A TEACHER'S GUIDE FOR ATTENTION DEFICIT CHILDREN

MASTER'S PROJECT

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by

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I would like to dedicate this project to my son Ian, that others like him may benefit from this work.
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CHAPTER I

INTRODUCTION

Recently, individuals with attention deficit problems (AD) have been discussed in both the popular (Fowler, 1990; Parker, 1988) and professional (Aleman, 1991; Stickley, 1992; Davila, Williams and MacDonald 1991; Schiller and Hauser, 1992) literature. The purpose of this study is to prepare a guide to help educators identify and serve AD's.

This study focuses on the procedures for identification, referral and educational support for AD children. Educators, informed with knowledge about ADD/ADHD, can be more productive in developing successful ADHD students (Stickley, 1992).

The area of ADD is becoming more significant in American education (Davila, Williams and MacDonald 1991; Aleman, 1991; Parker, 1988; Fowler, 1990). Recent Federal actions on AD have created a demand that American educators effectively and positively deal with the education of ADHD children (Aleman, 1991; Davila, Williams and MacDonald 1991). The major question at this moment remains how this issue will be addressed by the state and local educational agencies (Aleman, 1991; Davila, Williams and MacDonald 1991). Educators, according to newly established federal guidelines, should be informed regarding issues and techniques of working with AD children and the desired educational goal for these children (Aleman, 1991; Stickley, 1992).
Much of the knowledge that educators currently have is vague and inaccurate (Schiller and Hauser, 1992; Davila, Williams and MacDonald 1991; Aleman, 1991). Educators have not received assistance from federal, state, or local educational agencies, specific information on working with ADD/ADHD children within the classroom (Davila, Williams and MacDonald 1991; Aleman, 1991 and Stickley, 1992). Therefore, it is the stated objective of this study to provide educators with a resource guide that can assist educators when they work with AD individuals. For such a guide to be truly worthwhile, educators should consider the guide as one having merit. Without educators feeling that such a guide would contribute to working with these students the guide would likely not be used.

SIGNIFICANCE OF THE STUDY

It is estimated that three to five percent of the children in America's classrooms have significant educational problems related to Attention Deficit Disorders (Parker, 1988; Davila, Williams and MacDonald, 1991; Aleman, 1991; Stickley, 1992 and Silver, 1986). It is likely that every teacher in American education has or will encounter children with this disorder (Parker, 1988; Schiller and Hauser, 1992).
AD places stress upon children for they are victimized by a condition that causes them to be impulsive, easily distracted, and fidgety (Fowler, 1990; Thompson, Gickling and Havertape, 1983; Zametkin and Nordahl, 1990). The AD child has poor organizational skills that result in unfinished work of poor quality (Lerer, Lerer and Artner, 1977).

Children with this condition tend to be aware of everything that goes on around them (Fowler, 1990). However, AD children have poor skills in distinguishing what is the most important event to concentrate their attention on (Lerer, Lerer and Artner, 1977; Silver, 1986; Manuel, 1990).

ADD places stress upon the AD child's family because the impulsivity that these children tend to have (Fowler, 1990; Levine, 1987) often creates confusion and conflict among parents and siblings (Fowler, 1990).

Peer and sibling relationships tend to suffer in the presence of AD for it causes social stress. Fowler (1990) reported that AD children often miss subtle social cues given by peers in their social relationships. ADD children are often seen by their peers as trouble makers, classroom disrupters and children having strange behavior (Bickett and Milich, 1990; Levine, 1987; Fowler, 1990; Parker, 1988).

Classroom educators experience stress when dealing with AD children. Through their impulsivity, AD children tend to
distract other children and disrupt the classroom by blurting out verbally at inappropriate times (Weiss, 1990; Bickett and Milich, 1990). The stress that exists is often transformed into a communications barrier between the classroom teacher and the parents of the AD child (Fowler, 1990; Parker, 1988).

Educators have an opportunity to help troubled children with a condition that effects their self-esteem, peer and sibling relationships and their quality of work. Given their ethical and professional responsibility to assist children in need, this guide is being developed to help educators in meeting their professional and ethical responsibilities.

**PROBLEM**

This study was concerned with the preparation of a guide to help educators identify and serve AD's. With this purpose in mind a guide was developed to accomplish this task.

**PROCEDURE**

The guide was presented to twenty-five educators. They were asked to review the guide and then evaluate it as to its usefulness in their classroom.
HYPOTHESIS

It is hypothesized that all teachers will view the "Teacher Guide for AD Children" as being useful.

NULL HYPOTHESIS

The null hypothesis thus becomes, there is no significant difference in the opinions of various teacher groups regarding the usefulness of the "Teacher Guide for AD Children."

ASSUMPTIONS AND LIMITATIONS

This condition which has probably always been with American education, is currently being identified and defined more today than ever before (Fowler, 1990; Stickley, 1992; Thompson, Gickling and Havertape, 1983; Adesman and Wender, 1991).

