The role of the school counselor in assessment and treatment of attentional problem students

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Abstract
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THE ROLE OF THE SCHOOL COUNSELOR IN ASSESSMENT
AND TREATMENT OF ATTENTIONAL PROBLEM STUDENTS

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Currently, five percent of America's school-aged children are diagnosed with Attention Deficit Disorder with or without hyperactivity (ADHD), using the DSM-R III (American Psychiatric Association, 1980) classification system. Recognizing the increasing incidence of crack/cocaine babies in the 1990's, our educators will be faced with growing numbers of behaviorally disordered children (Rist, 1990). Ross and Ross (1982) suggested that like most childhood behavior disorders, ADHD is more common in boys than in girls with sex ratios ranging from 6:1 (Friedman & Doyal, 1987).

Brancaleone (1988) concluded that there is extreme difficulty in defining and diagnosing ADHD because children have various dimensions of hyperactivity, inattention and impulsive behaviors. Since many students exhibit some of the behaviors, but are not diagnosed, the researcher in this study selected to use the term, attentional problems as a broader category to describe behaviors typical of these children.

According to Barkley (1990), educators are primarily responsible for recommending attentional problem students' need for treatment. There are few ongoing services for hyperactive children and their families. With inadequate coordination among the
professionals in education, medicine, and psychology who serve these youngsters, attentional problem children frequently fall between the safety nets and are often in isolation (Whalen, 1987). The purpose of the present study was to identify the school counselor's role in addressing the needs of attentional problem students, their parents and teachers. The school counselor serves as a consultant to parents and teachers as well as implements strategies for attentional problem students.

Definition

Barkley (1990) recommended that the first step in the treatment process is to grasp the nature, course, outcome and causes of the child's disorder. The parents, teachers, and school counselor work as a team to identify the student's problematic symptoms.

Adapting the working definition of Campbell and Paulauskas (1978), today's hyperactive children are referred for help because of restlessness, short attention span, distractability, and poor impulse control. These symptoms are apparent both at home and school. Problems are chronic in nature, evident from infancy or the toddler stage onward. The child has no marked intellectual deficits, thought disorders or emotional disturbance that would serve as ready
explanations and neither the family nor the environment has posed great difficulties or been sufficiently provocative to have explanatory power (Henker & Whalen, 1989). Ross and Ross (1982) defined the primary characteristics of attention deficit disorder with hyperactivity (ADHD) to include: persistent and excessive activity in situations requiring motor inhibition (during mealtimes, in school, and in church) distractability, short attention span, learning disabilities, clumsiness, and/or emotional ability and poor academic performance.

Implications For Educators

Barkley (1990) proposed that the ADHD children display a wider range of problems in the classroom than in any other setting. ADHD students interrupt during quiet work periods and consistently demonstrate disorganized study habits. Several studies indicated that the hyperactive child population is not homogeneous, that behavior can include poor peer relations, impulsivity, sleep-related problems, negative self-statements, and antisocial aggression (Prinz, Connor, & Wilson, 1981; Roberts, Milich, Loney, & Caputo, 1981). Both research teams agreed that hyperactive children vary considerably on the aggression dimension.
Campbell, Endman, & Bern, (1977) reported that teachers complained of hyperactive children's inattentiveness and disruptive behavior in the classroom which led to more negative interaction between the teacher and pupils. They also inferred that the disruptive behavior initiated by one hyperactive youngster becomes contagious with peers and causes a disruptive ecology in the classroom. Where there was a hyperactive child in a classroom, the teacher interacted more negatively, not only with the child in question, but with other children in the class (Weiss & Hechtman, 1986). According to Ross and Ross (1982), the cycle is set in motion when the child's behavior elicits controlling behavior from the teacher because the hyperactive child is at his best when he is in charge and can dominate the situation. The teacher becomes more intense and controlling and the student becomes more restless and noncompliant. Loney's (1980) subjects reported that they felt disapproval from the teacher and were unable to control themselves. The "difficult student" solicited teacher attention at inappropriate times, and usurped inordinate teaching time (Whalen, Henker, & Dotemoto, 1981). Teachers felt inadequate when working with these students, needing support from parents
and colleagues, including the school counselor.

