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Drama education: A teaching strategy for young children affected by attention deficit-hyperactive disorder

Janice C. Miller
University of Northern Iowa

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Abstract

According to many experts, Attention Deficit-Hyperactivity Disorder (ADHD) represents the most common developmental problem in school children (Coleman & Levine, 1988; Goodyear & Hynd 1992; Henker & Whalen, 1989). Children diagnosed with ADHD share a group of symptoms including: impulsiveness, inappropriate attention span, distractibility, and in some cases, hyperactivity (American Psychiatriatric Association [APA], 1987). Problems associated with ADHD result in chronic academic and social failure (Parker, 1990). This study is a concerted effort to help parents and teachers understand the difficulties children affected by ADHD experience and to present a strategy that will help the ADHD affected child achieve success.

Drama Education: A Teaching Strategy for Young Children Affected by Attention Deficit-Hyperactivity Disorder

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Janice C. Miller

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Date Approved

Judith M. Finkelstein
Director of Research Paper

June 23, 1993
Date Approved

Judith M. Finkelstein
Graduate Faculty Adviser

June 23, 1993
Date Approved

Graduate Faculty Reader

June 23, 1993
Date Approved

Peggy Ishler
Head, Department of Curriculum and Instruction

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Chapter 1

Introduction

According to many experts, Attention Deficit-Hyperactivity Disorder (ADHD) represents the most common developmental problem in school children (Coleman & Levine, 1988; Goodyear & Hynd 1992; Henker & Whalen, 1989). Children diagnosed with ADHD share a group of symptoms including: impulsiveness, inappropriate attention span, distractibility, and in some cases, hyperactivity (American Psychiatriatric Association [APA], 1987). Problems associated with ADHD result in chronic academic and social failure (Parker, 1990). This study is a concerted effort to help parents and teachers understand the difficulties children affected by ADHD experience and to present a strategy that will help the ADHD affected child achieve success.

This document includes the following points of study.

- Reports a broad view of past research and historical contributions including an explanation of past and present terminology used to describe children affected by ADHD.
- Examines effects of ADHD on the lives of affected children, family relationships, social interactions, and academic successes.
- Describes characteristics and symptoms used for identification of ADHD.
- Presents intervention techniques suggested by research.
- Proposes drama education as an intervention strategy.

This study investigates the benefits of using drama education as an intervention strategy for treatment of children affected by ADHD. Studies conducted with primary age children suggest that drama education can improve behavior and increase social skills (Doyle & Connolly, 1989; Gresham, 1982; Hazen, Black & Johnson, 1984; Strain & Odom, 1986). The action research investigated in this study determined that there is a positive correlation between drama education and improved control of behavior and enhanced social competencies.

Definition of Terms

The following paragraphs list and define some of the primary terms used in this study.

Attention Deficit-Hyperactivity Disorder (ADHD) refers to a disorder characterized by having pervasive problems with impulsiveness, inattention, and hyperactivity (APA, 1987).

CH.A.D.D. represents a national association for parents and professionals who support and who have an interest in children with ADHD.

Drama Education refers to a process in which dramatic elements such as sensory awareness, movement, pantomime, story dramatization, and role-play, are used to promote social, intellectual, and creative exploration. Active learner involvement provides opportunities for children to imitate situations which will assist them in their understanding of real life. The objective is for children to acquire basic skills such as: concentration, problem solving, critical thinking, environmental awareness, communication, coordination, cooperation, and self-discipline.

This process gives children the opportunity to apply knowledge, skills, and dispositions in the context of a planned curriculum (Berghammer, Federlein & Nielsen, 1991).

DSM-III-R is the revised edition of the *Diagnostic and Statistical Manual of Mental Disorders, published in 1987 by the American Psychiatric Association.*

Iowa Attention Deficit Disorder (ADD) Coalition represents local support groups for the purpose of networking and communicating about issues related to ADHD.

Public Law 94-142 refers to the Education for All Handicapped Children Act of 1975, to provide handicapped children with a free, appropriate public education in the least restrictive environment.

Role-playing refers to a technique used to practice situation awareness. Role-playing is planned and includes creating a character(s) through both movement and speech in relation to location and conflict (Berghammer et al., 1991).

Story Dramatization refers to a process of creating a play based upon a story. Young children portray the roles of the character(s) in the story, work in their own spaces, and are guided by a leader who tells or reads the story. Older children assume specific roles and collaborate to dramatize a story and often interchange roles and experiment with ideas (Berghammer et al., 1991).

Whole Intelligence Development Progress/Assessment Model refers to the measurement instrument used for this study. It was compiled by

Greta Berghammer, Associate Professor of Child Drama at the University of Northern Iowa, Cedar Falls, Iowa, and is based upon the research and findings of Howard Gardner.

History

Russell Barkley (1981) provides an extensive review of the history of ADHD. The first published report of children with behavior characterized by hyperactivity, behavior problems, inattentiveness, and learning difficulties was by George F. Still in 1902. He attributed their difficulties to neurological factors. Interest in this area continued after World War I when other researchers (e.g., Hohman and Ebaugh) observed a high incidence of children displaying signs of hyperactivity, impulsiveness and behavior disorders. Like Still, subsequent researchers attributed the development of these behavior characteristics to neurological factors.

Prior to the 1940s, children who had difficulty learning or attending to tasks were considered either mentally retarded, emotionally disturbed, or culturally disadvantaged. Research of the 1940s identified children who had difficulty from the way their nervous systems worked. This disorder was referred to as Minimal Brain Damage or Minimal Brain Dysfunction (Parker, 1990; Silver, 1990). These terms referred to children who had near or above average general intelligence and were diagnosed as having certain learning or behavioral disabilities ranging from mild to severe. Their disabilities were associated with deviations in function of the central nervous system manifested by various combinations of impairment in

perception, conceptualization, language, memory, attention and impulse control, or motor function (Clements & Peters, 1962).

During the 1940s, children with neurologically based academic problems became a separate focus of study. These problems were identified and named to reflect the primary area of skill difficulty such as dyslexia (reading), dysgraphia (writing), and dyscalculia (mathematics). The term Learning Disability later was applied to the types of learning difficulties that underlie skill problems. Research shows a high rate of children having both learning disabilities and ADHD symptoms (Silver, 1990).

