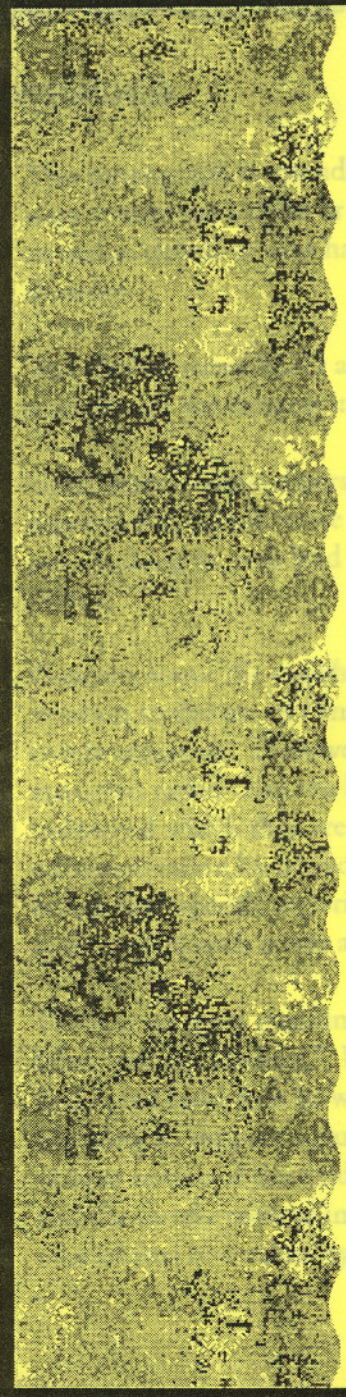

School District No. 38
RICHMOND

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Attention-Deficit Hyperactivity Disorder

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FOREWORD

This monograph is intended for teachers and parents who are looking for better ways to support a child or youth who seems to be exhibiting the symptoms of an attention deficit or may have already been formally diagnosed as having this disorder.

The clinical terms ADD and ADHD should be used carefully and with due attention to the dangers inherent in such global descriptors.

Understanding that a person has a neurological disability can empower us to support that person more effectively. It can also depersonalize and circumscribe our thinking or even lead to negative subconscious assumptions about that person.

Concern about the possible adverse consequences of labeling does not imply an aversion to the use of clinical terms. In fact, such terms are an essential aid to communication. However, when these terms occupy the foreground of our attention rather than the background, and eclipse the uniqueness of the individual which they are presumed to describe, then they can impede communication by introducing assumptions and pre-judgments based on global rather than specific experience. Thus, such terms should be used with sensitivity and never in such a way as to create an apparently homogeneous category.

There is no more meaning to the label "ADHD student" than there is to the label "average student." If the term is necessary it should be used as a secondary descriptor only; that is, we should refer to "a student with ADHD." When planning to support a student it is important to be aware of and responsive to the unique nature of the student's strengths and needs, the classroom environment and the family context in addition to applying general knowledge about educational or medical syndromes.

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Attention-Deficit Hyperactivity Disorder

WHAT IS ADHD?

In *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment* Dr. Russell Barkley states that "ADHD must be viewed as a developmentally disabling disorder of inattention, behavioural disinhibition, and the regulation of activity level to situational demands." He notes that this condition results in a powerful tension "between the sincere desire to be good and the strong pull of disinhibition within these children" and concludes that "ADHD is a disorder that cries out... for broad societal recognition as a neuropsychological impairment of the individual shaped to final form by its environmental context." (pp. ix-x)

Dr. Larry Silver provides the same description in less clinical terms in *Dr. Larry Silver's Advice to Parents on Attention-Deficit Hyperactivity Disorder.*

> Many children get up each school morning and promise their parents that they will try to be good in class that day. They do try. But because these children may be hyperactive, distractible, and/or impulsive, their behaviours disrupt class activities, annoy the teacher, and push their classmates away. Such children cannot help their behaviours. Yet the message they hear is always the same: "Why can't you be good?"

Although hyperactivity is the most evident characteristic of a child with ADHD, the primary clinical issues are inattention and impulsivity. However, it should be noted that some researchers feel that ADHD arises out of a neurologically based insensitivity to consequences – reinforcement, or punishment, or both – rather than an attention or cognitive dysfunction at all.

Not all children struggling with the challenge of an attention deficit will also exhibit hyperactivity. In this case the syndrome is variously labeled ADD, ADD/-H, ADD/WO or UADD. Because it does not have the same overt behavioural consequences, ADD can easily go unrecognized but has an equally harmful effect on learning.

ADHD is a particularly challenging disorder because we are often unprepared to accept "the progressively accepted conclusion from our research that disorders of social conduct can have biological and often hereditary origins." (Barkley, p. 38) We are prone to interpret all misbehaviour as resulting from environmental factors alone and to assume that better parenting or stricter discipline will resolve the problem. For a child with ADHD, however, the misbehaviour originates in a neuropsychological impairment and is beyond conscious control. The child is born with the handicap and, while environmental influences may aggravate (or alleviate!) the condition, they are not the cause.