It should be noted that through medical research there has been found to be a significant decrease of glucose metabolism in specific regions of the brain among hyperactive individuals when compared with non-hyperactive individuals (Zametkin and Nordahl, 1990). Educational and medical research will continue to redefine the AD condition as our current knowledge is increased and expanded on this subject (Zametkin and Nordahl, 1990; Levine, 1987; Adesman and Wender, 1991).
Because of the expanding knowledge base, the information in this guide will probably have to be updated periodically in order to maintain timeliness and accuracy.

DEFINITIONS

ATTENTION DISORDER (AD)
A disorder that is a chronic or acute health problem that limits alertness and adversely affects educational performance (Aleman, 1991). This disorder encompasses subsets of attention deficit problems (e.g. ADD and ADHD).

ATTENTION DEFICIT DISORDER (ADD)
The old Diagnostic and Statistical Manual (DSM III) of the American Psychiatric Association (1980) defined Attention Deficit Disorder as a reference to children with disturbances in which the primary characteristic is significant inattentiveness without signs of hyperactivity (Parker, 1988). Note: This definition has been excluded in the revised DSM III-R (American Psychiatric Association, 1987).

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)
The Diagnostic and Statistical Manual - Revised (DSM III-R) of the American Psychiatric Association (1987) defined Attention Deficit Hyperactivity Disorder as a disturbance
lasting at least six months. At least eight of the following fourteen symptoms must appear before the age of seven according to Stickley of the Ohio Department of Education (1992):

(1) Often squirms or fidgets in seat.

(2) Has difficulty remaining seated when required to do so.

(3) Is easily distracted by extraneous stimuli.

(4) Has difficulty awaiting turns in games or group situations.

(5) Often blurts out answers to questions before they have been completed.

(6) Has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension, e.g., fails to finish chores).

(7) Has difficulty sustaining attention in tasks or play activities.

(8) Often shifts from one uncompleted activity to another.

(9) Has difficulty playing quietly.

(10) Often talks excessively.

(11) Often interrupts or intrudes on others, e.g., butts into other childrens' games.

(12) Often does not seem to listen to what is being said to him or her.

(13) Often loses things necessary for tasks or activities at school or at home (e.g., toys, pencils, books, assignments).

(14) Often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking), e.g., runs into street without looking.
EVALUATION TEAM

An evaluation team consists of the students teacher(s), school psychologists, counselor, and principal. The purpose of this meeting is to decide if the student is eligible for special services under PL 94-142.

AD GENETIC FACTORS

Genetic factors are seen as a significant cause of ADD/ADHD in children.

HANDICAPPED PERSON

A handicapped person, according to the Individuals with Disabilities Act (IDEA), is anyone who is physically or mentally impaired and which substantially limits a major life activity (e.g., learning).

INATTENTIVENESS

Inattentiveness is a condition of having difficulty sustaining or focusing attention on tasks that require continued concentration such as listening to a teacher during class or doing chores at home.

MEDICAL DATA

Medical data is information collected to determine whether the frequency of the core symptoms of hyperactivity,
impulsiveness and inattentiveness are greater than is normally expected within the child's age group and to rule out any underlying medical or environmental conditions that could be causing these symptoms (Davila, Williams and MacDonald, 1991; Aleman, 1991; Stickley, 1992). Neurological testing in the form of an Electroencephalogram (EEG) may be ordered.

PL 91-142
Public Law 91-142 is The Rehabilitation Act of 1973 which provides due process protection for all identified handicapped persons.

PSYCHOLOGICAL DATA
Psychological data refers to the identification of functional strengths and weaknesses of the child to perform on tasks found to be affected by ADD/ADHD. Data may be gathered through an individual intelligence test to determine the child's cognitive abilities, language skills, perceptual functioning, memory, attention span, and overall style of learning.

PSYCHOSTIMULANT MEDICATIONS
The most common component of treatment regimes is medication. Stimulant drugs such as Ritalin (Methylphenidate), Dexedrine (Dextroamphetamine), and Cylert
(Pemoline) are typically used to enable ADD/ADHD children to concentrate longer. As a consequence these drugs help the child to control impulsive behavior.

SUPPORT GROUP
A support group is an organized group within a community that provides information and support for parents or individuals regarding the conditions of ADD/ADHD, assists in management programs for behavior, and helps to provide information regarding socialization skills.
CHAPTER II

REVIEW OF THE RELATED LITERATURE

Children with AD may have problems with attentiveness, and impulsivity inside and outside a classroom environment (Fowler, 1990; Parker, 1988; Zametkin and Nordahl, 1990; Silver, 1986). The inability to discriminate among various external stimuli results in an inability to determine what is the most important item to concentrate mentally on. AD may cause a disability that may affect the academic performance, self esteem, and the social status of the AD individual (Fowler, 1990; Parker, 1988; Zametkin and Nordahl, 1990; Silver, 1986).

It is perhaps inaccurate to assume that AD children cannot concentrate on tasks. AD children concentrate on everything within their immediate environment (Fowler, 1990; Parker, 1988). For example, they concentrate on the ticking of a clock, what is happening in a hallway, or what is happening in the back of a classroom. Sometimes they may concentrate on what the instructor is doing (Fowler, 1990; Parker, 1988).