In 1968, the ADHD disorder was known as Hyperkinetic Reaction of Childhood. Diagnostic emphasis was on the high activity level with little emphasis on symptoms of inattention (Henker & Whalen, 1989). The term Attention Deficit Disorder (ADD) was introduced in 1980 to emphasize that inattention, rather than hyperactivity, was the major issue (Goodyear & Hynd, 1992). The name was changed again to reflect the reality that all of the problems were significant. The contemporary term for this disorder is Attention Deficit-Hyperactivity Disorder (APA, 1987).

ADHD Induced Effects

Researchers have attempted to define the social and academic difficulties encountered by children affected by ADHD. Although there are many unanswered questions, it is apparent during the past decade that the condition touches all aspects of affected children's lives—family relationships, social interactions, and academic successes (Silver, 1990).

Family Relationships. To exemplify how disruptive ADHD can be to family relations, Fowler (1990) cites the following example in the first chapter of her book *Maybe You Know My Kid.*

> Maybe you know my kid. He's the one who acts before he thinks. . . . He's the one who says the first thing that comes to his mind. . . . He's the kid who scrapes his knee and screams so loud and long that I worry the neighbors think I am beating him. . . . He's the kid in school with ants in his pants who could do the work if he really tried. Or so we have been told over and over. (p. 1)

According to Jane Brody's (1991) review of Fowler's book, it took 6 years of torment, family chaos, and self-doubt about her ability to be a mother before Fowler learned that her son had a medical problem called ADHD, a syndrome that can disrupt every aspect of normal life at home, at school, and at play.

Fowler (1990) describes the symptoms of the disorder as being present usually in one form or another from birth. From the irritable infant who cries all the time, the toddler who becomes over stimulated and runs reckless, to the aggressive preschooler who angers quickly and cannot seem to play nicely, or the child of any age who can be counted on to ruin every family outing. Unsuspecting parents may feel like failures, often blaming themselves for their child's poor behavior, and may have difficulty accepting the fact that their child has a disability. Unless the problems are recognized and treated, family problems may worsen.

Social Interactions. ADHD affected children often are rejected by their peers because of their aggressive behavior and inability to use social

cues (Henker & Whalen, 1989; Moore, Hughes & Robinson, 1992; Silver, 1990). Although the reasons remain elusive, one hypothesis is that children affected by ADHD process social information inadequately (Milich & Dodge, 1984). Another hypothesis is that these children lack age-appropriate interpersonal skills including the ability to initiate social harmony and disengage from social conflict (Whalen & Henker, 1985). It is likely that each hypothesis is valid for some ADHD affected children some of the time.

A study conducted by Moore, Hughes, and Robinson (1992) investigates the importance of identifying variables which contribute to the rejection of some hyperactive children. The results showed that hyperactive children, who are rejected by their peers, display social information processing deficits (e.g., recognizing social cues and assigning meaning to them). Because ADHD affected children are easily distracted and have difficulty concentrating, these children have problems internalizing social situations and recalling socially relevant information. Furthermore, the authors determined that interventions for improving social functioning of ADHD children often are unsuccessful because teachers and parents fail to focus on remediating the types of deficiencies that appear to be the cause of peer rejection. The study recommends behavioral interventions that specifically address social cue deficiencies.

Kisamore & Sobelman (1989) offer two suggestions when assisting the ADHD affected child in fulfilling his/her social needs: 1. create stories and role-play situations to assist the child with understanding other's

feelings, to cooperate in group activities, and to share ideas and materials, and 2. teach reflective listening by asking the child to summarize conversations and to identify other's nonverbal messages.

Academic Successes. Recent research suggests that there are many cognitive processing differences between normal children and children affected by ADHD (Reardon & Naglieri, 1992). Problems are particularly notable in academic settings. Some academic impacts of ADHD include: difficulty processing information; inability to memorize; fatigue; problems with fine motor skills; ineffective self-monitoring skills; need for intense motivation; disorganization; inconsistent performance; difficulty remaining on task; distractibility; and inattention to detail (Coleman & Levine, 1988; Lambert, 1988).

Reardon & Naglieri (1992) studied two groups of males 7- to 12-years-old. The control group included 28 subjects from regular education classrooms, and the experimental group included 28 subjects who were diagnosed as having ADHD according to the DSM-III-R criteria. Twelve cognitive processing tasks were administered individually to each subject. The scores on the 12 processing tasks revealed that the experimental group scored lower across most of the planning, attention, and successive processing tasks than the control group. The results indicated that the cognitive processing deficiencies penetrated throughout the experimental group. An explanation of these results is that ADHD affected children are characterized by cognitive deficits involving a failure

to invest, organize, and maintain attention and effort, and an inability to inhibit impulsive responses to meet task demands.

Purpose

The purposes of this study are twofold: 1. to assist parents and teachers with identifying characteristics of ADHD; and 2. to provide parents and teachers with suggestions for specific interventions. This study experimentally determines the value of drama education as an intervention strategy for a primary age child diagnosed with ADHD.

Research Hypothesis

Primary age children with ADHD who experience a planned educational developmental drama program will improve control over their behavior and enhance their socialization competencies through practicing appropriate responses in a variety of situations.

Need for Study

The exclusion of children with ADHD from the Education for All Handicapped Children Act of 1975 (also known as *94-142*) places 75 to 90 percent of ADHD affected children in regular education classrooms (Iowa ADD Coalition, 1990; Parker, 1990). The trend toward inclusion and mainstreaming handicapped children into regular education is undoubtedly going to move these percentages even higher. The need for early identification and educational intervention is critical to improve ADHD affected children's academic and social achievements (Coleman & Levine, 1988; Parker, 1990). Teachers and parents must be educated about the characteristics and techniques pertinent to identifying and

understanding ADHD. They also need support and assistance in developing and implementing strategies to help the ADHD affected child to succeed academically and socially both in and out of the classroom (Henker & Whalen, 1989; Parker, 1990; Silver, 1990).