Social Implications For Students

The demanding, controlling and bossy nature of the hyperactive child's behavior plus problems in attention and impulse control affected play patterns when children began to engage in games with rules. Teachers rated hyperactive and aggressive subjects as more likely to become involved in interpersonal conflicts. Campbell et al. (1977) concluded that teachers rated ADHD children as aggressive, annoying and uncooperative in a group and were easily led by others. Teachers reported that hyperactive children perceive themselves more negatively including less popular, less happy and assign themselves to negative roles such as "class clown" or "bad guy."

Henker and Whalen (1989) describe these children as "scampering through their days in what appears to be a free-wheeling fashion, relatively uncurbed by the social codes and situational cues that guide the actions of others. They are often surprised and even alarmed when they finally notice how upset they have made other people. It is not surprising to find that ADHD children are rejected by their peers" (p. 217).

Cantwell (1986) implied that a substantial proportion (approximately half) of ADHD children continue
to have difficulties, at least through adolescence and young adulthood, probably throughout their lives. It is common to find hyperactivity treatment programs extended into adolescence and adulthood. Adulthood is laced with above-average rates of job changes, traffic accidents, marital disruptions, legal infractions, conduct disorders, and substance abuse.

Role of the School Counselor

Believing that preventive education is a major contribution of today's counseling programs, the school counselor's goal is to help children gain knowledge about their feelings and to learn how to apply this knowledge to cope and solve problems throughout life. Emotional education is geared toward the "whole" child--social, emotional and cognitive (Vernon, 1983). Henker and Whalen (1989) recommended that school counselors, working within the developmental framework, can reinforce attentional problem students' assets of spontaneity, zest, facets of intensity, and indefatigability. The availability of a supportive "significant other" seems to be a positive predictor for long-term adjustment. Weiss and Hechtman (1986) reported that attentional problem adults attribute a
teacher's caring attitude and extra attention as "turning points" in helping them overcome their childhood problems. Counselors can serve as a role model demonstrating appropriate behaviors. As a trusted confidant, the counselor attempts to provide a positive significant adult relationship with an attentional problem student.

Multimodal Assessment and Treatment

School counselors report a large percentage of the students who are referred to them for help are attentional problem students who have problems academically, socially and behaviorally (Keats, 1990).

According to Loney (1980), major work is still needed to construct an operational diagnostic system that will provide a multimodal assessment of relevant attentional problem dimensions. The multimodal assessment/treatment approach is appropriate for the school counselor. Lazarus (1989) recommended the BASIC ID: Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal relationships, and Drugs/health diagnosis to investigate the child's physical, social, behavioral, and psychological dimensions, where the total child is considered in assessment and treatment. Cognitions, social interactions, emotions, and physical health are
investigated in addition to obvious off task behaviors.

Behavior

Impulsivity, inattention and hyperactivity are the most obvious inappropriate behaviors of the attentional problem child. Parents and teachers identified these maladaptive behaviors by observation using Conners' (1973) rating scales. A variety of behavior modification strategies may be implemented, but as Barkley (1990) suggested, parents and teachers need motivation and a personal philosophy that endorses a behavioral procedure in order to implement a program of contingencies, token economies, or time-out techniques.

In recent research there is disagreement between the efficacy of positive vs. negative reinforcement. Campbell and Paulauskas (1978) suggested that additional research is needed to support evidence on the effects teachers and peers have on ADHD students, but hyperactive subjects received more teacher directions and positive feedback than their classroom controls. Studies by Pfiffner, Rosen, and O'Leary (1985), and Rosen, O'Leary, Joyce, Conway, and Pfiffner (1984) compared the effects of positive vs. negative reinforcement by classroom teachers. Pfiffner et al. proposed that an all positive approach that relied primarily on praise was not
effective for behavior problems. Hyperactive children's social (on-task) behaviors and academic productivity deteriorated when the teacher stopped providing negative consequences for inappropriate behaviors (Rosen et al.). Negative consequences were ineffective if the reprimands were delivered late, inconsistently and nonspecifically. A good working relationship with the class of hyperactive children uses a combination of positive and negative consequences, where negative consequences may be more important than praise.

Recognizing the frustrations of the teachers and students in the classroom, and family conflicts at home, the counselor plays a vital role in serving as a consultant who initiates behavioral assessment and treatment strategy for the attentional problem child (Ross & Ross, 1982).