Perhaps the AD individual "flitters" from one environmental event to another. AD children sometimes have
difficulty determining what to concentrate on. They cannot exclude other stimuli (Parker, 1988; Fowler, 1990). Parents, siblings, peers, teachers and the AD children themselves can get frustrated with this condition (Fowler, 1990; Parker, 1988; Zametkin and Nordahl, 1990; Silver, 1986).

Attention Deficit Problems

**Identification and Treatment**

ADD. ADD children may have difficulty staying on task. They may not maintain normal concentration within a classroom (Adesman and Wender, 1991; Silver, 1986; Thompson, Gickling and Havertape, 1983). These children may have difficulty with their peers (Bickett and Milich, 1990; Fowler, 1990; Parker, 1988). ADD children may be seen as loners by their peers and they may not be welcomed in group activities (Bickett and Milich, 1990; Fowler, 1990; Parker, 1988). ADD students may have difficulty with their self-esteem. It may be due to their inability to maintain concentration on activities (Bickett and Milich, 1990; Fowler, 1990; Parker, 1988; Lerer, Lerer and Artner, 1977). Academic work may be turned in incomplete if at all (Parker, 1988; Fowler, 1990; Lerer, Lerer and Artner, 1977). Poor grades may result in poor self-esteem (Lerer, Lerer and Artner, 1977, Parker, 1988; Fowler, 1990).
ADHD. Attention Deficit Hyperactive Disorder children may be aggressive, impulsive, and pushy toward their peers (Hinshaw, 1987; Zametkin, 1991; Silver, 1986; Bickett and Milich, 1990; Parker, 1988). Unlike ADD children who are ignored by their peers, ADHD children may be rejected by peers (Hinshaw, 1987; Zametkin, 1991; Silver, 1986; Bickett and Milich, 1990; Parker, 1988). ADHD children are often ostracized by peers and may not be allowed to participate in group activities (Hinshaw, 1987; Zametkin, 1991; Silver, 1986; Bickett and Milich, 1990; Parker, 1988). The low self-esteem that ADHD children experience may result from poor academic work and peer rejection (Fowler, 1990; Silver, 1986; Hinshaw, 1987).

Medical Assistance. Recent medical and psychological research have shown that AD is much more complex than was previously realized (Levin, 1987; Adesman and Wender, 1991; Manuel, 1990; Bickett and Milich, 1990; Silver, 1986; Zametkin and Nordahl, 1990). Researchers are finding that it is difficult to categorize accurately attention deficits into a single category (American Psychiatric Association, 1988; Silver, 1986; Cowart, 1982; Thompson, Gickling and Havertape, 1983; Schiller and Hauser, 1991).

Researchers have found many different forms of attention deficits. For this reason each AD classification may require different treatment from every other type of
attention deficit problem (Silver, 1986; Cowart, 1982; Dulcan, 1985; Adesman and Wender, 1991; Levine, 1987).

Current medical research is attempting to determine, from a physiological perspective, causes for the conditions known as Attention Deficit (Stickley, 1992; Zametkin, 1991; and Zametkin and Nordahl, 1990).

There may be a physiological linkage between specific attention deficits and neural transmissions within specific portions of the brain (Stickley, 1992; Cowart, 1982; and Zametkin and Nordahl, 1990).

Some researchers are attempting to prove there is a genetic link in the transmission of ADD from generation to generation (Parker, 1988; and Manuel, 1990).

In the area of medical intervention much positive success has been demonstrated with the use of psychostimulate medication as prescribed by medical specialists. Psychostimulants have been used in order to increase the students ability to discriminate the most important item to concentrate on (Dulcan, 1985; Levine, 1987; Manuel, 1990; Zametkin, 1990; Lerer, Lerer and Artner, 1977).

Some students may have anxieties and depression along with AD. Physicians may decide to treat these students with an antidepressant drug rather than psychostimulants (Dulcan, 1985; Levine, 1987; Manuel, 1990; Zametkin and Nordahl, 1990 and Lerer, Lerer and Artner, 1977).
Because of the complexities of the various disorders, physicians must diagnose, prescribe and treat each individual's condition.

Psychological Assistance. Finally, current thought regarding the treatment of ADD children regards psychological services as being critical for the successful treatment of the child and family. Psychological treatment deals mainly with modifying the ADD child's behavior at home and within the classroom. These services provide parents with the knowledge and techniques regarding the modification of behavior of ADD children. Psychological services provide parents with the knowledge and techniques on how to affect positively the ADD child's behavior at home and in the classroom.

Educational Assistance. Political activity is beginning to address this area of diagnosis. The U.S. Department of Education has written a position letter on this topic and they indicate "State and local education agencies have an affirmative obligation to evaluate a child who is suspected of having a disability to determine the child's need for special education and related services. These agencies must have procedures for locating, identifying and evaluating all children who are suspected of having a disability" (Davila, Williams and MacDonald 1991).
The tools used to help diagnose ADD include parent and teacher questionnaires, a neurological examination, and a psychological examination (Stickley, 1992; Adesman and Wender, 1991; Levine, 1987; Parker, 1988; and Lerer, Lerer and Artner, 1977).