A child with ADHD can be quite literally incapable of sustained attention or restrained activity in many situations. Some of the conditions of the classroom may be just those which the child finds most difficult to cope with. Therefore, we must look upon ADHD as a disorder that results in impairment of ability to concentrate, not a misbehaviour, and respond with the same empathy and support which we would afford a child who is confined to a wheelchair because of a physical handicap. This does not mean that inappropriate behaviours are to be excused or ignored but rather that our response must be conditioned by an understanding of the child's disability.

HOW COMMON IS ADHD?

Estimates of the incidence of attention deficits range as high as 13% depending upon the definition used and the severity required for diagnosis but it is commonly accepted that between 3% and 5% of children have a clinically significant form of ADHD. It is one of the most prevalent childhood disorders. Boys are diagnosed three times as often as girls. It is not clear to what extent this may represent a referral bias resulting from the fact that girls with ADHD are less likely to be aggressive or oppositional.

Even a conservative estimate of the incidence rate would lead one to expect to find, on average, at least one child in every class who could be clinically diagnosed as having ADHD and others who exhibit some or all of its characteristics. Therefore, we must seriously reexamine our personal assumptions about the causes of misbehaviour and the way in which we respond to it. We have a responsibility to expect and promote high standards of conduct in our classrooms but we also have a responsibility to support those students who do misbehave by teaching them how to do better. Where the misbehaviour is based on a neurological disability it is an educator's responsibility to adapt classroom practices, curriculum materials and instructional approaches to support the needs of the child.

There may be many children who do not have a diagnosable attention deficit but will face some of the same challenges, perhaps to a lesser degree or only for a short period of time for environmental rather than neurological reasons. Even though the cause may be different or the severity less, any child who is impulsive or distractible will benefit from a classroom environment which acknowledges these common childhood behaviours and is designed to help the student deal with them rather than to suppress them. Thus, as we deepen our understanding and strengthen our pedagogy in response to the specific needs of those students with a neurological disability the benefits of an "ADHD friendly" classroom can be felt by many of our students.

HOW CAN I TELL IF A CHILD IN MY CLASS HAS ADHD?

The symptoms of ADHD are inattention, impulsivity and overactivity. All children will display these behaviours to one extent or another quite naturally but those who might be clinically termed to have ADHD will display them early in life, across a wide variety of situations and to an extent which is clearly inappropriate for their age or developmental level.

Dr. Larry Silver describes these behaviours as follows.

> [Overactivity:] Most hyperactive children and adolescents are not running around the room or jumping on the furniture [although that too is possible]. They appear to be fidgety. Their fingers are tapping; their pencil is moving; their leg is swinging; they are up and down from their desk or the dinner table. Something is always in motion. Parents may report that these children are equally restless at night, moving about the bed. [This behaviour is normally evident from an early age, even *in utero.*] An anxious child can be hyperactive; not all fidgety students have ADHD.
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> [Inattention:] The teacher might report that such a child is not paying attention. In reality, though, the daydreaming might reflect family or other stress, an emotional disorder, or the excitement of an event (such as the day before a holiday or a vacation) ...if there is more than one sound in the environment (students talking, activity in the hall, teacher talking), they may have difficulty knowing which sounds to listen to... Their internal thoughts protrude into their conscious behaviours. They are in class and suddenly start to talk about something that appears to be off the topic. Younger children might suddenly start to talk about dinosaurs or space, or they might begin to laugh...

> [Impulsivity:] Impulsivity is described as the inability (or difficulty with being able) to stop and reflect before speaking or acting. Thus the impulsive child or adolescent interrupts the teacher or parent, answers a question with the first thought that occurs, or says something and then is immediately sorry he or she said it. This individual might get frustrated or angry and yell, throw something, or hit someone... The impulsive child or adolescent does not have the luxury of the time to think first. (pp. 22-26)

While significant levels of inattention, impulsivity and hyperactivity may indicate ADHD, it should be noted that the most common causes of these symptoms are anxiety and depression. However, if these causes are ruled out and if the behaviour is persistent and occurs across a wide variety of situations at school and at home then they may indicate ADHD.

Although it is not yet commonly accepted, Dr. Barkley also notes that "there is little doubt in my mind that poor rule-governed behaviour is closely associated with the behavioural disinhibition that is the distinctive feature of ADHD." (p. 45) If a child does not adhere to rules and instructions and this is not due to defiance, impaired language development, emotional stress or a sensory handicap (e.g. deafness) then this may be an indication that the child is unable to do so because of ADHD.

