the steps. Directions should be brief and concise with the emphasis on the goal. Freed and Parsons (1997) believe children with ADD are global thinkers who need to see the whole picture rather than the minute details. Establishing the purpose of a lesson helps develop motivation for learning. Moghadam (1988) says,

The ADHD children, more than normal children, need to know not only what it is they are required to learn, but also its relevance by explicitly relating vocabulary and concepts to the child's background experience.

Half of the battle is won if the teacher can engage the child. (p. 81)


While children are working teachers should provide plenty of feedback, praise, and reinforcement.

 Know when to ignore minor fidgeting that does not disrupt the class. If possible, provide opportunities for purposeful movement. Children who have Tourette's Syndrome as well as ADD cannot easily control motor tics. They may need a safe place for release where they can freely move around. Some schools provide a room for these children but when this is not available, the child could briefly step out of the classroom. Teachers can use opportunities such as taking the attendance sheet to the office as a way of providing purposeful movement. Other ideas might be holding a softball or small toy rather than tapping a pencil or foot. Souveny (1995) suggests a masking tape circle or square around a child's desk which defines the parameters within which the child is allowed to wander during class time. This allows the child to move out of his/her desk but not to disturb other students. His book, entitled, "ABC's For Success: Attention Deficit Disorder"

(Souveny,1995) contains many good ideas that offer positive support to the child with ADD.

- ✎ Children with ADD often have poor peer relationships because of their impulsive and sometimes aggressive behaviour. One way to help a child build social skills while building good work habits, is to reward increased productivity or time on task with an opportunity for positive peer attention. For example, a child with a specific talent might be able to demonstrate this talent for the class. If a child tries to get attention by making jokes or funny sounds at inappropriate times, give him the chance to show his skills at an appropriate time. His/her peers will take a more positive view of the child if he/she is using this skill in a legitimate and appropriate manner.
- ✎ Take the time to learn how to use cognitive behaviour training programs such as “Think Aloud” Camp and Bash (1985) so that you can help children with ADD take control of their behaviour and learning. It will be beneficial to the child, the rest of the children, and to the teacher.
- ✎ Some children with ADD exhibit poor anger management skills. They are easily over-aroused and have difficulty regaining control. This may manifest itself in temper tantrums and defiant behaviour. Moghadam (1988) says that it is important to recognize the stages of a temper tantrum so that it can be handled in a suitable manner. He outlines the following four stages:
  - a) Grumbling - If possible the teacher should help the child verbalize his/her feelings and problems. This may prevent a major tantrum.

- b) Noisy - Here the child is aware that he is in trouble and signals for help. The teacher can help him make his needs known in a more appropriate manner. She can acknowledge his anger and give him a way to regain control. For example, "Step out into the hall until you feel ready to return to class or sit in your desk for two minutes, then we will talk about this issue." This intervention gives the child an opportunity to save face and to cool down. There are no winners in a confrontation and this is the last stage where a full blown tantrum can be averted.
- c) Full-blown tantrum - The child is incapable of accepting any suggestions from the teacher and may need to be removed from the class until he/she regains control.
- d) Leave me alone - The child who is recovering from a major tantrum needs time alone without any comment or intervention.
- e) Reflection - The teacher asks questions about the incident in an effort to develop better coping skills. If the child can understand how and why the situation deteriorated, then he/she may be able to think of alternate ways of handling similar situations.

 Children with ADD are high-needs children and they require a lot of energy. Teachers need to know where to turn for support and help in planning for these children. The resource room teacher can be an invaluable source of strategies and support. Parents know their children very well, they too can and should be part of the planning for their children. Not many teacher education programs routinely offer courses that prepare a teacher for all the different learning needs which will

present themselves in a regular classroom. My own teacher training did not provide the necessary training that I needed to work with special needs children. As teachers we must remember to be kind to ourselves and seek help when it is needed rather than let a situation become overwhelming. When this happens it is easy to become resentful of the child because we find it too difficult to cope with all our responsibilities. Sharing the load can lighten the burden. Finding a safe outlet for discussing your concerns is essential to good mental health. Teachers must press administration to provide the necessary professional development and support we require when dealing with students whose unique learning needs have not been part of our education and experience. Luckily there are numerous books on the topic of educating children with ADD. The reference list at the end of this paper contains the titles of several current resources (see Appendix E). In Southern Alberta we are fortunate to have learning and family centres that offer professional services, education, and support.