Current thought indicates that children with suspected ADD should be diagnosed by way of a diagnostic team. This team evaluation uses "medical, psychological, behavioral, and educational data (Parker, 1988; Adesman and Wender, 1991)."

The most controversial topic of this condition may be the area of interventions. The U.S. Department of Education has recognized need to developing regional resource centers. These centers will collect and disseminate information on successful programs of intervention with ADD children.

**Educational Treatment Elaborated**

As educators, teachers must understand that they make a positive or negative difference in the quality of life of ADHD children. However, this difference will be a positive or negative difference in that quality (Stickley, 1992 and Parker, 1988).

Educators must have empathy for parents who must deal with AD as they try to solve the needs of their child and their family (Stickley, 1992 and Parker, 1988). Families need to realize that they are not alone with the AD
condition. A good way for teachers to help parents to adjust to family needs as well as establishing good communications, is to suggest that parents investigate local family AD support groups (Fowler, 1990; Parker, 1988).

Educators can assist parents and physicians by giving continuous feedback regarding classroom behavior, and academic and social performance (Fowler, 1990; Parker, 1988).

One area that teachers need to be aware of is that of behavior modification. Some AD children need a program of behavior management. Several programs that look favorable are contingency management programs and behavior therapy programs (Fowler, 1990; Parker, 1988). Contingency management deals with immediate behavior control. This is a good program for modifying severely hyperactive, impulsive and distractible children. The problem with contingency management is that it requires much teacher time and it works best in small classrooms (Fowler, 1990; Parker, 1988).

Behavior therapy is a second type of behavior modification program. Both the teacher and the family of the AD student must coordinate their programs to ensure maximum effect. Several behaviors are selected for monitoring and change (Fowler, 1990; Parker, 1988). Behavior therapy programs are easy to use. These programs do not tend to work well with severe AD symptoms because they are not based on immediate rewards and consequences (Fowler, 1990; Parker, 1988).
Teachers of AD children need to understand and accept the child's disorder. The teacher of the AD child needs to provide a structured environment for the child (Parker, 1988; Fowler, 1990). Visual cues and oral directions, as well as maintaining eye contact with the child are several ways to help children follow directions (Stickley, 1992).

Summary

Despite all of the complexities concerning these disorders there have been some characteristics identified in a general way with most of them.

A primary characteristic of ADD is a "significant inattentiveness" within a structured environment (Parker, 1988; Dulcan, 1985; Aleman, 1991). This is a main criteria for identifying the condition from a political perspective (vis-a-vis the United States Department of Education) (Davila, Williams and MacDonald, 1991).

Another identifying characteristic is that ADD children are not very popular with their peers. These children tend to be rejected by non-ADD children (Bickett and Milich, 1990). ADD children seem to be unable to respond in an appropriate manner within the context of a social situation involving other children. They seem to be unable to restrain behavior that results in rejection by their peers in almost every interactive setting such as the playground,
classroom, and within the neighborhood (Fowler, 1990; Bickett and Milich, 1990; Adesman and Wender, 1991).

In conclusion, intervention techniques regarding ADD children requires a multiplicity of approaches. Educators must be aware that they are only one part of a team in dealing with this matter. Their responsibility is to provide important feedback on the ADD child's behavior and performance in the classroom for physicians and psychologists in order that program modification can be developed to provide better services for the ADD child and the families of ADD children.
CHAPTER III
DESIGN

Process

The purpose of the study was to design a guide to assist classroom educators identify and more effectively teach attention deficit children. The focus of the design was in four areas:

1. Identification of AD children
2. The referral procedure
3. Teacher-parent relations
4. Interventions (medical, psychological, educational)

The guide was designed based on findings from research conducted by educators, physicians and clinicians. The elements within the guide were grouped according to topics and they were presented in as succinct a manner as possible while maintaining the full meaning of the topical findings.

Sources of Data

A survey form was designed to be given to classroom teachers. The teachers were given copies of the guide. Eight teachers were given five copies of the "Teacher Guide for AD Children." These teachers distributed the guides and survey forms to four other colleagues. They were asked to make notations on the reverse side of the survey form of any areas that they felt there was a weakness. Written
recommendations to strengthen the identified weak areas were requested. The teachers were asked to respond to each item on the survey. All survey forms were returned to the researcher via the eight cooperating teachers.

The responses on each survey sheet were carefully noted on a master sheet as to how the individual respondent answered each item of the survey. The responses of each individual were then entered into a spreadsheet to determine statistical significance of the responses of each of the participants.

The educators that were involved in the study were a mixture of classroom teachers and learning disabilities (LD) teachers. Primary elementary, Intermediate elementary, middle school and high school teachers.

The findings of the survey are presented in the "Presentation and Analysis" (Chapter IV).

To review, the current study hypothesizes that all teachers will view the "Teacher Guide for AD Children" as being useful. The null hypothesis thus indicates that there is no significant difference in teacher opinion as to the usefulness of the "Teacher Guide for AD Children."