You may also notice much greater variability in behaviour, classroom performance and homework than one might normally expect. A child with ADHD may do things quickly and accurately on some occasions but sloppily or not at all at other times.

While formal diagnosis can only be made by a qualified person, the definition of Attention-Deficit Hyperactivity Disorder which follows may be of value to you in recognizing possible cases of ADHD. It is based on the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R) published by the American Psychiatric Association in 1987.

a) A disturbance of at least six months during which at least eight of the following are present.

- Often fidgets with hands or feet or squirms in seat (in adolescents, may be limited to subjective feelings of restlessness)
- Has difficulty remaining seated when required to do so
- Is easily distracted by extraneous stimuli
- Has difficulty awaiting turn in games or group situations
- Often blurts out answers to questions before they have been completed
- Has difficulty following through on instructions from others (not due to oppositional behaviour or failure of comprehension), e.g. fails to finish chores
- Has difficulty sustaining attention in tasks or play activities
- Often shifts from one uncompleted activity to another
- Has difficulty playing quietly
- Often talks excessively
- Often interrupts or intrudes on others, e.g. butts into other children's games
- Often does not seem to listen to what is being said to him or her
- Often loses things necessary for tasks or activities at school or at home, e.g. toys, pencils, books, assignments
- Often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g. runs into street without looking

  [Note: The above items are listed in descending order of discriminating power.]

b) Onset before the age of seven [although the actual diagnosis may occur later].

c) Does not meet the criteria for a pervasive developmental disorder [a more serious disorder].

It should be noted that the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* will soon be available. It is expected to recognize ADHD and ADD as distinct syndromes and may modify the preceding list of symptoms slightly.

Dr. Barkley notes that identifying symptoms included in the formal definition of ADHD will occur for all children and are naturally present to a greater degree with younger children. Thus, experience and discretion should be used in applying them to avoid over-identification. On the other hand, girls show considerably less of these characteristics and are, therefore, less liable to be diagnosed with ADHD unless careful allowance is made for this fact. In his opinion, the most distinguishing characteristic is impulsivity rather than the hyperactivity which is most obvious.

In order for a clinical diagnosis of ADHD to be made, the identifying symptoms must be present to an extent which is clearly inappropriate for the age or developmental level of the child and should be evident across a wide variety of home and public situations. However, that does not mean that the symptoms will be evident at all times to the same degree. When playing alone, watching television or engaged in a particularly stimulating and novel activity the child may show few, if any, of the symptoms while at other times they may be quite severe. Generally speaking, children have the greatest difficulty in school settings but several other factors are also important.

Dr. Barkley describes some of these factors as follows:

> ...the degree of "structure," or more specifically the extent to which caregivers make demands on ADHD children to restrict behaviour appears to affect the degree of deviance of these children's behaviour from that of normal children. In free-play or low-demand settings, ADHD children are less distinguishable from normal children than in highly restrictive settings. Related to this issue of setting demands is the effect of task complexity on ADHD children. The more complicated the task,

and hence the greater its demand for planning, organization, and executive regulation of behaviour, the greater the likelihood that ADHD children will perform more poorly on the task than normal children. Obviously the symptoms of ADHD are only handicapping when the demands of the environment or task exceed a child's capacity to sustain attention, regulate activity and restrain impulses

On tasks where instructions are repeated frequently to the ADHD child, problems with sustained responding are lessened... [However], it is not uncommon for parents and teachers frequently to complain that repeating their commands and instructions to ADHD children produces little change in compliance.

ADHD children display fewer behavioural problems in novel or unfamiliar surroundings, or when tasks are unusually novel, but increase their level of deviant behaviour as familiarity with the setting increases. It is not uncommon to find that ADHD children are rated as far better in their behaviour at the beginning of the academic year, when they are presented with new teachers, classmates, classrooms and even school facilities. Their behavioural control, however, usually deteriorates over the initial weeks of school...

Task stimulation also seems to be a factor in the performance of ADHD children. Research suggests that these children are likely to pay much more attention to colourful or highly stimulating educational materials than to relatively less stimulating or uncoloured materials. Interestingly, such highly stimulating materials may not affect the attention of normal children as much or may even worsen it.

Settings or tasks that involve a high rate of immediate reinforcement or punishment for compliance to instructions result in significant reductions in or in some cases, amelioration of, attentional deficits...

