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Children with attention deficit hyperactivity disorder and the role of the elementary school counselor

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Abstract

Ryan is eight years old and in second grade. His teacher is concerned that he is missing out on what is occurring in the classroom because of his behavior. Ryan is frequently out of his seat and disturbing other children. When the teacher gives directions, he doesn't appear to be listening. Assigned tasks are usually not completed. Ryan usually doesn't think before he acts, and often blurts out at inappropriate times. His teacher has the feeling that he wants to do well, even though he is in trouble much of the time.

CHILDREN WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER AND THE ROLE OF THE ELEMENTARY SCHOOL COUNSELOR

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Ryan is eight years old and in second grade. His teacher is concerned that he is missing out on what is occurring in the classroom because of his behavior. Ryan is frequently out of his seat and disturbing other children. When the teacher gives directions, he doesn't appear to be listening. Assigned tasks are usually not completed. Ryan usually doesn't think before he acts, and often blurts out at inappropriate times. His teacher has the feeling that he wants to do well, even though he is in trouble much of the time.

Molly's parents are worried because they don't know what to do with her. It is the second month of school and the teacher has already called them about Molly's behavior in the classroom. They admit that this 9-year-old is very tiring to live with because they always have to "get after her about everything". They have given up requiring her to do chores because it is easier to do it themselves. She doesn't sit still at dinner time, so going out to a restaurant is a disaster. Her

father reports that she seems truly mystified when she gets into trouble. It's as if she can't help herself, even though she surely knows the rules by now. She doesn't seem to learn by her own mistakes, and punishment seems to roll off her back. Her mother has also noticed that other children don't stay long when they come over to play, and that Molly doesn't get invited to play at anyone else's house very often. She argues with other children, and wants to do things her way. This is the same pattern of interaction she has with her siblings.

These hypothetical cases describe what teachers and parents say about children who are often diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). ADHD is the most recent diagnostic label for children presenting significant problems of attention, impulse control, and overactivity (Barkley, 1990).

Throughout the 20th century, ADHD has received various labels which reflect the evolution of thought about the

importance of either the causes or the symptoms of the disorder. While the characteristic symptoms of inattention, impulsivity, and hyperactivity have not changed since early descriptions, the disorder has been renamed more than 20 times in the past 90 years (Barkley, 1981). Initially, until well into the 1950's, children exhibiting these symptoms were thought to have some sort of brain damage or injury, and were labeled MBD, or Minimal Brain Dysfunction. However, it was found that many children who sustained brain injuries did not display the hyperactive behaviors, and conversely, very few hyperactive children had any evidence of structural brain damage (Wicks-Nelson & Israel, 1991). As a result, there was a shift away from an emphasis on the causes of the disorder, to an emphasis on the specific behaviors. In the 1960's, hyperactivity was seen as the primary problem and the disorder was renamed Hyperactive Child Syndrome. In the 1980's, hyperactivity gradually was seen as less central to the

syndrome, so it was known then as Attention Deficit Disorder with two distinct categories: ADD with hyperactivity and ADD without hyperactivity (American Psychiatric Association, 1987).

As researchers began to see an even greater distinction between children with and without hyperactivity, the DSM-III-R (American Psychiatric Association, 1987) reclassified Attention Deficit Disorder (ADD) to Attention Deficit Hyperactivity Disorder (ADHD) and attention problems without accompanying impulsivity and hyperactivity were categorized as UADD, or Undifferentiated Attention Deficit Disorder (Barkley, 1990). According to the DSM-III-R (American Psychiatric Association, 1987), to be diagnosed with ADHD a child has to display eight out of fourteen characteristics, with onset before the age of 7, and the symptoms need to be developmentally inappropriate for the child's mental age.

According to Barkley (1990), the conceptualization of ADHD is continuing to undergo changes. There are new theories developing at this time that stress the importance of motivational deficits rather than attentional deficits. The effects of this reconceptualization will probably not be seen for the next 8-10 years.

Likewise, the information about the etiology of ADHD is changing as research continues. Even though the exact cause of ADHD has not yet been discovered, researchers do know that it is a neurologically based problem (Barkley, 1990). There is strong evidence for a genetic mechanism of inheritance of dysfunction in the orbital-limbic pathways of the frontal area of the brain. This impairment is what is thought to give rise to the primary features of ADHD (Barkley, 1990). There is little, if any, evidence that ADHD is caused by social or environmental factors such as poor parenting, diet, family socioeconomic status or familial discord. These factors can

affect ADHD children's behavior, but do not cause it (Hunsucker, 1988).