Forty-eight educators (primary, intermediate, and secondary) took part in the survey concerning the "Teacher Guide for AD Children." The surveys were distributed and collected through eight cooperating teachers. The responses
were carefully recorded into and analyzed by using statistical post hoc procedures.
CHAPTER IV
ANALYSIS AND FINDINGS

The research was conducted by giving to forty-eight teachers the "Teacher Guide for AD Students" (Appendix A) and a survey form with ten statements (Appendix C). The respondents were asked to rate the survey statements on a Likert Scale of 1 to 5:

1 = not useful
2 = little use
3 = useful
4 = more useful
5 = most useful

Further, the respondents were asked to indicate if they desired or did not desire more information on the topic that each survey statement addressed. Other information that was sought by the survey was the:

Number of years of teaching experience of the respondent.

Number of AD children in the respondent's classroom.

Number of ADHD children in the respondent's classroom.

Total number of children in the respondent's classroom.

Characteristics that the AD students in the respondent's classroom exhibited.

Characteristics that the ADHD students in the respondent's classroom exhibited.

Although thirteen respondents failed to indicate their teaching experience in years, the remaining thirty-five
teachers had a total teaching experience of 196 years. The mean teaching experience for this group was 5.6 years, and the range of teaching experience was 23 years. Two educators indicated that they had not yet begun teaching, while one teacher noted a total teaching career of 23 years. Four teachers indicated that they had taught the median of 5 years.

Information was requested on the number of AD students, ADHD students, and total number of students within each classroom. However, there were so few responses that conclusions could not be determined from the data that were gathered. It was hoped that population percentages for AD and ADHD students could be calculated in order to compare the percentage of the served population with the governmental estimate of 2 to 3 percent of the national population having attention deficits.

The definition of attention deficits on the survey was deliberately short because of brevity of space and time. It was also hoped that the respondents would indicate other characteristics that were supported by research that these students exhibit. Appendix D, Table 4 listed the responses of those teachers that filled in this section of the survey. Phrases such as:

Inability to focus on teacher directions, 
No eye contact with teacher, 
Has difficulty in staying on task, 
Very difficult time staying on task, 
Short time on task,
Constantly asks if he can stop working on the activity,
Eventually removed from class for not working,
Disorganized,
Speaks out of turn on a different subject,
Low self-esteem,
Distracted, isolated,
Often quiet and withdrawn during instruction,

indicated that these educators were indeed viewing the same

type of population that medical, psychological and
educational research had indicated was within the category
of attention deficits.

Further, the definition of attention deficit
hyperactive disorder on the survey was also deliberately
short because of the brevity of space and time. It was
hoped that the respondents would indicate other
characteristics that were supported by research on the
characteristics that these students exhibited. Appendix D,
Table 4 listed the responses of those teachers that filled
in this section of the survey. Phrases such as:

Verbally blurts out in class,
Talkative,
Runs around the room disorganized,
Cannot sit still - fidgets constantly,
Inability to focus on task,
Inability to sit still,
Impulsive,
Always playing with objects at his desk,
Inability to finish task,
Easily distracted,
Over energetic,
Peer disapproval,
Cannot keep hands off other students,
Peer disapproval,
Intensely disliked by male peers,
Many fights,
Unliked by peers due to aggressiveness,
also indicated that these educators were indeed viewing the same type of population that medical, psychological and educational research had indicated was within the category of ADHD.

Many of the items were left blank by a number of respondents (Appendix D, Table 1). Because of the number of non-responses, some statistical analysis could not be conducted. Therefore, the remainder of this chapter will limit itself to a comparison of the question statements in determining the usefulness of the "Teacher Guide for AD Students."

In looking at the entire survey, all question topics that were addressed were rated as most useful by at least 45.8% (Appendix E) of the respondents. The responses to the question "The guide format is useful" (72.9%) and "The guide as it is presently written is useful in meeting your needs" (62.5%) indicates that more than half the respondents feel the guide does have some merit in meeting their needs and that the format of the guide is useful in meeting those needs. Thus, these two questions overwhelmingly indicate a difference in the opinions of various teacher groups regarding the usefulness of the "Teacher Guide for AD Children." The guide however, could not be supported through statistical procedures.
Of the eight other topics addressed in the survey, seven were rated by more than half the respondents as being "most useful." The only topic that less than half the respondents rated as being most useful was the question, "Information regarding the treatment that may be prescribed by physicians."

In identifying the weaknesses of the guide as indicated by the respondents, the question "The guide is useful in identifying AD students" was responded to as "useful" by 12.5% of the teachers. Those topics that were responded to as of "little use" were "The guide is useful in explaining the importance of medication for AD children," and "The guide is useful in providing information about parent support groups."

In support of the concept that these areas may be weak in the guide, Table 3 shows positive responses of the need for more information. Two-thirds of the respondents (66.7%) indicated that they desired more information on identifying AD students. More than half of the respondents (52.1%) indicated that they desired more information about parent support groups. Finally, nearly half the respondents (47.9%) indicated a desire for more information about the importance of medication for AD children.