> Fatigue or time of day (or both) may affect the degree to which ADHD symptoms are exhibited. Zagar and Bowers observed the behaviour of ADHD children in their classrooms and during various problem-solving tasks, and found that they performed significantly better on these tasks when given in the mornings... This is not to say that differences between hyperactive and normal children do not exist in early mornings but emerge only as time of day advances, for this is not the case. Normal children show similar effects of time of day upon their behaviour, and so hyperactive children appear to be more active and inattentive than normal children, regardless of time of day...
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> [There are some] methods or schedules of work that best fit with the ADHD child's limited capacities for sustaining attention and regulating activity level. Difficult, complex or tedious work can be organized into smaller units, provided with greater clarity, assisted by having the child think aloud and talk himself or herself through the task, and enhanced by providing more immediate and salient reinforcers for task completion. Scheduling such activities during morning hours as suggested earlier, may further enhance task performance. Permitting some motion and talking during task completion, and interspersing periods of restraint with periods of exercise or movement, may also help. (pp. 54-61)

Given the fact that the symptoms of ADHD will be naturally exhibited by all children to some degree and the further fact that these symptoms may vary in severity according to setting and circumstance, it is not a simple matter to establish a diagnosis of ADHD and this should not be done casually or without the guidance and involvement of qualified individuals.

In any event, the primary concern should not be diagnosis but how best to support the child. If any child is displaying the symptoms which might be typical of ADHD then it is important to respond immediately. One does not require a diagnosis in order to begin. The management of the undesirable behaviours and the educational support which are to be provided to a child with

ADHD are simply matters of good teaching and do not differ qualitatively from the manner in which all children are best treated, although they may well vary quantitatively. Should the symptoms persist, then the incremental involvement of other members of the school-based team can assist in the design of a program which will allow the child to succeed. Parents should be informed and involved throughout this process. If ADHD is suspected then they should be told so that they can decide whether to consult their physician and/or inform themselves about the syndrome.

Although you should respond immediately to behaviours such as those exhibited by a child with ADHD and need not depend upon a diagnosis, this is not to suggest that you should not be concerned with discerning the cause of the behaviour as well as with responding to it. It is important to remember that serious behavioural difficulties may be the result of factors which are beyond the child's control, such as anxiety, depression, or some form of neurological impairment. It has been said that teachers should suspend judgment in favour of curiosity. It is this curiosity to better understand the nature and source of difficulties so that we can respond more effectively which should drive assessment and not simply the desire to confirm a diagnosis.

Generally speaking, medical practitioners will find more value in a diagnosis than educators. This is partly due to the traditions of their profession and partly due to the fact that they may need to confirm a diagnosis before recommending medication.

Parents and teachers may also benefit from a diagnosis which brings the understanding that their child's problematic behaviour is the result of a disability rather than any fault on either their part or the child's and this knowledge can assist them in responding appropriately. In some cases a parent may not be able to reframe their interpretation of a child's behaviour unless they have been told that the child has an identified medical disability and in this case a diagnosis becomes most important.

WHAT SHOULD I DO IF I SUSPECT THAT ONE OF MY STUDENTS HAS ADHD?

The most effective first line of response to a problematic situation is often a conversation with colleagues who may have had similar experiences with other children. Area Counsellors can provide particular expertise in interpreting and responding to behaviour in general as well as in exploring the possibility that a student may be exhibiting the symptoms of ADHD. ADHD results in social, emotional and behavioural difficulties not only in the classroom but also in relationships with other children and with the family. This is another good reason for involving the Area Counsellor in order to provide support.

The distractibility and impulsivity which afflicts a child with ADHD usually result in difficulty with learning in and of themselves. However, approximately 20% of children with ADHD will also have a specific learning disability which must be recognized and supported. In some cases the anxiety which results from a learning disability may result in behaviours which can be confused with ADHD. It is also possible that anxiety or depression resulting from events entirely unrelated to school may produce the same behaviours as ADHD. It is important, therefore, to keep all of these possibilities in mind and not to make any rash judgments or assumptions which might result in a contributing cause to the behavioural problem remaining unrecognized.

If a learning disability is suspected, assistance may be available from the school based team. The team has the further option of requesting consultative assistance from district personnel such as Speech and Language Clinicians, School Psychologists or Teacher Consultants.

Since the behavioural symptoms may not result from ADHD but from other causes, attempts should be made to explore these possibilities. It may be that a non-obvious sensory impairment is the cause of the inattention or apparent impulsivity.

In addition to working with colleagues, the school-based team, school-based support staff and district support staff to better understand a child's complex behaviours and how his or her learning can be better supported you will also want to involve the parents. If a possible diagnosis of ADHD seems to be emerging they will want to consult a medical practitioner in order to consider the possibility that medication may be useful.

WHAT KINDS OF SUPPORT DOES A CHILD WHO HAS ADHD REQUIRE?

There is general agreement that a multi-modal approach is required and that no one intervention can succeed on its own. The important dimensions of a complete treatment plan are education about ADHD (for parent, teacher and child), ongoing social and emotional support in dealing with the stress of the situation (for parent, teacher and child), behavioural modification (including cognitive approaches) and medication. The least appreciated aspects of the treatment plan are education and emotional/social support. It is essential for all concerned to understand that they are dealing with a neurologically based disorder which is beyond the control of the child. Blaming is harmful and inappropriate, as is guilt. Education can establish an appreciation of this fact and ongoing support can sustain it. This greatly increases the chances that behavioural modification will succeed and that secondary behavioural and emotional distress can be avoided.