Attention Deficit Hyperactivity Disorder currently affects approximately 5 to 6% of children between 4 and 16 years of age (Barkley, 1990). The proportion of males versus females manifesting the disorder varies across studies from 2:1 to 10:1 (American Psychiatric Association, 1987), with an average of 6:1 most often cited for clinic-referred samples of children (Mash & Barkley, 1989).

Because ADHD is one of the most prevalent childhood disorders and is usually diagnosed after children are in school, an informed school counselor is in an advantageous position to help in the diagnosis and management of children with ADHD. The purpose of this paper is to identify the characteristics of children with ADHD, as well as the elementary school

counselor's role in working with children, as well as with their parents, and teachers to maximize success in these children's lives.

Primary Characteristics of Children with ADHD

As the label implies, attentional problems plague children with ADHD. Parents and teachers often say these children do not listen, fail to finish work, do not concentrate, often lose things, and are easily distracted. The difficulties are most often seen when the children are in situations that require attention to dull, boring, repetitive tasks (Barkley, 1990). Therefore, inattentiveness is not present at all times. Indeed, many teachers report that children diagnosed with ADHD do well in novel situations and when given one-to-one attention. Likewise, parents are confused when their child manifests inattention when it comes to independent homework or chores, but can engage in an activity they enjoy, watch T.V., or play video games for hours. This paradox is actually part of

the disability. T.V. is not boring or dull, and is, in fact reinforcing to the way ADHD children think because it switches rapidly from scene to scene, and idea to idea (Durbin, 1993; Rosemond, 1990). According to Rosenthal and Allen (1980), ADHD children are no more distractible than normal children by extraneous stimulation. Instead, the problem appears to be one of diminished persistence of effort in responding to tasks that have little intrinsic appeal or minimal immediate consequences for completion (Barkley, 1990).

A second primary behavioral characteristic of children with ADHD is impulsivity, defined by Barkley (1990) as "a deficiency in inhibiting behavior in response to situational demands" (p. 41). In real life situations, ADHD children don't seem to think before acting. They may be involved in frequent risk taking because of their inability to consider the possibility of negative or dangerous consequences. In school

they have trouble waiting their turn in a game or being able to stay in line when passing to a new activity. They are often the ones to blurt out answers in class before the question from the teacher is completed. Children with ADHD have a very difficult time in situations in which they are encouraged to delay seeking gratification, such as working toward a long term goal. Parents often notice the same behaviors when ADHD children are made to wait for something they want to do. They incessantly badger the parents and appear to be very demanding and self centered. A person uninformed about ADHD would probably describe these children as rude, childish, and irresponsible even though they are behaving in a way that comes naturally to them (Luk, 1985).

Excessive or developmentally inappropriate levels of activity, either motor or vocal, is another primary characteristic of children with ADHD (Barkley, 1990). At school, these children may squirm or be out of their seat more

than other students, may wander about the classroom, and may have some part of the body in motion even when attending (Luk, 1985). These children appear to have difficulty regulating their actions according to the wishes of others or the demands of the particular situation.

It is important to remember that children can vary in the degree to which they manifest any of the behaviors characteristic of ADHD. Not only can behaviors differ from child to child, but there can be extreme variability in the same child from day to day, or even hour to hour (Iowa Department of Education, 1991). Teachers and parents may incorrectly attribute this inconsistency to a lack of effort and motivation, rather than a symptom of the disorder.

Fluctuations of the primary symptoms can be exaggerated by the children's environment. In situations where there are fewer demands by caregivers for ADHD children to restrict their behavior, they will behave more like normal

children. The greater the complexity of the tasks that these children are asked to do, the more deviant the behavior will be. The more novel the situation, the less the primary behaviors will be seen. ADHD children are more likely to pay attention to brightly colored or highly stimulating educational materials. The time of day or fatigue can affect the degree to which ADHD symptoms are exhibited. These children tend to have better performance in the morning than the afternoon (Hunsucker, 1988). In environments that supply immediate reinforcement and punishment, ADHD symptoms will diminish. Gordon (1991) describes ADHD children as having "a thick barrier between themselves and life's many consequences" (p. 29), so that reinforcements and punishments need to be meted out often and consistently to continue their positive effect on behavior.

Secondary Characteristics

ADHD children often have other difficulties besides the primary problems with inattention, impulsivity and

overactivity. As a group, these children have more than their share of medical, emotional, academic, and social problems. Not all ADHD children will have all of these problems, but many display them to a greater extent than is expected in normal children (Barkley, 1990).