One alarming area of the survey is found in Table 3: Positive Responses. Half the respondents (50%) indicated that they desired more information regarding how the guide
is presently written in meeting their needs. It may be that this need for more information may be due to a possible weakness in the intervention techniques of the classroom teacher in meeting the needs of the AD child. One respondent wrote that:

As I looked through the information and the survey I was struck by one primary thought. This guide, although useful to some degree, would need to be a part of a comprehensive staff development program in order to increase identification and treatment of ADD children beyond what I feel is common in most classrooms. *Most teachers strive to meet the individual needs of students without further guidelines. I feel what is necessary is education about ADD where the existing knowledge base is increased and the information then used to meet individual classroom situations* [italics added].

In conclusion, most of the respondents found the "Teacher Guide for AD Children" most useful in meeting their classroom needs. Thus, the findings of the survey tend to refute the null hypothesis that states "there is no significant difference in the opinions of various teacher groups regarding the usefulness of the "Teacher Guide for AD Children."

Because this is a topic that is constantly changing however, due to research and information by physicians, psychologists and educators, there may be weaknesses in the guide that should be further researched.
CHAPTER V
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Restatement of the Problem

The researcher designed a "Teacher Guide for AD Children." The study concerned the gathering of data from educators concerning the usefulness of this guide as a classroom tool. The data that was gathered was designed to expose areas of the guide that were determined by the respondents as weak and in need of revision.

Conclusions

Much recent interest has been generated in the area of attention deficits. However, little actual information has been gathered and disseminated about practical and beneficial programs that have proven effective.

The "Teacher Guide for AD Children" was designed to give classroom teachers recommendations concerning identification, classroom interventions, parent-teacher relations and family support groups.

The area of attention deficits has come under the scrutiny of the United States Department of Education. For this reason effective intervention programs will be identified and disseminated throughout the nation. Regional collection centers have been established by the U.S.
Department of Education in order to collect data and then to disseminate the results of this data throughout the educational community. It is advisable that educators keep their knowledge current regarding effective program development in this vital area.

Recommendations

This survey was conducted during the summer. School was not in session. This may have contributed to the lack of response that was requested for the number of AD, ADHD and the total number of students in the classroom of each of the respondents.

Therefore, it is recommended that the survey be conducted during a current school year to see if the respondents are more likely to give this information. It is further recommended that the "Teacher Guide for AD Students" be modified to include more intervention techniques within the classroom, more information about medication, and more information concerning parent support groups.

With a revision of the "Teacher Guide for AD Students" as indicated above, it is recommended that the survey be conducted once again. Teachers should be given access to the revised "Teacher Guide for AD Students." They should also be given intensive and continual inservice training that stresses identification of AD children. Training
should also be given in intervention techniques that help teachers be more effective with the AD population. In this way it is hoped that a more positive relationship can be established between the schools and families of AD children.
APPENDIX A

TEACHER GUIDE FOR AD STUDENTS
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**TEACHER GUIDE FOR AD CHILDREN**

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</tr>
<tr>
<td>Teacher Advise for Parents</td>
</tr>
<tr>
<td>Support Groups</td>
</tr>
<tr>
<td>Form 1</td>
</tr>
</tbody>
</table>
TEACHER GUIDE FOR AD CHILDREN

The following guide is designed around the general process that will probably be followed from the identification of a suspected problem to classroom techniques of assisting AD students. Each of the steps in this process are identified with a capital letter followed by a period positioned at the left margin.

Teacher Suspects Problem

Signs and symptoms of AD in elementary school-age children may include:

1. inappropriate activity unrelated to task
2. poor ability to sustain attention and concentrate
3. difficulty inhibiting impulses
4. organizational problems
5. attention-seeking behaviors
6. low frustration tolerance
7. low self-esteem
8. interpersonal difficulties with peers
9. learning difficulties, particularly under circumstances of partial or no reinforcement
Teacher Refers Student To School Psychologist

If the teacher suspects that there may be a problem it is suggested that documentation be kept including dates and time of the action(s).

When referring a student to your school psychologists it is vital you have documentation to support your referral. There are different ways of documenting your observations of a student. These are suggestions:

1. Prepare a folder for the student. Keep documentation of incidents that occur. Note dates and time of the incidents. FORM 1 in the back of the guide can be reproduced and used for this task.

2. You can also use a calendar to document incidents. This may be useful for some teachers for they can refer back to specific days.

3. A computer data base can be very efficient for logging daily incidents and categorizing types of behavior. A data base can be utilized to search and find behavior patterns that may be difficult to see without such analytic capability.
Role of the School Psychologist

Psychologists gather data through testing, observation (in the classroom) and teacher(s) data.

The psychological and educational evaluation focuses on strengths and weaknesses of the child. An individual intelligence test (Wechsler Intelligence Scale for Children-R [WISC-R] or the Stanford-Binet Intelligence Scale) may be administered.

Intelligence test results can give valuable information about the child's cognitive abilities, language skills, perceptual functioning, memory, attention span, and overall style of learning.

FINDINGS

With these results the school psychologist will meet with a team of teachers to give information and make a recommendation.

If the results indicate possible attention deficits, the parent will be met with and referred for further testing to the child's physician.
If the results indicate no attention deficits, the process stops.
Recommend Medical Evaluation

A physician or psychologists may conduct a comprehensive diagnostic evaluation. This evaluation may consist of a parent, child and teacher checklists, physical and neurological examinations, laboratory tests and psychometric testing.