Chapter 2

Review of Related Literature

ADHD is defined as a chronic disorder that exhibits developmentally inappropriate degrees of inattention, impulsiveness, and over activity which can begin in early childhood and extend through adult life (Barkley, 1990; Cantwell, 1986; Coleman & Levine, 1988; Education Committee of CH.A.D.D., 1988; Henker & Whalen 1989; Johnson, 1988). The disorder is pervasive and appears to have a biological predisposition. The majority of children diagnosed with ADHD have no identifiable causes; however, many of these children are from families having a family member with similar symptoms (Jesshke, 1988; Parker, 1990). This disorder is not a result of brain damage, psychosis, autism, or mental retardation (Barkley, 1990).

ADHD is most obvious in group situations (Scott, 1987). Although statistics vary, they show that from 4 percent to 20 percent of school-age children in the U.S. exhibit symptoms of ADHD (Parker, 1990; Szatmari, Offord & Boyle, 1989). There is a high rate of co-existence between ADHD and both psychiatric disorders and learning disabilities (Parker, 1990; Silver, 1990). The following paragraphs discuss how ADHD is identified, explain some major symptoms of ADHD, and detail many of the intervention techniques recommended by experts.

Identification of ADHD

The first purpose of this study is to assist parents and teachers with identifying characteristics of ADHD. Teachers and parents are the

observers who usually seek help for children exhibiting ADHD symptoms. Children from 8- to 10-years-old are the most likely age group to be referred to professionals and to be diagnosed with ADHD. The younger the child is diagnosed, the more severe the ADHD symptoms usually are (Scott, 1987). Szatmari et al. (1989) state that ADHD, with or without hyperactivity, is more prevalent in males than in females, and research supports this fact (Parker, 1990; Scott, 1987; Henker & Whalen, 1989).

The revised edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) published in 1987 by the American Psychiatric Association defines hyperactivity, inattention, and impulsiveness based upon specific symptoms. To meet the diagnostic standard of the DSM-III-R, at least eight of the of the following 14 symptoms must be present for a period of 6 months or more, and the onset of the symptoms should occur before age 7.

1. Fidgets, squirms or seems restless.
2. Has difficulty remaining seated.
3. Is easily distracted.
4. Has difficulty waiting for turns.
5. Blurts out answers.
6. Has difficulty following instructions.
7. Has difficulty sustaining attention.
8. Shifts from one uncompleted task to another.
9. Has difficulty playing quietly.
10. Talks excessively.

11. Interrupts or intrudes on others.
12. Does not seem to listen.
13. Often loses things necessary for tasks.
14. Often engages in dangerous actions.

Because ADHD is a medical diagnosis, it is important for parents and teachers to document these symptoms. To assist in this process, a form is included in Appendix A. This form lists the symptoms of ADHD, provides a scale to rate the severity of the symptoms, and offers additional information for obtaining data reflective of the whole child.

Major Symptoms of ADHD

The three types of behavior that characterize children with ADHD are: hyperactivity, inattention, and impulsiveness (APA, 1987; Education Committee of CH.A.D.D., 1988; Jesshke, 1988; Johnson, 1988; Silver, 1990). A closer review of each of these characteristics may assist understanding the effect that ADHD has on a child's life at home, school, and within his/her community.

Hyperactivity. Although childhood hyperactivity has been in medical literature since the 1880s, it remains a controversial subject. Hyperactivity has no single, known cause and is classified as a syndrome because it has a cluster of symptoms (Hadley, 1984). One characteristic of hyperactivity is that of a child appearing to be in constant motion (e.g., fingers tapping, legs swinging, or body wiggling in the chair). The teacher may notice that the student may be up and down at his/her desk or may be doing several things at once during play or work. Children identified

as hyperactive are easily stimulated and may be physically overactive (e.g. climbing, running, and fidgeting) (Hadley, 1984; Johnson, 1988; Silver, 1990). Professionals have classified two types of hyperactivity. One type, which is caused by a particular situation, may disappear either when a situation changes, or when the child learns to cope with the stress of a situation. Anxiety or depression can cause hyperactivity in children, adolescents, and adults, but this form of hyperactivity is not ADHD symptomatic. The second type of hyperactivity is caused by neurological differences in the brain. The history of the problem helps the physician determine if the hyperactivity stems from an emotional problem or from ADHD (Silver, 1990). Since not all ADHD affected children are hyperactive, the hyperactive symptom must be carefully evaluated as to its role in the child's problem (Goodyear & Hynd, 1992; Jesshke, 1988).

For the first time, researchers have found a specific brain abnormality that may explain why some children and adults are hyperactive and unable to pay attention or sit still. Zametkin (1990) and his coworkers at the National Institute of Mental Health in Bethesda, Maryland, found that adults who have been hyperactive since childhood had less active brains overall and that this inactivity was most prevalent in two regions—the premotor cortex and the superior prefrontal cortex. Both regions are known to control attention and movement. Researchers are encouraged that the findings eventually could lead to safe, definitive testing for hyperactivity.

Inattention. Children with ADHD are easily distracted by movement

or sound and have difficulty filtering unnecessary information from their environment. The resulting inattention contributes to decreased organizational skills, poor listening skills, and general learning problems. An ADHD affected child may sustain an extended period of attention if either the child's interest or motivation for the activity is extremely high (Jesshke, 1988). As with hyperactivity, anxiety or depression may cause children and adults to be distracted and appear inattentive. However, if the problem is chronic and pervasive, it most likely is neurologically based or ADHD symptomatic (Silver, 1990).

Impulsiveness. Some ADHD affected children exhibit a low frustration tolerance which manifests itself in inappropriate physical activity. These children do not stop to think before they act. For example, they may become angry and yell, throw, or hit while giving no thought to the consequences of their inappropriate acts. They also may say things that they are sorry for even before they finish verbalizing it or may answer before the teacher finishes asking a question (Silver, 1990). Affected children have difficulty waiting their turn in group situations and games. Teachers and parents describe these children as restless, disruptive, and in need of constant supervision. These children experience behavioral difficulties with peers, teachers, and parents (Jesshke, 1988). As with hyperactivity or inattention, anxiety or depression may cause impulsiveness; however, if the impulsiveness is chronic and pervasive, clinical evidence supports that it either is neurologically based, or ADHD symptomatic (Silver, 1990).