Dr. Derryck Smith, Head of Psychiatry at Children's Hospital, suggests the following sequence of response to a diagnosis of ADHD.

1) Educate teacher and family about ADHD.
2) Provide the necessary structure at school and at home.
3) Provide the necessary educational support for special learning needs.
4) Provide training in effective ADHD parenting skills. (Even the best of parents will benefit from honing and revising their skills specifically for the child with ADHD.)
5) Encourage physical activity for the child. (Some can manage cooperative sports and benefit by developing social skills in this way while others will prefer individual sports like swimming or tennis. Often a child will benefit from the discipline of the martial arts.)
6) Medication

He suggests that ninety percent of children who are diagnosed to have ADHD will respond positively to stimulant medication but that parents should only make such a choice once they have been fully informed about it by their doctor. Dr. Smith also advises that the effect of stimulant medication is most pronounced in the short term and that it is items 1 - 5 which are most likely to produce lasting positive results. He draws an analogy with caffeine in explaining the effect of stimulant medication and suggests that the stimulant effect actually allows the child's mind to function normally. However, medication alone is not sufficient: long term improvement depends on cognitive approaches. (Dr. Smith also notes that there are other types of medication such as Imipramine, Clonadine and neuroleptic medication which can benefit some children and that there may be indications with particular children or particular families for individual or family psychotherapy.)

Dr. Charlotte Johnston of UBC makes the following suggestions to parents about dealing with children with ADHD. These suggestions are also applicable to the classroom.

1) Check your expectations to make sure they are achievable and reasonable.
2) Set your priorities and give only important rules and instructions.
3) Get your child's attention and establish eye contact before speaking.
4) Give clear, specific, simple instructions. Tell you child what to do, not what not to do.
5) Check to make sure your child understands the rule or instruction.
6) Help your child remember the rule or instruction with a mnemonic or other strategy.
7) Monitor your child's behaviour.
8) Follow through with a consequence.

Dr. Barkley provides the following discussion of treatment issues.

[It may appear that] the initial targets of intervention are the child's disruptive and poorly regulated behaviours, [but] this is hardly the case. The actual initial target of intervention is the teacher's knowledge of and attitude toward the disorder of ADHD for we have found that where teachers have a poor grasp of the nature, course, outcome, and causes of this disorder and misperceptions about appropriate therapies, attempting to establish behaviour management programs within that classroom will have little impact…

A variety of behavioural interventions have been utilized to modify classroom behaviour. The primary interventions include teacher- and peer-administered consequences, home-based consequences, cognitive-behavioural interventions, and modification of factors related to academic tasks in the classroom environment .

…teachers may believe that problems of ADHD are due to emotional problems stemming from conflictual family relationships or that medication is indicated because of the disorders presumed biological origin. In either case, some teachers may believe that changing their interactions will have little impact on the children. Other teachers may resent altering their teaching style if they believe this suggests that their own behaviour is causing the child's problems. Because antagonism on a parent's or teacher's part may undermine any intervention, these problems need to be addressed…

In many cases, behavioural interventions are used in conjunction with pharmacological approaches to treat ADHD children's school problems…Whether or not medication is used, a number of general principles apply to classroom management of ADHD children…

1. Rules and instructions provided to ADHD children must be clear, brief, and often delivered through more visible and external modes of presentation than is required for the management of normal

children. Stating directions clearly, having the children repeat them out loud, having the children utter them softly to themselves while following through on the instruction, and displaying sets of [age appropriate] rules or rule prompts (e.g., stop signs, big eyes, and big ears for "Stop, Look, and Listen" reminders) prominently throughout the classroom are essential to proper management of ADHD children. Relying on the children's recollection of the rules as well as upon purely verbal reminders is often ineffective. Externally represented rules, therefore, are more influential at regulating behaviour than are internally represented ones…

2. Consequences used to manage the behaviour of ADHD children must be delivered more swiftly and immediately than is needed for normal children…

3. Consequences must be delivered more frequently, not just more immediately, to ADHD children in view of the motivational deficits. This means that feedback for ongoing task performance must be delivered more often if the children are to use such feedback to shape and regulate behaviour toward the task or instruction…

4. The consequences used with ADHD children must often be of a higher magnitude, or more powerful, than those needed to manage the behaviour of normal children…

5. Appropriate and often richer incentives or motivational parameters must be provided within a setting or task to reinforce appropriate behaviour before punishment can be implemented. This means that punishment must remain within a relative balance with rewards or it is unlikely to succeed. It is therefore imperative that powerful reinforcement programs be established first and instituted over one to two weeks before implementing punishment in order for the punishment, sparingly used, to be maximally effective ... "positives

before negatives" is the order of the day with ADHD children. When punishment fails, this is the first area that clinicians, consultants, or educators should explore for problems before higher magnitude or more frequent punishment…