The Calgary Learning Centre  
3930 - 20 Street S.W.  
Calgary, AB T2T 4Z9  
Tel.: (403) 686-9300 • Fax: (403) 686-0627

The Calgary Learning Centre provides services to individuals and organizations that deal with learning difficulties and disorders. They offer workshops, doctors, psychologists, parent support, and access to their library of books and videos.

Children's Service Centre  
#401, 5000 Gaetz Ave.  
Red Deer, AB T4N 6C2  
Tel.: (403) 340-2606 • Fax: (403) 340-2615

The Children's Service Centre provides an in-centre play-based assessment of children's behaviour. The centre also provides workshops and a support group as well as professional services. For a nominal membership fee, books and videos may be borrowed from the library.

The Family Centre  
1010 - 4th Avenue South  
Lethbridge, AB  
Tel.: (403) 320-4232

The Family Centre provides information and support for families. They have a lending library and run information workshops and support groups.



## CHAPTER 4. STRATEGIES FOR THE HOME

In this chapter I will discuss strategies that can be used in the home. I will use some of my own experiences as a parent to support the strategies that are described. ADD has an impact on the whole family. It is extremely important for families to find ways to manage the affected child's behaviour at home so that their day-to-day living is not fraught with struggles which undermine any hope of maintaining positive relationships within the family.

☺ The most important strategy for parents in my view is the acceptance that they are human and not superhuman. Too often parents are made to feel inadequate when their children experience difficulties with behaviour. Even well-meaning friends, family, and professionals can inadvertently make parents, particularly mothers (Minde,1988) feel as though the child's behaviour problems are directly related to their poor parenting. Ideally we would all have 8 hours sleep and work at non-stressful jobs which provide adequate salary to pay for our homes, food and other necessities. Ideally our children would go to school, learn what is required, and move on through the grades without a hitch.

Realistically this is not the case in many families, and the daily stresses of life can be hard on the strongest of people. When a family has a child with ADD, they have usually spent the first several years trying to control and understand their child's behaviour and have agonized over trying to find a way of coping with the great demands on their time and energy. If there are other children in the family, they have had to balance their time and energy between the needs of the child with ADD and the needs of their other children. I facilitate a parent support group and have heard comments such as:

“My mother tells me I should be firmer with -----.”

“I dread answering the phone during the day because I am afraid it will be the school.”

“I am afraid to answer the door because I know it will be a neighbour complaining about my child.”

“We never go visiting. Who would want us to come to their home?”

“I have no friends.”

“When my child comes to my workplace, I am ashamed because I am not happy to see him.”

“I am sick with worry each day that my child is at school.”

“My family say that maybe he (adopted child) should have stayed with his kind.”

Parents need to find ways to take care of themselves. They can do this by attending a support group with other parents who share their experiences and concerns. The support group should be a safe place where parents can freely talk about their feelings and worries. It should also be a productive and positive experience where parents can come to believe that they can help one another and educate their community. Our support group raised over \$1,000.00 to host a workshop for parents, teachers, health care professionals, and families. The parents involved were so highly energized and happy with their work because they felt that they had accomplished something concrete and worthwhile.

Other sources of respite can come from simple pleasures such as a hot bath or an evening out. Sometimes, however, a family needs to seek professional help to identify and deal with their feelings or to learn more effective parenting styles. Moghadam (1988)

makes several suggestions for families seeking professional help. He believes using these suggestions will create a working alliance which will benefit the family. He offers ideas on setting a goal for counselling and learning to listen efficiently. In addition to information on seeking professional help, Moghadam (1988) also provides an extensive discussion on parental and family issues that is too long to summarize in this paper but it is certainly worthwhile reading.

☺ Parents need to become experts on ADD. They need to know everything there is to know about it and they need to keep reading and listening as new research is published. Goldstein(1989) says parents must thoroughly understand the disorder, including developmental, scholastic, behavioural, and emotional issues. Ignorance generates fear and avoidance. Parents need to know how this disorder affects their particular child so that they can accommodate his/her needs at home and advocate for him/her at school. Parents must create a positive relationship with their child's teachers and the school administration so that they can work as a team to educate the child in the least restrictive way. They must be involved in all decisions surrounding the child's educational program and placement. Because there is evidence that ADD is transmitted genetically, parents, who have ADD themselves, may not have positive memories of their own school experiences. It may be difficult for them to advocate for their children in an environment that is perceived as hostile. If they need support in this role, they can seek help from other members of their support group or a friend who knows the child. The child's physician or counsellor may need to become involved if necessary.

☺ Structure at home is as important as structure in the classroom. The child needs clear and concise rules of behaviour as well as consistent consequences for both

appropriate and inappropriate behaviour. Rewarding appropriate behaviour is equally important as punishing misbehaviour. When a child has some choices within the boundaries set by parents, it helps him develop initiatives. If limits are firm but fair, a child will learn self-control.