Intervention Techniques

The second purpose of this study is to provide parents and teachers with suggestions for specific interventions. Treatment of the ADHD child usually requires a multi-modal approach involving a team comprising parents, teachers, physicians, and behavioral or mental health professionals (Education Committee of CH.A.D.D., 1988; Henker & Whalen, 1989; Johnson, 1988; Klein, 1987; Parker, 1990). Research consistently shows that successful treatment of ADHD uses a combination of stimulant medication, behavior modification, supportive psychotherapy, and educational intervention (Coleman & Levine, 1988; Henker & Whalen, 1989; Parker, 1990; Silver, 1990).

Drama Education has yet to be documented in research as an intervention strategy for children affected by ADHD; however, literature shows a relationship between development of social role understanding and development of social competencies in young children (Doyle & Connolly, 1989). Research suggests that educators teach social skills and provide opportunities for children to practice social behaviors to facilitate social interactions with peers (Gresham, 1982; Hazen et al., 1984; Strain & Odom, 1986). Social interaction intervention is one technique that is found repeatedly to result in positive social behavior change (Strain & Odom, 1986).

For this document to be used as a meaningful tool, it is necessary to detail recommended intervention techniques that research deems beneficial to children affected by ADHD.

Medication. "Stimulant medication is the most effective single treatment for ADHD" (Johnson, 1988, p. 351). The medication most often prescribed by physicians is methylphenidate *Ritalin* (Brody, 1991; Education Committee of CH.A.D.D., 1988; Henker & Wahlen, 1989; Johnson, 1988). Other stimulant medications used are *Dexedrine*, *Cylert*, and *Tofranil* (Henker & Whalen, 1989). Individual children react differently to drugs, and because all drugs can have side effects, a physician should determine the type of drug and dosage best suited to each child. Parents, teachers, and professionals should monitor dosage timing and the drug's effectiveness to minimize most side effects (Education Committee of CH.A.D.D., 1988; Nemeth, 1990).

Medication improves such characteristics as hyperactivity, inattention, and impulsiveness for approximately 75 percent of children affected by ADHD (Education Committee of CH.A.D.D., 1988; Johnson, 1988). Desirable changes often are immediate and affect everyday life situations. Experts say, "Changes appear to be decreases in demanding, disruptive, and noncompliant behaviors in family and peer cultures, accompanied by welcome improvements in interpersonal responsiveness and in goal-directed efforts in the classroom" (Henker & Whalen, 1989, p. 219).

Use of medication alone is not recommended for treatment of ADHD (Education Committee of CH.A.D.D., 1988; Nemeth, 1990). Medication should be combined with other treatments to produce desirable results.

Research supports using a multidisciplinary approach to assist the child medically, educationally, psychologically, and behaviorally.

Teaching Strategies. Goldstein and Goldstein (1987) suggest the following teaching strategies which parents and teachers may implement to assist ADHD affected children.

- Provide a great deal of structure and consistency. (e.g., consistent seating arrangements, daily schedules, and clearly defined rules, expectations and consequences.)
- Give the student much encouragement, praise, and affection as ADHD affected children are easily discouraged. Promote a feeling of inclusion and self-worth by delegating responsibilities that the student successfully can complete. Begin with simple tasks and gradually build toward more complex ones.
- Provide a nonstressful climate with adequate emotional warmth and physical contact from the teacher and the child's peers whenever possible.
- Utilize small group learning and create social opportunities. Many ADHD affected children do much better academically, behaviorally, and socially in smaller groups rather than in larger groups.
- Communicate often with the child's parents. Parents often know best what works with their child.
- Allow opportunities for controlled movement, such as a trip to

the office, a chance to sharpen a pencil, a walk to take a note to another teacher, or an opportunity to water the plants or feed the classroom pet.

- Adjust your expectations to accommodate the ADHD affected student's deficits and disabilities. For example, if the student has a short attention span, do not expect him/her to concentrate on a single task for an extended period.
- Include social and organizational training in the classroom.
- Offer a screened corner to your class as an earned privilege (rather than as a punishment) during scheduled times. This avoids segregating the ADHD affected student when he/she needs the screened corner to reduce distractions.
- Develop a repertoire of physical activities for the entire class, such as stretch breaks or isometric exercises.
- Set predictable intervals of *no-work periods* which the student may earn as a reward for effort. This increases attention span and prolongs impulse control through gradual training.
- Note whether the child withdraws during noisy, stimulating recreational situations. This behavior may signal coordination or auditory processing difficulties which may require additional intervention.
- Prepare the student in advance for new situations. ADHD affected students may be extra sensitive to their limitations and easily may become frightened and discouraged.

- Develop a variety of sensory approaches (e.g., sound, vision, or touch) for successful teaching ideas. However, when new experiences involve a myriad of sensations, such as multiple sounds, movements, emotions, or colors, allow the ADHD affected student extra time to complete tasks.
- Encourage using a word processor or computer for school work.
- Recognize tolerance limits and vary the student's program only to the degree to which you feel comfortable to prevent resentment and frustration from overextending personal limitations.
- Communicate frequently with the school psychologist, learning consultant, and social worker as these professionals are the best liaisons between school, parents, and physician.

The Education of CH.A.D.D. (1988) recognizes the importance of the teacher's role to ensure success in the lives of children with ADHD. The committee recommends the following specific techniques to prepare the environment of the classroom, to give instructions, to assign tasks, and to implement a behavior modification program.

Environmental Techniques.

- Include the student in regular class seating, but locate the student near the teacher's desk.
- Locate the student in the front of the classroom with his/her back to the rest of the class. The objective is to avoid

distracting the student with classmates in the student's line of sight.