6. Those reinforcers or rewards that are employed must be changed or rotated more frequently with ADHD children than with normal children, given the penchant of the former for more rapid habituation or satiation to response consequences, apparently rewards in particular…

7. Anticipation is the key with ADHD children. This means that teachers must be more mindful of planning ahead in managing ADHD children, particularly during phases of transition across activities or classes, to ensure that the children are cognizant of the shift in rules (and consequences) that is about to occur. It is useful for a teacher to take a moment to prompt a child to recall the rules of conduct in the upcoming situation, repeat them orally and recall what the rewards and punishments will be in the impending situation before the child enters that activity or situation. "Think aloud, think ahead" is the important message to educators here. (pp. 500-505)

The focus of the advice from Dr. Johnston and Dr. Barkley is on management of behaviour. Area Counsellors, School Psychologists, Curriculum Coordinators and Teacher Consultants can provide assistance in the design of behavioural modification programs.

The purpose of behavioural modification is to assist the child in monitoring and regulating his own behaviour but it is not intended to be oppressively controlling. The child should be given control in all appropriate times and in all appropriate ways. The goal, after all, is to foster independence.

CHADD (Children with Attention Deficit Disorder), an American and Canadian advocacy and parent support group, makes the following suggestions for support students with attention deficits.

Recommendations for the Proper Learning Environment

- Seat ADD student near teacher's desk, but include as part of regular class seating.
- Place ADD student up front with his back to the rest of the class to keep other students out of view.
- Surround ADD student with "good role models", preferably students that the ADD child views as "significant others." Encourage peer tutoring and cooperative, collaborative learning.
- Avoid distracting stimuli. Try not to place the ADD student near: air conditioner, heater, high traffic area, doors or windows.
- ADD children do not handle change well so avoid: transitions, changes in schedule, physical relocation, and disruptions. Monitor closely on field trips.
- Be creative! Produce a "stimuli-reduced study area." Let all students have access to this area so the ADD child will not feel different.
- Encourage parents to set up appropriate study space at home with routines established as far as set times for study, parental review of completed homework, and periodic notebook and/or book bag organization.

Recommendations for Giving Instructions to Students

- Maintain eye contact with the ADD child during verbal instructions.
- Make directions clear and concise. Be consistent with daily instructions.
- Simplify complex instructions. Avoid multiple commands.

- Make sure ADD student comprehends before assigning the task.
- Repeat in a calm, positive manner, if needed.
- Help ADD child to feel comfortable with seeking assistance (most won't ask).
- Require a daily assignment notebook signed by parents if necessary.

Some commentators, particularly those who are not educators, suggest that a "traditional" classroom is best for the child with ADHD and that the "progressive" classroom is inappropriate. This judgment is based on the assumption, the false assumption, that the progressive educational theory advocates an unstructured environment similar to the "open classroom" of a few decades ago. It also seems to arise from a confusion between structure and rigidity. All classrooms need to be highly organized in intellectual, procedural and physical terms but they also need to offer the scaffolding which will allow children to learn to make choices and to participate in the shaping of their own educational program. The needs of the child with ADHD can be accommodated without compromising the flexibility and responsiveness which is so important for students. It is the responsibility of the teacher to interpret recommendations from various sources in light of his or her own judgment and knowledge of desirable educational practice, but not to feel unduly bound by recommendations from individuals who many not understand the classroom.

Dr. Mel Levine comments in *Developmental Variation and Learning Disorders* as follows.

> Traditionally, a highly structured classroom has been considered better than an open classroom for children with attention problems. These children probably do thrive best on predictability and routine, and their most disorganized behaviour is likely to occur during free time. However, many open classrooms offer a great deal of structure and predictability. Many children with attention deficits have abundantly rich imaginations and a high level of creativity. Classroom routine

should not be so rigid and predictable as to stifle their inventiveness and constrain opportunities for its expression. finding a sympathetic teacher who is consistent in methods, in feedback, and in daily routines is much more important than the type of classroom. (p. 63)

Group work is particularly challenging for children with an attention deficit. They will require specific personal support to work successfully in a group setting but this can also present a valuable social learning opportunity if the required support is available. An effective strategy for refocusing attention, perhaps cues from other students or an adult, will probably be necessary to keep the child on task during group discussion and planning. Once students begin to work independently on various parts of the project the child may benefit from being allowed to work in a low stimulus setting such as an individual study carol. Because the child's disability specifically handicaps him or her for unstructured group activities with abundant distractions it is unfair to place him or her in that situation without forethought and support but this does not necessarily mean that the situation should be entirely avoided.