Children may need help managing their behaviour at home. Medication such as stimulants cannot be taken in the evening because it causes insomnia. For this reason, parents need to help their children learn self-control at home. Structure and consistency, as mentioned earlier, help children to know what is expected and what will happen if expectations are met and if they are not. Beugin (1990) offers helpful information on setting up a behaviour management system, based on these two principles. The system involves stating clear rules, rewards, privileges, and penalties. A simple charting system is included in the appendix as well as a planning sheet. (See Appendices H & I.)

☺ Homework can be a real problem for families and nearly every parent in our support group expressed frustration with helping their child complete homework assignments. I recall spending hours helping my child and going from extreme patience to anger after so little was accomplished yet so much energy had been expended. I remember watching him struggle to stay on task and finally dissolving into tears and saying, “There is something wrong with my brain!” In the end we both felt defeated and frustrated. Now I have learned to stay out of his way and I have been pleasantly surprised at his accomplishments. Rosemond (1990) suggests a management approach called the “ABC’s of Effective Homework Management.”

A - ALL BY MYSELF: The child works on his own which serves two purposes. The homework is not the central focus for the family and there is less temptation for the

parents to interfere. If the homework area is comfortable and contains all the material the child needs, he/she should be able to do the homework without leaving his work area. This teaches the child autonomy. Goldstein and Goldstein (1994a) caution parents to remember to avoid clutter and distracting colours because the child with ADD has problems filtering out unnecessary stimulation.

**B - BACK OFF:** The parents must train themselves not to get involved unless the child asks for his/her involvement. When the child finds his/her own solutions to homework problems, he/she learns initiative. Rosemond (1990) does not advocate ignoring a child's legitimate request for help but suggests three conditions for helping: (1) clarifying or reinterpreting directions, (2) demonstrating or giving an example of a particular procedure, and (3) reviewing or checking work for accuracy, clarity, and adequacy.

**C- CALL IT QUILTS AT A REASONABLE HOUR:** Parents need to set an upper limit for homework which should be consistent except in cases of unusual circumstances such as special projects. This teaches a child how to manage his time efficiently.

Rosemond (1990) believes that this approach sends a positive message to children that they can accomplish their tasks and that as parents we trust that they can and will do so.

☺ Children need an honest discussion of their disorder so that they can understand what it is and what implications it may have for them. Painting (1983) says, "Discuss problems with the child. Most Specific Learning Disabled children are painfully aware that something is wrong. They may not be able to explain it but they recognize discrepancies in their skills" (p. 101). My son would often say that there was something wrong with his brain. The day we finally had a name for his disorder was a great relief to

him. In his words, “I had a stomach ache all the way to the doctor’s office but now it is gone.”

Hallowell and Ratey (1994) provide several strategies for families to use in discussions about this disorder both with the child and with other members of the immediate and extended family. They believe a frank discussion helps a family accept the condition and thereby normalizes it in the eyes of all concerned. Accommodating the disorder just as you would accommodate any condition that affects the whole family allows a family to deal with it by not allowing it to dominate the family. When the disorder is allowed to dominate a family, it becomes their identity. When every conversation revolves around the disorder, the child does not have a chance to develop his true identity. Just as the child with severe allergies needs to live his life normally while being mindful of allergens, so does the child with ADD.

☺ If a child is placed on medication for ADD, it is crucial that he/she understand why this decision was made, what effects the medication will have and what side effects may occur. When a child understands that some of his/her behaviours are beyond his/her control, he/she can start to rebuild his/her self-esteem. Behaviours like poor impulse control, inattention, and hyperactivity cause children problems in school and with their peers. Medication can help to control these behaviours but ultimately they are still responsible for their behaviour choices. The medication can be helpful but it does not control the child. He/she still has the freedom to choose to behave appropriately or inappropriately. Medication should never be viewed as having ‘magical’ effects. The child needs to learn to use the medication as a tool not as a crutch. Part of the discussion could revolve around situations that the child would like to improve and then it can be

explained that the medication will make it easier for the child to move toward improving his/her behaviour in these situations. As Beugin (1990) says, “. . . he will be in the driver’s seat; it will just be easier now for him to steer the car where he wants it to go” (p. 88). If we want children to realize that they are in control we must also be cautious about attributing inappropriate behaviour to not taking medication. When we respond to poor behaviour choices with comments such as, “Did you take your pill this morning?”, we are telling the child that it is the medication controlling the child. This is not the case and parents need to make sure they are knowledgeable about the effects of the medication before talking with their child so that there is no misunderstanding. Rosemond (1990) states that when a child learns to accept responsibility for his behaviour he learns self-control which leads to self-sufficiency which is the essence of self-esteem. The child’s doctor can be helpful in explaining the medication’s effects to your child. There is also a very good video and booklet called, “It’s Just Attention Disorder: A Video Guide for Kids” (Goldstein, 1991). My son has always had realistic expectations of his medication and I credit his pediatrician with helping us all comprehend its significance. I will always remember his final words, “It won’t make you any smarter, it will probably help you get through high school with your self-esteem intact.”