- Surround the student with good role models, preferably students who the ADHD affected child may view as *significant others*. Encourage peer tutoring and cooperative, collaborative learning.
- Avoid seating the child in proximity to distracting stimuli such as an air conditioner, heater, doors, windows, or high traffic areas.
- Avoid changes such as: transitions, schedules, physical relocation, and disruptions, and monitor the student closely on field trips.
- Encourage the ADHD affected child's parents to establish appropriate study space, routines, and set times for study at home. Encourage parental review of homework and periodic checking of the notebook and/or book bag organization.

Techniques for Giving Instructions.

- Maintain eye contact with the student while administering verbal instructions.
- Make directions clear and concise. Be consistent with daily instructions.
- Simplify complex directions and avoid multiple commands.
- Ensure that the student fully comprehends before beginning the task.

- Repeat instructions in a calm, positive manner when necessary.
- Help the student to feel comfortable about asking for help as most ADHD affected children will not ask questions.
- Evaluate the use of a daily assignment notebook and require it if necessary.
- When using a daily assignment notebook:
  - — Make sure that the student correctly enters all assignments each day, and help the student make entries when necessary.
  - — Require parents and teachers to sign the notebook daily to signify completion of homework assignments.

Techniques for Assigning Tasks.

- Assign only one task at a time.
- Monitor assignments frequently and maintain a supportive attitude.
- Consult with special education personnel to determine specific strengths and weaknesses of the student. Develop an individual educational program for the student.
- Ensure that testing evaluates knowledge rather than attention span.
- Allow additional time for certain tasks as the student may work more slowly. Do not penalize the need for additional time.

- Remember that the student is frustrated easily and that stress pressure, and fatigue may break down the student's self-control and lead to adverse behavior.

Techniques for Behavior Modification.

- Develop and communicate pre-established consequences for misbehavior.
- Remain calm, state infraction of rule, and do not debate or argue with the student.
- Administer consequences immediately and frequently monitor proper behavior.
- Enforce classroom rules consistently.
- Ensure that discipline is not harsh and is appropriate to the misbehavior.
- Avoid ridicule and criticism.
- Remind the student in private to take prescribed medication.
- Reward more than punish.
- Praise immediately any and all good behavior and performance.
- Change rewards if they are not effective in motivating behavioral change.
- Experiment with and discover differing methods to encourage the student.
- Promote the student's positive self-image by teaching the student to reward him/herself and encourage positive self-talk.

Chapter 3

Action Research

The treatment team for this study's action research comprised five teachers — classroom (2), music, physical education, and art — an Area Education Agency psychologist, the subject's parents, and the author of this study. The teachers were responsible for obtaining a baseline observation and implementing treatment activities. The psychologist offered suggestions for effective implementation of the treatment program. An initial interview with the subject's parents provided additional information about the child and ensured their commitment to implement the same treatment at home. The form, Parent to Teacher, found in Appendix B, was developed by this author for use as a guide for the interview process. The objectives of the initial interview were: to understand parental concerns about their child; to gather background information about the child's learning style, behaviors, and specific needs; and to determine which management strategies are effective. The author of this study: interviewed the subject's parents; planned, facilitated, and evaluated all of the drama activities conducted by the treatment team; and participated as a team member during the day-to-day treatment activities.

Background

This case study involved a 7-year-old male first grade student. His parents reported that the pregnancy was carried to full term through an uncomplicated birth. The parents described the child as an alert, active and content baby who rolled fairly early and used rolling for mobility. The

child did not crawl, but began walking at approximately 9 months, and by his first birthday was described by the parents as a child who ran. By the age of 2 years, they began to question his level of activity and impulsiveness. By the age of 4 years, the parents were convinced that he was showing signs of having difficulty with coordination and learning skills as well as with impulsiveness and excess activity. The parents described their son as excitable, distractible, inattentive, and fidgety. The subject was in constant motion to the extreme of eating on the run. He had no difficulty falling asleep and no unusual sleep patterns. The parents reported that the child's worst habit was constant chatter.

The parents did not consider the subject socially well adjusted as they could not take him places without his causing problems. He appeared immature and quarrelsome in that he wanted things his way and would debate trying to get it. The subject talked back when corrected and did as he pleased rather than what he was instructed to do. The subject was defiant, manipulative, and moody which made their disciplining him difficult. The parents reported that of the variety of disciplines they tried, isolation was the most effective.

The subject attended preschool where he experienced difficulty completing tasks, exhibited a short attention span (unless it was with something that he liked), distracted easily, and displayed impulsive behavior. When frustrated, the subject became angry and occasionally would bite others. His social skills were limited in that he was a loner and experienced peer rejection.

A team of physicians diagnosed the subject with ADHD at 4 years 8 months, and prescribed *Ritalin* medication therapy. The parents observed that after taking the medication, he appeared happier and more compliant. The subject completed kindergarten and currently attends first grade in a regular education classroom at a medium-sized rural elementary school district in Northeast Iowa.

Prior to the study, the subject continued to display symptoms of ADHD in the classroom and at home depending upon the day and the time. His symptoms were: inability to transition between activities or changes in routine; problems with beginning and completing tasks; trouble with control of fine motor skills; and dissatisfying social interaction with peers.

Parents and teachers reported that the subject had difficulty making school and neighborhood friends. He often was teased about his inept learning and behavior. His inappropriate behaviors—impulsiveness, lack of self control, and aggressiveness—discouraged possible friendships. He had problems internalizing what was occurring in social situations. He appeared to notice neither other children's body movements, facial expressions or gestures, nor did he recognize other's feelings. The subject enjoyed controlling situations and considered himself the center of the universe. He became agitated when his ideas were rejected. The subject assumed little responsibility for his behavior and often responded to this frustration in temper outbursts of tears, resistive behaviors, and

demands. Isolation continued to be the most effective treatment when the subject appeared out of control.

Method

This study used a single-subject experimental design to determine if drama education relates to acquisition of appropriate behavior and social skills. In practice, the design was found effective because of the close attention given to the individual subject, interrater reliability of repeated measurements, and emphasis on practical rather than statistical data. The internal validity of this design depended upon the ability of each teacher to eliminate factors other than drama education as possible causes for specific changes observed in the subject's behavior and social competencies. To achieve internal validity and reliability, targeted behaviors and skills were consistently monitored, and descriptions of intervention strategies were detailed to permit replication.