Some rating scales that have been devised to gather information from teachers and parents include the "Connors Parent Questionnaire" and the "Connors Teacher Questionnaire," the "ADD-H Comprehensive Teacher Rating Scale," the "Child Behavior Checklist," and the "Werry-Weiss-Peters Activity Rating Scale."

FINDINGS

If the physician finds no abnormalities the process is terminated.

If the physician determines that there is an attention deficit, the physician and parents decide upon treatment (intervention).
Treatment of Attention Deficits

For educators it is important to be aware that AD children may have a multiple approach to controlling their condition. Some AD children may simultaneously be in programs of medical management, psychological counseling, educational planning and behavior modification.
MEDICAL MANAGEMENT

The children who require the use of medication in treating attention deficit the most common prescribed are the psychostimulants and the tricyclic antidepressants. Medication is used to help the AD student to determine what to concentrate on. Medication also has a positive side effect of positively modifying the AD student's behavior.

Psychostimulants

Ritalin

Ritalin is released immediately into the child's body and usually is effective for two hours per 10 mg tablet.

SR-20 (Sustained Release Ritalin)

A 20 mg tablet that is gradually released into the child's body. The effectiveness of the medication is 4 to 6 hours.

Cylert

This medication has the advantage of long lasting duration of action. The disadvantage of cylert is that it takes four to six weeks to reach the maximum level of effectiveness.

Tricyclic Antidepressants

This group of medications are used with children that have signs of anxiety and depression. Tofranil and Norpramine are the most commonly used drugs in this group.
PSYCHOLOGICAL COUNSELING

Even though the educator will not normally be involved in a psychological counseling program, it is important that the educator be aware of the goals of such a program.

The goals of psychological counseling are to:

1. Reduce stress between AD child and the rest of the family.
2. Help repair injured self-esteem, demoralized feelings and possibly depression.
3. Learn effective problem solving behavior patterns.
4. To help the AD child understand his or her behavior.
EDUCATIONAL PLANNING

Educational planning is a series of tools or techniques used by the teacher to more effectively teach AD children and increase their rate of academic success.

Interventions

1. The teacher can manipulate the environment by modifying teaching styles, methods of instruction, and physical placement of the child.

2. School charts - helps students track their performance and progress. Examples: behavior chart, homework chart.

3. Modify task requirements both in class and homework (may need to take spelling test orally).

4. Use of medication: (make sure the student has taken prescribed medication at the correct time or times during the school day).

5. Help develop a formal homework program for the AD child (assignment notebook).

6. Teach study skills
   Use of flash cards, cues, drill and practice.

7. Use cognitive training strategies.
   Riddles for memorization (two vowels go walking the first does the talking).
   Cues for memorization tasks.

8. Frequent positive reinforcement and verbal praise.

9. Maintain frequent open communication with the parents and other educators of the AD child.
Teachers of AD students need to realize that these students require more supervision, structure and encouragement than other students. They tend to be disorganized and unfocused. Therefore, the teacher needs to consistently remind these children to refocus and reorganize. To help the student focus, the teacher should seat the AD student near the teacher's desk and away from distractors such as windows, interesting centers in the room and talkative classmates.

The AD child has a short attention span. The teacher needs to make sure the child maintains eye contact during oral instruction. The teacher can write instructions on the chalk board in addition to presenting them orally.

Assertive discipline techniques are useful in managing the behavior of the AD child in the classroom. The use of time-out, warnings with consequences for repeated misbehavior, and above all positive reinforcement and verbal praise are all needed by the AD student.
BEHAVIOR MODIFICATION

Behavior modification programs include contingency management programs and behavior therapy programs.

Contingency Management Programs

These programs are precise on the spot procedures to influence the child's behavior through positive social reinforcement, and token programs.

Response-cost Contingency Management Program

A child receives a fine for inappropriate behavior and a reward for appropriate behavior.

Disadvantages are that it requires a lot of teacher time, and a small pupil-teacher ratio is needed.

Advantages are that it is good for modifying behavior of severe hyperactive, impulsive, and distractible children.

Behavior Therapy Programs

Behavioral therapy programs require cooperation between the home and the school. Several behaviors are targeted for monitoring and change.

The advantages of these programs are that they are easy to implement, and they are effective if parents and the school work together.

Disadvantage is that the more severe the AD symptoms the less effective the program. This program is not based on immediate rewards and consequences.
Parent Refuses Any Treatment

See interventions above for working with the AD student in the classroom.
Teacher advise for Parents

1. Know your rights and your child's rights.
2. Be involved in your child's school program.
3. Develop a good working relationship with the school personnel, particularly your child's teachers.
4. Have realistic expectations for your child.
5. Make reasonable requests of the school.
6. Communicate regularly with your child's teacher.
8. Be a diplomat.
11. Use positive reinforcement.
12. Use assertive communication.
14. Use token program.
15. Use praise when your child does well.
16. AD support groups (see page 13).
SUPPORT GROUPS

ADDA - Attention-deficit Disorder Association
Ms. Linda Phillips – ADDA Contact Person for
National Referral to ADHD support services
University of California, Ervine
Child Development Center
19262 Jamboree Blvd.
Ervine, California 92715
(714)-856-8700