Hartmann (1993) suggests that it is helpful to discuss the differences in pre- and post-drug states of consciousness and concentration. He thinks that this awareness will help to develop appropriate behaviours at times when children are not medicated. He cites the analogy of using training wheels while learning the skills needed to ride a bicycle. “Once the skills become second nature, the training wheels can be safely discarded” (p. 82).

Knowledge about the medication and how it works will also be useful for parents and children when dealing with those who believe that the medication turns the child into a 'zombie'. The child can be as good or as bad as he/she wishes because the medication will not change the child's basic personality. Some medication does reduce the mood swings and anxiety seen in some children but proper dosage does not turn them into 'zombies'.

There are other misconceptions about the drugs used for ADD. I recall one teacher who had a misconception about Ritalin which could have had a major impact on my son's success. I was concerned that my son's marks were dropping in math, a subject in which he had previously done well. The teacher said that his marks were 'good' for him considering the fact that he had heard that Ritalin negatively affected intelligence. I took this opportunity to educate this teacher and by so doing halted the prophecy fulfilling that had already started to take its toll on his progress. My son's marks started to improve and he is currently taking Math 20.

The Calgary Learning Centre has an information sheet called "Talking to Children and Adolescents About ADHD: Suggestions for Parents." It contains useful information to ensure that your discussion is based on accurate information and thoroughly covers all the needed information. Permission has been granted to include this sheet as an appendix. (See Appendix A.)

☺ Over the course of a day we give our children many directions. Some simple ideas may reduce the risk of confrontation.

- When giving a child direction, do so in a positive way. For example, "We walk in the house" rather than , "Don't run!". This type of communication



tells the child what he/she should be doing. It also models a respectful way of communicating.

- Give the child one direction at a time. Children with ADD cannot always remember a series of directions. Recently my son told me he took a Ritalin before his after-school job because he could not remember all the directions customers gave him regarding their deli orders.

If there are problems despite these simple strategies, the real issue may be incompetence rather than non-compliance. Goldstein (1991) tells parents to develop an understanding of both types of behaviour. Incompetence results from inconsistent application of skills which result in poor performance. This type of behaviour is non-purposeful. Non-compliance, on the other hand, is a purposeful choice not to do as directed. Parents respond correctly when they can differentiate between the two.

☺ Rewards and punishments must be provided as soon as possible and with consistency. Some families develop a list of chores or directions and consequent rewards for compliance and punishments for non-compliance. This system can be adapted even for beginner readers by using pictures. A sample list is included in the appendix. (See Appendix J.)

A variation of this system is the response cost approach. A child has a certain number of credits at the start of each day and loses a certain amount with each non-compliant behaviour. Or the child has no credit to start with and builds up his/her reserve throughout the day. The child can exchange credit for certain special privileges at the end of each day. It is not advisable to aim for long term goals such as a reward at the end of a

good week or month because children with ADD have difficulty with delayed gratification (Goldstein & Goldstein, 1994a).

☺ The child with ADD is often very sensitive and as parents we need to be cautious about how misbehaviour is addressed. It must be clear to the child that it is the behaviour and not the child that is the problem. There is a vast difference between saying, “I don’t like it when you punch the walls” and “You are so destructive.” In the first statement, the undesirable behaviour is clearly labelled and in the second statement the child himself is the object of criticism. Beugin (1990) explains that criticizing the behaviour is easier for the child to accept and it is easier on his self-esteem. Goldstein & Goldstein (1994b) say that children with ADD are at a greater risk for depression because of their poor self-image. For this reason it is extremely important that the child’s feelings be considered when dealing with poor behaviour.

☺ A busy household is a stimulating environment. It is best to be mindful of the effects of too much stimulation on a child with ADD. If children have homework to do, the television should be turned off and any other needless noise removed so that the child can concentrate.