Measures and Procedures

Prior to treatment, the team established a baseline using the *Whole Intelligence Development Progress/Assessment Model* to measure and record observations. A copy of the assessment model used is presented in Appendix C. This assessment was used to gather baseline data to enable comparing and evaluating treatment effects. The team identified one social goal: to increase social interactions with others; and one behavior change: to adjust to activity transitions for treatment.

During drama education treatment, the subject participated in a variety of role-playing situations that were used as methods to increase

his social interactions with others and improve his ability to successfully transition between activities. The intervention strategies were presented to the subject daily for a 6-week period. The *Whole Intelligence Development Progress/Assessment Model* was used to measure progress during each week of treatment.

The drama education study was conducted in three phases. The subject was introduced to drama activities, role-played social situations, and imitated and practiced the skills necessary to complete a transition in activities.

Introduction to Drama Activities. This author conducted introductory drama activities 3 weeks prior to active treatment. The following introductory drama activities were used to gather baseline information about the subject.

Aerobic activities were planned for the first grade class to enable observation of the subject's large group activity participation, ability to follow directions, and coordination skills. This observation indicated that the subject watched others, then experienced coordination difficulty while following directions when he attempted to participate.

The subject's parents stated that he enjoyed the less confining outdoors. This information led to the planning of a class winter walk to the park for the purpose of discovering animal tracks in the snow. After observing and identifying the animal tracks, the children simulated how the animals must have moved. They hopped like a squirrel, walked like a

beaver, and ran like a deer. The subject participated in each of the activities, followed directions, and attempted each creative movement.

The subject's parents and teachers identified small groups as the most positive learning situation for him. *The Snowy Day*, by Ezra Jack Keats was read to a small group of children as a center activity in the classroom. All of the children in the small group assumed the role of the young boy called Peter and participated in dramatizing the story. The center leader guided the children through the story by having each child perform in his/her own space. The subject enjoyed the activity, followed directions, and role-played the character in the story using both movement and speech. The subject then rotated to the next center activity without incident.

Social Intervention Strategy. Because the subject usually played alone, it was necessary to enhance his self-esteem by using a strategy to increase his social interaction and facilitate his social acceptance.

The objective of this exercise was to provide the subject with an opportunity to practice interacting with other children without experiencing confusing stimulation of the entire group. To facilitate this objective, the subject was allowed to choose one playmate during recess. The teacher assisted in the choice as it was important to select a playmate who was a good role model and who had a positive social history. To enable the subject to learn social interaction skills, the subject participated in role-playing as the other child. This focused him on the other's needs. The teacher suggested, "Let's ask what your friend would like to do today.

What would your friend like to play? What could you do to help with that?" The teacher functioned as an interpreter and helped the subject practice appropriate initiations for play.

Behavior Change Strategy. Making a successful transition from one activity to another was identified as a behavior that the subject needed to develop. The subject's initial response to transition and change was of anger, crying, and non cooperation.

The story, *I Was So Mad*, by Norma Simon was used to help the subject understand his feelings of anger, and allow him to imitate alternative approaches to these inappropriate behaviors. The subject and four carefully selected classmates were removed from the classroom to participate in this treatment. The author of this study read the story, then the children dramatized it. The children role-played their own version of the story, and each child wrote and illustrated his/her own story. On the third day, the subject became angry that he had to leave his classroom, cried, and refused to cooperate in the activity. It was evident that the subject could not adjust to removal from the classroom or change in his routine. After consultation, the team determined that it was in the subject's best interest to provide the treatment in his regular classroom with his classroom teachers.

To further assist the subject in transitional adjustment, the psychologist recommended that a daily schedule be prepared by the subject and his classroom teachers. File cards (3" x 5") were placed in a ring binder to record the subject's daily events. Through daily imitation

and practice, the subject role-played the impending transitions until he adjusted to the actual scheduled activities. The same type of daily schedule was implemented at home to facilitate transitions out of the school environment.

Teachers and parents modeled appropriate behaviors for changing activities and provided verbal prompting and reinforcements. The team operated under the premise, from Brandwein's workshop (1992), "When you know what you're looking for, you will see more of it" (p. 3). The following responses were used and praise was bestowed when the subject exhibited each behavior.

- When the subject responded to a request the first time asked, it was considered **respect** and **responsibility**. The praise used was, "That is good listening".
- When the subject responded to a request without being told, it was considered **initiative**. The praise used was, "You picked up before I asked you to. You did that without being asked; that's being a leader".
- When the subject responded on his own, it was considered **independence**. The praise used was, "You did that on your own".
- When the subject did something new, it was considered **creative** as it included discovering a different means of doing something. The praise used was, "You found a new way to get ready for music today".

- When the subject did something difficult, it was considered **courage** as it included harder choices. The praise used was, "That's tenacity".
- When the subject did something repeatedly, it was considered **persistence** and **concentration**. The praise used was, "You're concentrating. You've been working on this for a long time. You really are persistent".

Results

The most striking finding of this study was the immediate success that the subject experienced during treatment. The treatment team documented the following social and behavioral changes during and after drama education treatment.

Social Changes

The subject successfully chose a classmate each day to play with at recess. Through role-playing, the subject became aware of himself and the feelings of others and learned and practiced appropriate responses for initiating play with others.

A relationship between drama education and increased social competencies was documented during the first week of treatment. By the third week of treatment, the subject no longer needed prompting from teachers to initiate an invitation of play to another child. The subject appeared confident and proud of his peer acceptance. The subject began adapting his new skills to other social situations both at school and at home. In physical education class, the subject responded to a classmate

with a compliment, which was new to his behavior repertoire. His mother reported that they had invited a friend to play at home. She heard her son ask the friend, "What would you like to do at my house today?" The subject experienced peer acceptance as he began to learn how to manage his newly acquired social skills.

Behavioral Changes

Preliminary results indicate that the methods used in treatment enabled the subject to learn appropriate behavior for use during successful transition between activities. The subject began to put materials away and transition to the next activity without incident. The following procedures and effects support this result. Dramatization of the story, "I Am Mad," provided the subject with a kinesthetic imprint of the story. This helped the subject to understand his reactions to anger. Using the file cards to record his schedule provided the subject with a visual imprint of the changes required of him each day and prepared him for the frequency of daily transitions.