Affect

Whalen (1987) suggested that we need to examine not only what the attentional problem child is doing, but also what he is thinking and feeling and about what is being done to him. The hyperactive child appears to act impulsively on his internal feeling states rather than allowing cognition to mediate the behavior process. In simple terms, the child has not learned to "think" about
his feelings. The healing process is the working-through or re-experiencing early emotional experiences which might have occurred before the child spoke his or her first word. Greater self-control is attained as the child becomes more able to "think" about his current feelings in the therapeutic relationship (Grinberg, Sor & Tabak de Biancherdi, 1977). As Whalen and Henker (1985) reported, over time, attentional problem students have low self esteem and negative self perceptions. Their difficulty in controlling their own actions, being socially ostracized by peers, and being in trouble with parents and teachers, generate feelings of inadequacy. Investigating the child's perceptions of self and those around him can be achieved through individual therapy sessions with the school counselor or private therapist.

**Sensation**

In addition to behaviors and feelings, counselors investigate attentional problem children's reactions to their senses including touch, sight, and sound. Individual levels of energy, anxieties, and pain are relevant to treatment. Differing intensities of responses in this category suggest individual treatment plans. As Whalen (1987) reported: there is no possibility of a "quick fix", and we have learned that needs and approaches
change as the individual progresses from one developmental phase to the next. Teachers, parents, siblings, and peers are likely to report unusual levels of sensing reactivity.

Lazarus (1989) recommended relaxation techniques and physical exercise as tension release strategies, that are appropriate for the school-aged child.

**Imagery**

As counselors elicit the student's feelings and perceptions of self, they determine the reality of the child's perceptions. In addition, the child's ability to visualize abstract concepts, and creative aptitudes are observed. Attentional problem children differ extensively in this dimension. Whalen (1987) predicted that there may be a link between hyperactivity and giftedness, where some individuals may become society's most creative and innovative contributors. She proposed that many of our interventions which enhance manageability may stifle unique talents and creative styles in the attentional problem students. Being able to identify unique talents and abilities of the "special students" and to encourage these student interests outside the classroom are challenges to the school counselor.
Cognitive

By associating imagery with cognitive functions, Lazarus (1989) also recommended strategies to promote self-control and to imagine self-achievement. Included in cognitive restructuring procedures are: investigating perceptions of self, self-downing tendencies, cognitive overgeneralization, low frustration tolerance and excessive desires for approval (Lazarus). In combination with behavioral techniques, cognitive-behavioral treatment focuses on the development of self-control skills and reflective problem-solving strategies aimed at providing skills for children to regulate their own behavior (Meichenbaum & Asarnow, 1979). They also encouraged students to use positive self statements for coping with stressors and to reinforce one's appropriate behaviors. Proponents of rational emotive therapy teach children to minimize their self-defeating outlook and to acquire a more realistic tolerant philosophy of life (Bernard & Joyce, 1985).

There is lack of research evidence to support significant success when cognitive treatments are used exclusively, as Whalen and Henker (1985) stated in a review of treatment outcome literature report: "the controversial bottom line is that the results of cognitive-
behavioral treatments are not very strong, somewhat inconsistent, difficult to replicate and decidedly disappointing" (p. 393). Brancaleone (1988) suggested that cognitive-behavioral programs have not been fashioned on the basis of individual subject differences, making positive conclusions negligible. He also indicated a lack of information about steps in the problem-solving chain that pose difficulties for a particular child.

Piaget's theory of cognitive development which recommended that children under the age of twelve need to learn from real life experiences might explain the ineffectiveness of cognitive-behavioral strategies. This approach contends that the cognitive restructuring treatment will not be effective until children reach the formal operational stage. Copeland (1982) also suggested that young children need more explicit instructions (what to think) whereas older children (8-12 years of age) are more able to generate their own self-instructions and can benefit from more general concepts. Selection of cognitive strategies is dependant on the counselor's personal philosophy.

Interpersonal Skills

Social skill deficiencies are common to attentional problem students relating to their hyperactivity and
impulsivity. Studies using sociometric ratings have uniformly found hyperactive children to receive greater peer rejection than other children (Klein & Young, 1979). It is likely that poor peer relationships could stem from deficient and immature social skills or an aggressive response style (Mainville & Friedman, 1976).