☺ Children with ADD should be encouraged to pursue their special interests. If the child enjoys art, music or dance, try to develop this interest by providing opportunities for him/her to use this talent. My coffee table is always cluttered with art material because my son loves art. His room looks like a disaster zone but he knows where to find his paints and pencils. He usually ends the evening with artwork. He has received a great deal of recognition for his art which has boosted his confidence tremendously.

Sometimes a child's interest can be strengthened through books or videos on their topic of interest. A trip to the library with your child will offer a chance for positive time together as well as be a source of free books and videos. Family memberships are usually quite reasonable and many libraries even have Internet access. I remember how proud I was of my 3-year-old son's knowledge of dinosaurs. At 6 he questioned whether a dinosaur display was accurate. He was right: the display showed a plant-eater pursuing another animal for food. A red-faced librarian corrected the figures and he was able to relax and enjoy the display. It is important for every child to recognize their talents and interests, but for a child who receives a lot of negative interactions in life, it is especially important.

☺ Finally, a child with ADD may need help to label and express his/her feelings. It is heart-wrenching for parents to see a child suffer and our first instinct is to fix the problem but that is not always possible. Children who have emotional difficulties may benefit from working with a mental health professional. As parents we must realize when we don't have the expertise to help our children. ADD is a complicated disorder that is draining physically and emotionally for the person effected as well as the family. A team approach helps to alleviate some of the burden by sharing the management and supporting the family.

There are no easy paths to the management of ADD at home or school but it is my hope that this paper will help children, parents and teachers who want to find a way. My son is the inspiration for this paper. He has taught me so much and humbled me with his indomitable spirit. He has overcome tremendous obstacles through his own efforts and the efforts, love and dedication of his family, friends, some of his teachers, his

pediatrician and the astute young mental health professional who pointed us all in the right direction 5 years ago. This paper is a tribute to my son who graciously allowed me to use our experiences so that others might be spared some of the hardships that we experienced while searching for an answer.

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**APPENDIX A:**

**Talking to Children and Adolescents About ADHD:**

**Suggestions for Parents**



## TALKING TO CHILDREN AND ADOLESCENTS ABOUT ADHD:

### SUGGESTIONS FOR PARENTS

#### Why?

- children and adolescents can have misconceptions
- misconceptions may lead to fears
- children and adolescents must have knowledge to be able to advocate for themselves
- children and adolescents need to understand that there is a reason why certain situations are difficult for them
- children and adolescents need to understand when ADHD is a “reason” and when it is an “excuse”
- increased understanding helps children and adolescents be more amenable to treatment
- increased understanding increases the individual’s awareness so that s/he can begin to use strategies for an understandable reason and at the appropriate time
- talking about ADHD opens doors for honest and productive dialogue about the child’s or adolescent’s difficulties
- increased understanding can help the child or adolescent to build a reality-based view of self, and it in turn, improve self-image

#### Where to begin?

- build your own knowledge base about ADHD (books, videos, workshops)
- become comfortable with information on ADHD so it can be expressed to the child or adolescent in a manner which is understandable
- initiate discussions when comfortable and when interactions with the child or adolescent have been positive
- if the child or adolescent initiates the discussion, focus on their feelings first, then discuss content

#### What to talk about - in general?

- explain that ADHD is a life-long biologically based condition
- talk about ADHD as being part of the child or adolescent (like hair colour or eye colour), rather than a problem
- find comparisons that mean something to the child or adolescent, like a friend with asthma
- acknowledge the child’s or adolescent’s feelings
- talk about symptoms - school, family, friends
- explain how ADHD affects normal childhood/adolescent development
- reframe school failure and family contact



- debunk common myths about ADHD
- emphasize the positives

#### What to talk about - re medication?

- provide accurate information about medication - doctor, book, video as resources
- explain medication as being a coping technique for symptoms of inattention, poor task persistence and impulsive behaviour
- use the metaphor of needing glasses for a visual problem
- look at advantages and disadvantages of medication:
  - make a list of pros and cons
  - decide whether advantages outweigh the disadvantages
  - take objections seriously

#### What to be prepared for?

- the child or adolescent may deny his/her difficulties; it is important to use descriptive feedback to raise his/her awareness
- the child or adolescent may have strong emotional reactions to the information, such as anger; becoming aware of the grief cycle can be of help in understanding these feelings
- the child or adolescent may blame you (parents) and lash out at you
- the child or adolescent may suggest that you favour other kids: "That's why you're mean to me!"
- the child or adolescent may use ADHD as an excuse: "What do you expect? I have ADHD."
- lots of questions that are difficult to answer:
  - don't be afraid to say: "I don't know, we'll find out together."
  - don't be afraid to give accurate information, even if you think it may hurt the child's or adolescent's feelings

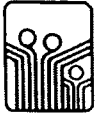
#### What to avoid?