At the conclusion of treatment, other behavioral changes also were noted. The subject was completing more assignments (e.g., math papers and journal entries). The treatment appeared to assist the subject in developing confidence in academic situations.

Chapter 4

Summary, Conclusions, and Recommendations

This section provides a concise overview of all aspects of this study. The summary and conclusions discuss characteristics pertinent to identifying ADHD, suggests specific intervention strategies, and documents the value of drama education.

Summary and Conclusions

Medical and psychological history documents a variety of terms used to describe children suffering from symptoms of hyperactivity, inattention, and impulsiveness. These terms include: Minimal Brain Damage, Minimal Brain Dysfunction, Hyperkenetic Reaction of Childhood, and Attention Deficit Disorder (Goodyear & Hynd, 1992; Henker & Whalen, 1989; Silver, 1990). The contemporary term describing this disorder is ADHD (APA, 1987). ADHD is a disability that impacts all aspects of a child's life — family relationships, social interactions, and academic successes (Silver, 1990). Children affected by ADHD have trouble completing tasks and socializing with others both at home and at school. Henker & Whalen (1987) describe children who may be at risk because they exhibit behaviors that are symptomatic of ADHD. "They can't sit still; they don't pay attention to the teacher; they mess around and get into trouble; . . . they are rude; they get mad when they don't get their way; . . . " (p.216).

The form found in Appendix A is included in this study to assist teachers with identification of children affected by ADHD using the diagnostic criteria set forth by the American Psychiatric Association

(1987). ADHD is a medical diagnosis; therefore, the information from this form should be shared with the child's parents, and the child's parents should provide the information to the child's physician for diagnosis.

There appears to be no explanation for the chronic and pervasive behaviors children diagnosed with ADHD exhibit (Jesshke, 1988; Parker, 1990). Past research indicates that ADHD results from neurological factors (Parker, 1990; Silver, 1990). Research supports using a multi-modal approach to assist ADHD affected children medically, educationally, psychologically, and behaviorally (Education Committee of CH.A.D.D., 1988; Nemeth, 1990). Medication is the single most effective treatment and improves the characteristics of 75 percent of children affected by ADHD (Education Committee of CH.A.D.D., 1988; Johnson, 1988).

Teachers and parents must be educated and understand effective management of the educational and social needs of ADHD affected children (Parker, 1990, Silver, 1990). The form Parent to Teacher presented in Appendix B was developed by this author for the purpose of gathering specific information from parents about their child's specific needs. To assist teachers and parents with helping the ADHD affected child achieve success in the classroom, this study includes teaching strategies suggested by Goldstein & Goldstein (1987) and learning techniques recommended by the Education Committee of CH.A.D.D. (1988). Some of these strategies and techniques that were used in this study include: following a daily schedule; using encouragement and

praise; providing emotional warmth from both teachers and peers; utilizing small group learning; surrounding the subject with good role models; and communicating with the school psychologist and parents.

The objective of this experiment was to determine the contribution of drama education to the acquisition of social competencies and improvement in control of behavior for a child affected by ADHD. This experiment introduced role-playing to the subject's teachers and parents as an effective technique for teaching this child how to initiate social play and how to begin to interact with others in a social situation. Role-playing appropriate behavior for each transition enabled the subject to understand his feelings and provided practice for acceptable reactions to transitions between activities.

During this study, the teachers documented procedural validity for both the subject's enhanced social competencies, and the subject's ability to make successful transitions between activities. This provided a positive correlation between treatment and results. Because the procedural validity measures indicated clear differences in the subject's social interactions with others and successful transitions between activities, this author believes that the improved control over behavior and enhanced socialization skills are attributed to the drama education treatment.

The subject's parents and teachers are pleased with the changes that they witnessed in the subject's behavior and are committed to continued use of the methods and procedures established by this study.

Their goals are to continue to enhance the subject's interpersonal and teamwork skills and to improve the subject's adaptation to transitions in his life both in and out of the classroom.

Recommendations

The following recommendations include a discussion of the educational implications and limitations of this study.

Educational Implications. The needs of ADHD affected children may be met within the regular classroom as long as accommodations for the student's learning and behavioral difficulties are considered. Accommodations may involve revising expectations that recognize the student's disability, implementing behavior management techniques, and seeking child and family services from professionals or support groups.

From a practitioner's point-of-view, the fact that this study showed that role-playing correlates positively with improved behavior and enhanced social skills is evidence for including drama education in curricula planning. An important question becomes, what can teachers do to provide opportunities for children affected by ADHD to experience drama education? Berghammer et al. (1991) offers two suggestions: 1. use drama education for all students to practice social skills at a developmentally appropriate level in a meaningful and purposeful context, and 2. use drama education in the classroom to role-play solutions to meaningful problems and to practice critical thinking skills by comparing and contrasting various views.

Limitations of the Study. Limitations of this study lie in the single case experimental design. In the future, it would be useful to replicate the use of drama education as an intervention technique to help other ADHD affected children learn about themselves and others. Further research also is needed to determine:

1. if similar results could be obtained with other exceptional children;
2. if the skills acquired during drama education generalize to other situations;
3. if any teacher can be a successful facilitator of drama education; and
4. if drama education should be included in the curricula planning for all children to practice social skills and role-play solutions to problems.

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Appendix A

The following form was developed by this author to assist teachers with documenting symptoms of ADHD. It lists the symptoms of ADHD (APA, 1987), provides a scale to rate the severity of the symptoms, and offers additional information for obtaining data reflective of the whole child.

DSM - III - R Diagnostic Criteria for Attention Deficit-Hyperactivity Disorder

Name _____ Age _____

Completed by _____ Date _____

Symptoms	Rarely	Sometimes	Often	Almost Constantly
1. Fidgets, squirms or seems restless.				
2. Has difficulty remaining seated.				
3. Is easily distracted.				
4. Has difficulty waiting for turns.				
5. Blurts out answers.				
6. Has difficulty following instructions.				
7. Has difficulty sustaining attention.				
8. Shifts from one uncompleted task to another.				
9. Has difficulty playing quietly.				
10. Talks excessively.				
11. Interrupts or intrudes on others.				
12. Does not seem to listen.				
13. Often loses things necessary for tasks.				
14. Often engages in dangerous actions.				