Once behavioural issues have been dealt with sufficiently that you can work with a child it is important to turn attention to academic problems. Mary Ellen Beugin discusses those academic problems as follows in her book *Coping: Attention Deficit Disorder.*

[The inability of children with ADHD to sustain their attention except in novel or highly motivating situations] interferes with their hearing of lessons and instructions. They cannot selectively focus their attention on one thing for very long. They cannot tune out other stimuli, so anything that they can hear or see might draw their attention. As well, they can be internally distracted – caught up by their own racing thoughts. Consequently they are often in trouble with the teacher for not paying attention.

The more potential distractions in a room the more problems these students have. They have particular difficulty if there is a lot of noise or movement… While they may not be much difference from some other children in this respect, they have greater difficulty attending when interest is low.

They sometimes get the general idea of instructions or a concept but miss important details. Yet, they don't know that they are missing important information until they have done something entirely wrong or are in the middle of a project…

Attending and keeping their thoughts moving at a teacher's pace can be extremely tedious for them. The discomfort such children describe in trying to keep "on track" can be likened to the feelings we might have if we have to drive 50 miles at five miles per hour - keeping our mind on the road at all times… These students have similar difficulties attending to written work for very long. They often have difficulty directing their attention to get started. Once started, and having done one or two problems of a certain kind or a part of report, they become very uncomfortable with the repetition and tedium of keeping their mind focused on one thing.

They may have a perfect understanding of how to do problems or know all the ideas necessary to complete a report, but have trouble with the sustained attention and organizational skills necessary to get the ideas down on paper…

The result of their inability to keep their minds on lessons and focus their attention on assignments is usually considerable underachievement compared to their ability level… Many times their problems will be cumulative. Because they have missed important information, they don't understand new ideas. (p. 59-60)

It should be remembered that approximately 20% of children with ADHD will also have a specific learning disability. Thus, in addition to the general difficulty which they have attending to classroom instruction and focusing on tasks which are assigned, they may be experiencing other learning problems. If this is the case, then further adaptations to instruction and materials may be required. Language disorders are not uncommon. In fact, some specialists suggest that every child with ADHD is going to have a problem with language to some degree. This may be simply a reflection of inattention and impulsivity or a more complex issue.

finally, you should recall that a child with ADHD often has difficulty with social skills and with maintaining friendships. Thus, emotional/social support, and possibly counselling, will be required. Diane Sherkin of Family Services of Greater Vancouver suggests that some children with ADHD may have a specific social skills learning disability and be unable to pick up the subtleties of social interaction by osmosis. This will probably result in difficulty making friends. "For these children social skills must be taught because they are not caught." For most children with ADHD, however, she indicates that recent research has shown that the problem is not that they cannot learn or do not know how to behave socially but their impulsivity over-runs that knowledge so they cannot apply it. They can make friends but they cannot keep them because their impulsivity sabotages the relationship. In either case, support will be required.

WHO CAN HELP ME?

The school-based team is the first line of advice and support. Problem solving with colleagues and obtaining further information about ADHD can bring immediate returns. The range of experience and expertise which is represented on a school-based team is ideal for this purpose. Area Counsellors, Speech and Language Clinicians and Psychologists can contribute specific expertise. In some cases, the school-based team may wish to request assistance from a Teacher Consultant.

The school-based team may also suggest that a classroom assistant work with the student in order to assist with the behaviour management program or instructional modifications. While this may be helpful it is not always necessary. If a CA is assigned then he or she should have specific objectives to meet. Simply "riding herd" on the child is not appropriate. Supportive adult intervention, whether by a teacher or a CA, can be counterproductive if it results in dependency or learned helplessness on the part of the student. The goal of promoting independence should always be kept in the foreground of our attention In some cases peers can help provide the feedback which the child needs without the involvement of another adult.

In order to ensure consistency across settings, the family should be actively involved in whatever program is established. Early consultation with the family and their involvement in any treatment plan will increase the chance of success. It is a mistake to wait for a problem to become serious before contacting parents. Often they will have valuable information or advice which can prevent matters reaching a critical stage.

It is generally helpful to involve the child as well by educating him or her about ADHD and involving him or her in developing a treatment plan. Dr. Mel Levine's book *Keeping A Head in School*, which is available in the school library, may be useful in this regard. In many cases educating other students in the class about the disorder can help them to be supportive as well.

Members of the extended family, neighbours and others who have contact with the student should also be educated about his/her disorder so that they will know how to respond appropriately.

If the situation warrants it, the Area Counsellor can suggest and facilitate a referral to the Richmond School Mental Health Program or other outside agencies. If there is a definite suspicion of ADHD then a medical referral is important.

finally, it is important for the good of the child that a teacher who has discovered successful strategies for supporting a child with ADHD take the time to ensure that knowledge is not lost when the child moves on to another class or school. This might be done through school-based team records, by writing a brief note for parents to deliver to the next teacher, or by having a conversation directly with him or her. This constructive communication does not limit that teacher's professional autonomy. Clearly he or she will have to adapt past strategies to new classroom contexts and the evolving needs of the child and may have many new ideas to contribute but knowing what has been successful in the past can only be seen as helpful information.