- "hiding" the disorder from family, friends and teachers
- telling the child or adolescent not to talk about ADHD with others
- talking about the child's or adolescent's difficulties to others as if s/he wasn't there
- encouraging the child or adolescent to take medication when no one can see
- always focussing on the negative aspects of ADHD

#### What to do for yourself?

- use resources in the community
- seek a parent support group

**APPENDIX B:****Application of Behaviour Management Principles**



## APPLICATION OF BEHAVIOUR MANAGEMENT PRINCIPLES

Inappropriate behaviour:

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Rule:

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Descriptive feedback:

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Choices that can be presented to the child:

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What will be said to the child to generate his/her own choices:

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Other things that can be done to make this work:

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How will I know if this works:

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## **APPENDIX C:**

### **Guidelines for Successfully Parenting ADHD Children**

## GUIDELINES FOR SUCCESSFULLY PARENTING ADHD CHILDREN

To effectively parent a child with ADHD you must be an effective manager. Your interactions with your ADHD child must be consistent, predictable and most important, understanding of the chronic difficulties this child will likely experience. The following guidelines are essential:

1. **Education.** You must become an educated consumer. You must thoroughly understand this disorder, including developmental, scholastic, behavioral and emotional issues.
2. **Incompetence vs. Non-compliance.** You must develop an understanding of incompetence (non-purposeful problems that result from the child's inconsistent application of skills leading to performance and behavioral deficits) and non-compliance (purposeful problems which occur when children do not wish to do as they are asked or directed). ADHD is principally a disorder of incompetence. However, since at least 50% of children with ADHD also experience other disruptive, non-compliant problems, parents must develop a system to differentiate between these two issues and have a set of interventions for both.
3. **Positive Directions** (telling children what to do rather than what not to do, or giving them a 'start' rather than a 'stop' direction). This provides the most effective type of commands for the ADHD population.
4. **Rewards.** Remember that children with ADHD need more frequent, predictable and consistent rewards. Both social rewards (praise) and tangible rewards (toys, treats, privileges) must be provided at a higher rate when the ADHD child is compliant or succeeds. Remember, it is likely that the ADHD child receives less positive reinforcement than siblings. Make an effort to keep the scales balanced.
5. **Timing.** Consequences (both rewards and punishment) must be provided quickly and consistently.
6. **Response Cost.** A modified response cost program (you can lose what you earn) must be utilized with this child at home. This system can provide the child with all the reinforcers starting the day and the child must work to keep them or can start the child with a blank slate, allowing the child to earn at least three to five times the amount of rewards for good behavior versus what is lost for negative behavior (earn five chips for doing something right, lose one chip for doing something wrong).
7. **Planning.** Understanding the forces that affect your ADHD child, as well as the child's limits, should be used in a proactive way. Avoid placing the child in



situations in which there is an increased likelihood the child's temperamental problems will result in difficulty.

8. **Take Care of Yourself.** Families with one or more children experiencing ADHD are likely to experience a greater stress, more marital disharmony, potentially more severe emotional problems in parents and often rise and fall based upon this child's behavior. It is important to understand the impact this child may have upon a family and deal with these problems in a positive, preventative way rather than a frustrated, angry and negative way after you have reached your tolerance.
9. **Take Care of Your Child.** Remember that your relationship with this child is likely to be strained. It is important to take extra time to balance the scales and maintain a positive relationship. Find an enjoyable activity and engage in this activity with your child as often as possible, at least a number of times per week.

**APPENDIX D:**  
**Family Problem-Solving**

## FAMILY PROBLEM-SOLVING

1. Stop! What is the problem we are having?
  - Try to avoid blaming individuals.
  - Focus on how each family member is interacting and causing problems together.
  - State specifically what the problem is so that everyone agrees.
2. What are some plans we can use?
  - Think of as many alternative plans as possible.
  - Don't evaluate or criticize any family members' ideas.
3. What is the best plan we could use?
  - Think of what would happen if the family used each of the alternatives.
  - Think about how each alternative would make each family member feel.
  - Decide which alternative is most likely to succeed.
  - Reach an agreement by most or all family members if possible.
4. Do the plan.
  - Try the plan as best the family can.
  - Don't criticize or say "I told you so," etc.
5. Did our plan work?
  - Evaluate the plan.
  - Determine if everyone is satisfied with the way the problem was solved.
  - If the solution didn't work, repeat the entire family problem-solving process again.