ADDITIONAL INFORMATION

Describe: Beginning Development, Demonstrated Development, Strong Demonstrated Development

Intra/Interpersonal Relationships _____

Body Control _____

Environmental Awareness _____

Levels of Cognitive Knowledge:

Math _____ Science _____ Social Science _____
Reading _____ Language _____ Music _____
Drama _____ Art _____ Physical Education _____

Appendix B

The following 2 pages present a form for teachers to use during an initial conference with parents of ADHD affected children. The form was developed by this author as an interview guide and for use as a permanent record of parental responses to specific questions about the child.

Parent to Teacher

Attention Deficit - Hyperactivity Disorder

Fill out responses and share with your child's teacher

1. What distractions cause problems?

   sound _____movement _____physical touch _____visual _____other _____

2. What learning situations are positive?

   large group _____small group _____individual _____other _____

3. Is one location in the classroom more conducive to learning?

   near the teacher _____front, back, isle _____near friend _____other _____

4. What are effective, positive reinforcements?

   notes _____stickers _____verbal _____hug _____other _____

5. Are there "warning signs" that indicate a problem or a "blow up" is coming? _____

_____

_____

6. Is "time out" an effective discipline technique? If not, what techniques do you use?

_____

_____

7. How does your child react to change in routine? _____

_____

_____

8. What social activities is your child interested in? _____

_____

_____

9. How does your child relate to other children?

   very well_____ as most this age do _____ poorly _____

10. Does your child know he/she has been diagnosed with ADHD? _____

11. How does your child feel about this?

open/accepting _____ fearful _____ashamed _____ resentful/closed _____

12. What does your child know about ADHD? _____

_____

_____

13. Does your child take medication related to ADHD? _____

what kind _____

how much _____

how often _____

any side effects _____

14. What are your goals for your child this year? _____

_____

_____

15. Do you have any concerns about school?

content areas _____labels_____social interactions _____

organizational skills _____other _____

16. How much communication do you want as a parent?

daily _____weekly _____monthly _____journal _____

only when there is a problem _____

Appendix C

Howard Gardner's research and findings remind us that children have intra/interpersonal intelligence, bodily-kinesthetic intelligence, spatial intelligence, logical-mathematical intelligence, musical intelligence, and linguistic intelligence. His research suggests what young children should be doing. He emphasizes that appropriate assessment includes more than measuring isolated facts, and that the use of standardized tests during the first years of school ignore the marvelous abilities of children and doom some children to failure before they discover who they are and what they might become. He feels that assessment should be used for understanding each child's abilities and needs (Bayer, 1993).

The following four pages present the *Whole Intelligence Development* Progress/Assessment Model that was used as a means of measurement in this study. The original model was compiled by Gretta Berghammer, Associate Professor of Child Drama, at the University of Northern Iowa, Cedar Falls, Iowa. It is based upon the research and findings of Howard Gardner. The model we present was reprinted, and the rating scale was added by this author with permission from Gretta Berghammer.

WHOLE INTELLIGENCE DEVELOPMENT
Progress/Assessment Model

Name of Student:

Name of Observer:

Rating Scale

Rarely
Sometimes
Often
Almost Constantly

INTRA/INTERPERSONAL INTELLIGENCE									
Demonstrates self-esteem by sharing ideas and feelings.									
Demonstrates self-esteem and respect for others through cooperative interaction (planning,playing).									
Listens to ideas of others.									
Watches efforts of peers with respect and enthusiasm.									
Demonstrates intellectual risk-taking by a willingness to explore new ideas and try new things.									
Articulates both verbally and non-verbally appreciation for the work of others.									
Shows increased abilities to deal with both praise and constructive criticism of own behavior.									
Begins to show individual preferences and ability to talk about personal choices.									
Assumes role of leader.									
Assumes role of follower.									
BODILY-KINESTHETIC INTELLIGENCE									
Uses body parts and/or whole body in doing imitative actions.									

Demonstrates body control.									
Demonstrates comprehension through body movement.									
Demonstrates original, imaginative ideas through movement.									
Moves through different kinds of environments.									
Uses the senses as a motivation for movement.									
Creates, through movement, a narrated experience.									
Demonstrates non-verbal communication through movement and gesture.									
Manipulates objects (large) during play.									
Manipulates objects (small) during play.									
Moves in a variety of ways.									
SPATIAL INTELLIGENCE									
Responds to concrete stimuli with an imaginative response.									
Gives evidence of understanding that something can stand for something else (symbolic thought).									
Creates objects with the imagination and without the presence of actual materials.									
Listens to sounds and words and visualizes objects, environments, and events within the mind.									
Provides group with original ideas.									

Demonstrates an understanding of self-space.									
Shares combined space during activities.									
Uses the senses as basis for visual thinking.									
Uses memory to recognize objects, people and places.									
Responds imaginatively to music, sounds, and colors.									
Responds to sensory stimuli, especially sights, sounds, and textures.									
LOGICAL-MATHEMATICAL INTELLIGENCE									
Demonstrates basic understanding of the ordering of events through participation in sequence/add-on activities.									
Demonstrates basic understanding of the order of events in a story read or told.									
Predicts patterns and actions.									
Begins to see cause and effect relationships.									
Performs with objects.									
MUSICAL INTELLIGENCE									
Demonstrates sensitivity through movement to rhythm, tempo and levels of energy.									
Produces imitative sounds and/or speech.									
Creates imitative sounds.									

Demonstrates through imitative sounds sensitivity to pitch, tonal quality.									
LINGUISTIC INTELLIGENCE									
Uses sense memory to generate verbal response.									
Creates dialogue.									
Uses language only to make a point, explain.									
Creates appropriate speech in response to motivational stimuli.									
Uses the voice to express different moods and emotions.									
Uses the voice in choric work.									
Uses words to produce strong sensory or action suggestions.									