Academic Problems

One of the secondary characteristics of children with ADHD is poor academic performance. Although ADHD does not affect intelligence as ordinarily defined and measured by intelligence tests (Wender, 1987), most of the clinically referred ADHD children are performing poorly at school (Barkley, 1990). Children with ADHD are not unable to learn, but the difficulties with impulsivity and inattention can make them "unavailable" for learning (Gordon, 1991). To succeed in school, children must have the ability to concentrate and attend for reasonable lengths of time, sometimes to tasks that are repetitive and boring. They must have the ability to

stick to a task even if it is difficult, and work much of the time without direct supervision. These behavioral expectations do not allow for the special difficulties experienced by children as a result of ADHD. The typical school environment tends to make ADHD children's problems greater by requiring them to do tasks in direct conflict with their nature (Parker, 1988). Therefore, many will fall short in their academic performance. Learning problems tend to snowball. Poor performance is often met with criticism, which in turn results in a negative opinion of self. When this occurs, motivation to do well decreases, which results in giving up (Wender, 1987).

ADHD can also overlap with learning disabilities (LD). Lambert & Sandoval (1980) found that 42.6% of the hyperactive subjects they studied could be classified as learning disabled. Depending on the criteria used to define learning disabilities, research studies have differing conclusions. According to a

study by Barkley (1990), between 19 and 26% of ADHD children have at least one type of LD, either in math, reading, or spelling. Most studies indicate a relationship between the two, though the nature of that relationship is not yet clear (Iowa Department of Education, 1991)

Social Functioning

In the area of social functioning, children with ADHD have many problems. Whalen and Henker (1985) estimate that misconduct and social problems are as high as 80% in children with ADHD. These children are often bothersome, intractable, and socially awkward. In the classroom and at home they are disruptive and have difficulty complying with requests. They appear to have little awareness as to how their misbehaviors lead to negative consequences. They tend to blame outside influences for their troubles, but yet show true remorse for misbehaviors incurred earlier (Hunsucker, 1988). This can be confusing to parents, particularly when the remorse does not

lead to a change in behavior. With siblings and peers they are often talkative and initiate social exchanges. Even though they seem to be adept at making friends, they typically have a hard time keeping them (Whalen & Henker, 1985). Their social style with other children can be bossy, demanding, loud, aggressive, and forceful, which does not win friends and influence them in a positive way. Studies have found ADHD children receive greater peer rejection than other children (Klein & Young, 1979).

Negative Self-Esteem

Children with ADHD are at risk of developing low self-esteem and negative self-perceptions (Barkley, 1990; Gordon, 1991; Hunsucker, 1989; Wender, 1987; Wicks-Nelson & Israel, 1991). With their difficulty in controlling their own actions, trouble with parents and teachers, and rejection from other children, it is no wonder that ADHD children may end up regarding themselves as stupid, unlikable, disobedient and a

failure (Hunsucker, 1989). ADHD children also have a greater likelihood of developing depression, particularly as they get older (Johnston, Pelham, & Murphy, 1985).

The Counselor's Role

In a comprehensive guidance program, the counselor works as part of a team with others in the school to help all children complete the "developmental tasks necessary to achieve a sense of personal fulfillment and lead a satisfying life in a contemporary society" (Vernon & Strub, 1990). Without appropriate intervention, the majority of children with ADHD will not achieve this goal. Serious academic failure and the inability to conform to the demands of the environment produce a debilitating outcome for these children. Over time they lose any sense of competence. Ultimately, they lose their sense of self-worth. These outcomes have a staggering social and economic impact. Many do not complete high school, and less than 5% complete college

(Weiss & Hechtman, 1986; Barkley, 1990). Henker and Whalen (1989) recommended that school counselors, working within the developmental framework, need to reinforce ADHD children's zest for living, spontaneity and creativity, while helping prevent school failure and loss of self-esteem. Retrospective studies of adults with ADHD repeatedly pointed to the positive effect a caring adult made in their lives. Others indicated how helpful it might have been if someone would have explained the various aspects of their problem to them (Garber, Garber & Spizman, 1990).

Even though the elementary school counselor is not a therapist, nor has the time to act in that capacity, she or he is in a position to act as both a coordinator and consultant who works with parents, teachers, and other professionals to be of significant value in helping with interventions beneficial to ADHD children (Lavin, 1991). According to Wender (1987), the earlier appropriate interventions are initiated, the more likely

the child will be successful. Interventions can be accomplished through individual and group counseling with ADHD children, and through consultation and education of parents and teachers.