*Note:* Try to stay focused on the here and now. Do not bring up old issues when trying to do family problem-solving.

**PROBLEM-SOLVING WORKSHEET**

What's the problem?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Which is it?

1	2	3	4
---	---	---	---

What solutions are available?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Which is the best solution?

1	2	3	4
---	---	---	---

What steps will this solution  
require?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

How will I check to see if it's working? \_\_\_\_\_

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**APPENDIX E:****Resources**

## Resources

Bain, L.J.(1991). *A Parent's Guide to Attention Deficit Disorders*. New York: Bantam Doubleday Dell Publishing Group.

Beugin, M.E. (1990). *Coping Attention Deficit Disorder: A Guide for Parents and Teachers*. Calgary: AB : Detselig Enterprises Ltd.

Clark, L. (1986). *SOS: Help for Parents*. Bowling Green, KY: Parent's Press.

Coleman, W.S. (1988). *Attention Deficit Disorders, hyperactivity and Associated Disorders: A Handbook for Parents and Professionals (5<sup>th</sup> Edition)*. Madison, WI: Calliope Books.

Phelan, T.W. *All About attention Deficit Disorder, Part 1 Symptoms, Development, Prognosis and Causes*. VIDEO. USA: Child Management. To order: 1-800-442-4453

Goldstein, Sam *Why Won't My Child Pay Attention?* VIDEO. The Neurology Learning and Behaviour Center, Salt Lake City, Utah

Goldstein, S. and Goldstein M. (1990). *Managing Attention Disorders In children: A Guide for Practitioners*. New York: Oxford University Press.

Hallowell, E.M. and Ratey, J.J. (1994). *Driven to distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood*. New York: NY: Simon and Schuster.

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Moghadam, H. (1988). *Attention Deficit Disorder Hyperactivity Revisited*. Calgary: AB: Detselig Enterprises Ltd.

Parker, H C.(1988). *The ADD Hyperactivity Workbook*. Plantation, Florida: Impact Publications.

Phelan, T.W. *All About Attention Deficit disorder, Part 11 Diagnosis and Treatment*. VIDEO. USA: Child Management To order 1-800-442-4453

Phelan, T.W. 1984. *1-2-3 Magic (Text and Video)*. Glen Ellyn, IL: Child Management

Phelan, T.W. 1995. *1-2-3 Magic: Training Your Preschoolers and Preteens to do What You Want*. Child Management Press, Glen Ellyn, IL

Rosemond, J.K. ( 1990). *Ending the Homework Hassle*. Kansas City, MI : Andrews and McMeel.

### Resources for the Classroom

Bash, M.S. and Camp, B. (1985) *Think Aloud: Increasing Social and Cognitive Skills. A Problem-Solving Program for Children*. Champaign, IL : Research Press.

Goldstein, A.P., Sprafkin, R.P., Gershaw, N.J. and Klein, P. (1980). *Skill-Streaming the Adolescent*. Champaign, IL : Research Press.

Goldstein, A.P. (1988). *The Prepare curriculum: Teaching Prosocial Competencies*. Champaign, IL : Research Press.

Jackson, D.A. and Monroe, C. ( 1983). *Getting Along With Others: Teaching Social Effectiveness to Children*. Champaign, IL : Research Press.

Kelley, M.L., (1990). *School-Home Notes: promoting Children's Classroom Success*. New York, NY : The Guilford Press.

McGinnis, E. and Goldstein, A.P. (1991). *Skills-Streaming in Early Childhood*. Champaign, IL : Research Press.

Vail, P., (1987). *Smart Kids with School Problems: Things to Know and Ways to Help*. New York, NY: E.P. Dutton.

Vail, E.P. (1994). *Emotion: The On/Off Switch for Learning*. Rosemont, NJ : Modern Learning Press.

Walker, H.M., Todis, B., Holmes, D. and Horton, G. (1988). *Adolescent Curriculum for Communication and Effective Social Skills (ACCESS)*. Austin, TX: Pro-Ed.

### Resources for Children

Nadeau, K.G. and Dixon, E.B. (1991). *Learning to Slow Down and Pay Attention*.

Galvin, M. (1988). *Otto Learns About His Medicine*.

Gehret, J. (1991). *Eagle Eyes*.

Gehret, J. (1990). *The Don't give Up Kid*.

Gordon, M. (1991). *Jumpin' Johnny: Get Back to Work*.