Barkley (1990) and Whalen (1987) endorsed social skills component in all treatment programs. Both researchers promoted small group interactions where both cooperation and competition is implemented. Since early peer reputations are so indelible, significant behavior changes of attentional problem students have little impact on their peers. Selecting students outside the targeted student's peer group is advisable for group membership. Counselors encourage students to act as cotherapists, in offering positive attention and praise to attentional problem students. Conversation skills, problem solving, conflict resolution, and anger control training in the group setting are recommended by Barkley (1990). The Council for Exceptional Children (1989) also advised social skills training, involvement in scouting and youth groups, and allowing children with attentional problems to play with younger children with whom they may have more in common developmentally.
Psychopharmacology for attentional problem students has had a profound impact on treatments the past twenty years. Although stimulant medication is not only the most prevalent therapy for attentional problem students, there is disagreement to its effectiveness. However, stimulant medication, is the most widely studied treatment across the entire spectrum of childhood behavior problems. The drug most often used is methylphenidate (Ritalin). Henker and Whalen (1989) reported that the success of stimulant effects is as heterogeneous as the heterogeneity of ADHD children. Although 75% of children with ADHD respond favorable to medication, Barkley (1990) concluded that most positive responses were in the subjects' attentional behaviors for short term effects. The short-term positive effects of stimulant drugs on excessive activity behaviors is well established, but improved long-term outcomes are not well established (Weiss et al., 1971). Henker and Whalen also warned that taking medications for behavior regulation is a process with a potent message value for the child, the family and the school. The message may confirm preexisting assumptions that the child will be unable to take control of his own behavior without external aids and constraints.
Latest researchers agree that a combination of stimulant medication with the accompanying multimodal treatments are most promising. Since attentional problem children are multiproblem youngsters, no one treatment modality can suffice. The goal of the school counselor is to empower the attentional problem student to correct his thinking, feeling and behaving through his own efforts. Whalen (1987) proposed initiating cognitive self-regulation training before a medication trial so the child will have an internal attributional anchor for change, developing his own competencies rather than depending on a somewhat magical chemical process.

Whether or not they are given stimulants, the majority of attentional problem children need tailored educational programs and help in their social development. Parents need assistance in coping with family conflict and learning management techniques (Henker & Whalen, 1989).

Discussion

Given the increased frequency of children with attentional problems in schools today, the school counselor has a vital role in the development of these students. The counselor needs current information on the nature, course, and outcomes of students with attentional problems. Serving as consultants to parents, peers,
siblings, and school staff members, counselors aid in diagnosing and implementing treatment plans.

Acknowledging the heterogeneity of behaviors and perceptions of the attentional problem students, individual treatment plans are encouraged by leading researchers (Henker & Whalen, 1989). The multimodal approach is recommended by many authors, yet to date, no study has assessed all of the dimensions of symptoms and characteristics that comprise this disorder. Loney (1980) suggested that major work is still needed to construct an operational diagnostic system that will provide a multimodal assessment of these relevant dimensions with accompanying treatments. Satterfield, Satterfield, and Cantwell (1981) have initiated some work in a multimodal approach, offering individual and group psychotherapy for children and their parents with medication prescribed to 100 hyperactive boys. Those students who dropped out of treatment within two years were compared with those who participated in the program from two to three years. The group receiving treatment had better school adjustment and home relations, less antisocial behavior, were closer to age achievement and intelligence achievement, and were globally more improved as rated by treating psychiatrists. This piloting effort provides some evidence for the
efficacy of multimodal therapy.

Barkley (1990) indicated that interventions are intended to maximize children's likelihood for success, not intended to cure or normalize their problems. It is likely children will continue to experience some difficulty in academic and social endeavors. A school counselor assumes the role of consultant, therapist, diagnostician, and role model for the attentional problem students. Knowledge of the needs of attentional problem children, their parents, siblings, and teachers is essential for the helping professional. Awareness of the individual student's self perceptions, behaviors and emotions enable the school counselor to assist these students. Personal observations and those of school staff members, parents, and peers will enable the counselor to make an assessment using the BASIC ID approach.

In reality, many attentional problem students will not meet diagnostic requirements for psychological and medical treatment. The school staff will be responsible for implementing an individualized program which may benefit the attentional problem student. Today's counselor working in the developmental/proactive framework, has the opportunity to facilitate a multimodal treatment plan addressing the "total child."
References