WHAT ARE THE PROSPECTS FOR A CHILD WITH ADHD?

Despite the fact that it originates from differences in brain function, ADHD does not involve intellectual impairment. In fact, children with ADHD can be highly creative as well as extremely energetic and can utilize these strengths as adults if they are accommodated appropriately in schools and taught how to cope with their distractibility, impulsivity and hyperactivity.

The symptoms of ADHD may disappear altogether at puberty in a few cases and may be diminished for approximately half of the children who are diagnosed in childhood but between 30% and 70% of them will retain significant symptoms into adulthood.

Dr. Mel Levine offers a hopeful prognosis in his book *Keeping A Head In School*, which is written especially for younger readers.

> [Attention deficits] can cause kids to do poorly in school, and they can cause behaviour problems, but many kids with attention deficits have thoughts and ideas that no one else would ever think of. Not only are these kids creative, they are also smart. Many kids with attention deficits can remember little details from far in the past better than most other people. Impulsive or hyperactive people can get a lot done during the day. They are on the move all the time. Their high energy allows them to accomplish much more than other people in the same amount of time. In fact, many grown-ups with attention deficits are very successful. They include artists, actors, actresses, business people, and all kinds of other adults. This means that if you have attention deficits you should not get discouraged. It's possible to improve your ability to concentrate and actually to use the way your attention works to become a unique and exciting person. (p. 37)

Dr. Levine goes even further in *Developmental Variation and Learning Disorders* by suggesting that school environments can actually be the artificial source of disabilities by virtue of the focus on sustained attention, limited activity, and insistence on a broad range of performance competencies.

> A major difference between childhood and adulthood resides in the intersection between dysfunction and handicap. Adults are able to practice specialties and to avoid their areas of weakness while children are constrained, in fact required, to be generalists. Adults who were relatively nonverbal children, whose language skills were clearly dysfunctional, may perform extremely well as architects, engineers, physicists, or artists, orchestrating vocational and avocational pursuits to minimize requirements for linguistic facility. Such options are not available to children…
>
> Thus, the "handicaps" that we encounter in children are sometimes artifacts - byproducts of our insistence that they be at least fairly good at everything. Ultimately, well-differentiated, highly specialized children who do not easily meet traditional educational requirements may, with their assets and deficits, achieve substantially as adults if they can survive with sufficient self-esteem. (pp. 4-5)

On the other hand, in the absence of understanding and support children with ADHD can find the experience of schooling to be extremely discouraging and unhappy, with the result that they have serious academic problems, leave school and/or develop serious secondary patterns of misconduct and emotional distress.

WHERE CAN I GET MORE INFORMATION ABOUT ADHD?

For more information about ADHD contact your Area Counsellor or School Psychologist.

Your school library contains the following books related to ADHD.

Your Hyperactive Child, Barbara Ingersoll, Ph. D.
This volume, which is subtitled "A Parent's Guide to Coping with Attention Deficit Disorder," is primarily intended for parents. It discusses school issues but focuses on the home environment.

Why Johnny Can't Concentrate, Robert A. Moss, M.D., with Helen Huff Dunlap
This volume will also be of interest to parents but contains much more discussion of schooling issues.

Keeping A Head in School, Dr. Mel Levine
This book is written to help children with neurological disabilities and/or learning disorders "gain a realistic insight into their personal strengths and weaknesses… The ideas in these pages combine candor and realism with justifiable optimism so that a student's enhanced insight into his or her learning disorders (and strengths) will engender hopefulness and ambition." It is intended to be read by a pre-adolescent or adolescent (gr. 6 plus) but contains much useful information for adults as well.

The Richmond Public Library also has a good collection of books on this subject.

There are two parent support groups active in Richmond, Attention Deficit Disorder Support Association (ADDSA) and Children with Attention Deficit Disorders (CHADD). Your Area Counsellor or the Assistant Superintendent (Learning Services) will assist you in contacting either group. Both run monthly parent support meetings in the evening in Richmond schools.

Family Services of Greater Vancouver runs a course titled "Successful Parenting of Children with ADHD." Contact Diane Sherkin of that organization at 874-2938 for further information.

The following contacts may also be of interest.

- Learning Disabilities Association of BC, 732-8006
- Vancouver Association for Learning Disabilities, 732-8006
- Society of Special Needs Adoptive Parents, 597-9552
- Difficult Child Support Association, 943-9978
- Parents Together, 588-1621 (for parents of teens with difficult behaviour)

This monograph was prepared by Bruce Beairsto, Assistant Superintendent.

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