**APPENDIX F:****Assessment Measures Sensitive to Attentional Skills**



## **ASSESSMENT MEASURES SENSITIVE TO ATTENTIONAL SKILLS**

### **Vigilance**

Detroit Test of Auditory Attention for Unrelated Words  
Detroit Test of Visual Attention for Objects  
Wechsler Intelligence Scale for Children - III  
Seashore Rhythm Test  
Speech Sounds Perception Test  
Gordon Diagnostic System Vigilance Task

### **Sustained Attention**

Rapidly Recurring Target Figures Test  
Wechsler Intelligence Scale for Children - III  
Seashore Rhythm Test  
Speech Sounds Perception Test  
Symbol Digit Modalities Test  
Halstead Trail Making Test  
Visual Closure Subtest of the Illinois Test of Psycholinguistic Abilities (ITPA)  
Gardner Motor Steadiness Test  
Gordon Diagnostic System Vigilance Task

### **Focused Attention**

Stroop Color Distraction Test  
Visual Closure Subtest of the Illinois Test of Psycholinguistic Abilities (ITPA)  
Halstead Trail Making Test  
Rapidly Recurring Target Figures Test

### **Selective Attention**

Rapidly Recurring Target Figures Test

### **Divided Attention**

Wechsler Intelligence Scale for Children - III (Arithmetic Subtest)  
Wechsler Intelligence Scale for Children - III (Digit Span Subtest)  
Halstead Trail Making

### **Impulsivity**

Matching Familiar Figures Test  
Wechsler Intelligence Scale for Children - III (Mazes Subtest)  
Gordon Diagnostic System Delay and Vigilance Tasks  
Halstead Trail Making Test

**APPENDIX G:**  
**Behaviour Evaluation Form**

## Appendix G

## Behaviour Evaluation Form

Name : \_\_\_\_\_ Date: \_\_\_\_\_

Class: Math

1. a) Percentage of work completed in class	0	25	50	75	100
b) Percentage of time on task	0	25	50	75	100
c) Cooperated during class period	yes	most of the time	some of the time	no	

Comment: \_\_\_\_\_

Class: Art

2. a) Percentage of work completed in class	0	25	50	75	100
b) Percentage of time on task	0	25	50	75	100
c) Cleaned up work area	yes	most of it	some of it	no	

Comment: \_\_\_\_\_

**\*\* Note:** The advantage of this system is that it is very quick and efficient. It can also be tailored for each child and each class.

**APPENDIX H:**  
**Planning Sheet Sample**

## Appendix H

## Planning Sheet Sample

Behaviour	Privilege	Penalty
1. Get up when alarm sounds	15 mins. of cartoons before school	15 mins. early to bed
2. Pack school bag after homework	Extra 10 mins. of reading time before bed	Lights out 10 mins. early
3. Walk dog after school	Choice of after school snack	Wash dog prints from the back door.

\*\*\* Note: Target behaviours should be prioritized and privileges delivered quickly and consistently. Remember that it is impossible to address all negative behaviours at once so choose the ones that cause the most problems and then slowly build on this list. Parents and children should make this plan together so that everyone understands how it works and what will happen. Unless there are extenuating circumstances that call for flexibility, parents need to be firmly committed to following through with both privileges and penalties.

**APPENDIX I:**  
**Charting System Sample**

## Appendix I

## Charting System Sample

Target Behaviour	Date	Consequence
1. Get up when alarm sounds	Mon. April 14	Yes - 15 mins. of cartoons before school  No - 15 mins. early to bed  Yes - 15 mins. of cartoons before school
2. Pack school bag after homework	Thurs. April 16	Yes - Extra 10 mins. of reading time before bed

\*\*\* Note: In a busy household it is easy to forget details such as whether or not a child did or did not perform the target behaviour. It is wise to develop an easy charting system in order to avoid arguments and hard feelings. The charting system can simply be a calendar with large squares for each day upon which you can write and keep track of behaviour. It may be helpful for the child to see the chart so that he/she can adjust his/her behaviour if needed. I have seen some charts that involve the use of colourful stickers to indicate that a child has performed the required behaviour. Young children could be involved in placing the stickers on the chart.

**APPENDIX J:**

**Sample Chore List & Consequences**



## Appendix J

## Sample Chore List and Consequences

Chore	Mon	Tue	Wed	Thur	Fri	Sat	Sun
make bed	☺	☺	☺	✖			
feed cat	☺	☺	✖				

3 happy faces in a row for any chore = choose an activity from the list below

1. pizza for supper 2. 15 mins. of Nintendo 3. Dad feeds cat today 4. Mom makes your bed

Less than 4 happy faces in the week for any chore = 30 minutes early to bed on Sunday

No happy faces in the week for any chore = no T.V. on Sunday and 30 minutes early to bed.