CHADD - Children with Attention-deficit Disorder
(national information center for children with ADD)
Suite 185
1859 North Pine Island Road
Plantation, Florida 33322
(305)-587-3700

ADD Support
1914 Yorktown Court
Lancaster, Ohio 43130

Parents of Hyperactive Children
2620 Ivy Place
Toledo, Ohio 43613

The Attention Deficit Disorder Counsel
of Greater Cincinnati
8477 Prilla Lane
Cincinnati, Ohio 45255

CHADD of Miami Valley
Connie Guyer
205 S. Columbus Street
Xenia, Ohio 45385
(513)-376-4705
FORM 1

STUDENT: _______________________________________

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</table>
Dear Fellow Educator,

My name is Brenda Asbury and I am a primary LD teacher at Virginia Stevenson Elementary School (Mad River - Montgomery Co. Schools). I am currently working on a Masters Project through the University of Dayton, which involves students with Attention Deficits (AD). The project's purpose is to design a guide that teachers will find useful in providing services for AD children in the regular classroom.

I would greatly appreciate any information you may be able to provide me. This will enhance my project's purpose. Please review the attached teachers guide and then fill out the questionnaire on the reverse side. If you have any comments that can help me to modify my guide please use the space below this letter.

Thank you,

Brenda K. Asbury
APPENDIX C

SURVEY
| Teaching Experience years | 1. Do you presently have a AD or ADHD student(s) in your classroom?  
# of AD ____  # of ADHD ____  # of students in classroom ____ |
<table>
<thead>
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<th></th>
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</thead>
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<tr>
<td>Define AD A disorder that limits alertness and adversely affects educational performance. Tends to be ignored by peers.</td>
<td>Define ADHD A disorder that results in hyperactivity that can limit alertness and educational performance. Tends to disrupt the classroom and tends to be rejected by peers.</td>
</tr>
<tr>
<td>#2 Describe the characteristics of students in your classroom that fit the AD definition.</td>
<td>#3 Describe the characteristics of students in your classroom that may fit the ADHD definition above.</td>
</tr>
</tbody>
</table>

**Questions**

Please review the guide and rate each of the following questions. Circle your choice.

If you wish to offer suggestions please feel free to write on back of sheet.

| 1=not useful  
3=useful  
5=very useful | Desire more information |
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</tr>
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<td>The guide is useful in identifying AD students.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>The guide is useful in helping to establish a more positive parent contact.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>The guide is useful in giving techniques to gain parent support.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>The guide is useful in explaining the importance of medication for AD children.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>The guide is useful in providing information about parent support groups.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>The guide is useful in helping to advise parents regarding AD children.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>The guide provides useful information regarding the treatment that may be prescribed by the physician.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>The guide provides useful information regarding the referral process in identifying AD children.</td>
<td>1 2 3 4 5</td>
</tr>
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<td>The guide as it is presently written is useful in meeting your needs.</td>
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APPENDIX D

TABLES
# TABLE 1

**BLANK RESPONSES***

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<th>ITEM</th>
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<td>Do you desire more information on establishing a more positive parent contact?</td>
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<td>Do you desire more information on gaining more parent support?</td>
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<td>Do you desire more information on the importance of medication for AD children?</td>
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<tr>
<td>Do you desire more information about parent support groups?</td>
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<tr>
<td>Do you desire more information on advising parents of AD children?</td>
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<tr>
<td>Do you desire more information regarding medical treatment that may be prescribed to AD children by physicians?</td>
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<tr>
<td>Do you desire more information regarding the referral process in identifying AD children?</td>
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<tr>
<td>Do you desire more information regarding how the guide is presently written in meeting your needs?</td>
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*Statements are paraphrased by combining columns 1 and 3 of the questionnaire.
## TABLE 2

**NEGATIVE RESPONSES***

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<td>Do you desire more information about parent support groups?</td>
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* Statements are paraphrased by combining columns 1 and 3 of the questionnaire.
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*Statements are paraphrased by combining columns 1 and 3 of the questionnaire.*
TABLE 4

TEACHER COMMENTS

Describe the characteristics of students in your classroom that fit the AD definition.

Inability to focus on teacher directions.
No eye contact with teacher.
Has difficulty in staying on task.
Very difficult time staying on task.
Short time on task.
Constantly asks if he can stop working on the activity.
Eventually removed from class for not working.
Disorganized.
Speaks out of turn on a different subject.
Low self-esteem.
Distracted, isolated.
Often quiet and withdrawn during instruction.

Describe the characteristics of students in your classroom that may fit the ADHD definition above.

Verbally blurts out in class.
Talkative.

Runs around the room disorganized.
Cannot sit still - fidgets constantly
Inability to focus on task
Inability to sit still.
Impulsive.

Always playing with objects at his desk.
Inability to finish task
Easily distracted.
Over energetic.

Peer disapproval.
Cannot keep hands off other students.
Peer disapproval.
Intensely disliked by male peers.
Many fights.
Unliked by peers due to aggressiveness.
APPENDIX E

GRAPH
REFERENCES