Individual Counseling

In addition to any therapeutic benefits from the techniques used in individual counseling, the relationship ADHD children develop with the counselor is important. If these children can see the counselor as a significant adult who understands their disability while emphasizing their strengths, it can offset the criticism they receive for their shortcomings (Weaver, 1992).

The focus of individual counseling includes helping children understand ADHD, teaching self-regulation skills and academic strategies, and helping with self-esteem development. It is important for ADHD children to know about the disorder they have. Learning more about their particular

problems is what Levine (1987) calls demystifying the problem. When children develop some insight about where they are most and least successful, they can participate in planning strategies for improvement with the counselor and teacher.

One technique that can be used is bibliotherapy. There are many books that can help explain ADHD and some skills to cope with it. For younger children, the counselor could use Jumpin' Johnny Get Back to Work by Gordon (1991), or Otto Learns About His Medication by Galvin (1988). Upper elementary children could read Keeping A Head In School: A Student's Book About Learning Abilities and Learning Disorders by Levine (1990), or Putting on the Brakes by Quinn and Stern (1991). Depending on the reading ability of the child, the books could be read together, or the counselor could assign very short segments to be read alone. Discussion of what was read would include answering any questions a child might have.

Self-regulation skills training has had modest success in helping children with ADHD (Whalen, Henker, & Hinshaw, 1985). Three techniques are commonly taught: Self-monitoring, self-reinforcement and self-instruction. With self-monitoring, children learn to observe and record their own behaviors. For example, they can record the frequency of on-task behavior during seat work. Children can then award themselves points that can be exchanged for reinforcers. This is called self-reinforcement. The third technique, self-instruction, is when children make statements to themselves to help focus and guide their behaviors on a task (Wicks-Nelson & Israel, 1991).

Academic strategies that the counselor can help children with are organization and study skills. Upper elementary students who have homework can benefit from a special notebook with two pockets, one for assignments, the other for completed work. The counselor can also help children to learn to think about what is needed for a task, to break

tasks down into smaller components and to take a short break after each segment is completed. Children can also be taught to move on to easier parts of a task, or a substitute task, while waiting for a teacher's help (Garber, Garber, & Spizman, 1990).

Along with educating children about ADHD and academic strategies, the counselor can help children develop positive self-esteem. When working with ADHD children it is important to call attention to the their strengths. Anytime the counselor works with these children is an opportunity to do this. The counselor could also plan a consistent time each week to drop in to the classroom of the ADHD children so they could show their talents. Rational Emotive Therapy can teach children to minimize their self-defeating outlook and to acquire a more realistic, tolerant philosophy of life (Bernard & Joyce, 1984).

Small Group Counseling

Working with children in a small group has several benefits: the counselor can serve more children in the amount of time available, children will realize that they are not alone in having ADHD, and children have the opportunity to learn from their peers.

There are many topics that can be covered through the small group format that will benefit children with ADHD. These include education about ADHD, social skills training, problem solving, anger control, conflict resolution, and behavioral management techniques (Barkley, 1990; Henker & Whalen, 1989; Guevremont, 1990). These topics can be introduced in a small group setting by using techniques such as role playing, puppetry, game playing, song writing, and storying writing.

An ongoing multi-age support group for students with ADHD might be an outgrowth of the small group. Older

students, with the help of the counselor or other adult, could be in a leadership position for the maintenance of the group. In this way, new students in the group would benefit from the experiences of the older students.

Consultation

In the role of a consultant, the school counselor will work with parents and teachers to help them deal more effectively with ADHD children. Because there is no cure for ADHD, it is imperative that the environment for ADHD children meet their needs (Weaver, 1992). It is not enough to just "treat" these children with medication and expect them to change their behavior. If parents and educators of ADHD children are to have any effect at all in changing the negative outcomes that result from this disability, it will be necessary for them to change their belief system. Parents and teachers need to understand that the child is in trouble and not the cause of trouble. They also need to understand that people and

situations can affect impulsive and hyperactive behavior, self-control and attention span. Parents and others involved with ADHD children need to be knowledgeable about the disorder and change how they interact with these children and what they expect and demand of them (Barkley, 1990; Gordon, 1991; Hunsucker, 1988; Parker, 1988). The elementary school counselor is a position to educate parents and teachers, to help them with classroom and home strategies, and to foster collaboration among all involved in the care of ADHD children (Lavin, 1991).

Parents

When a child has first been diagnosed as ADHD the counselor needs to assess the parent's knowledge about the disorder, how they are feeling about it, and what other agencies or professionals are involved with the family. The answers to theses questions, and a knowledge of community

resources, will help the school counselor know how to work with each child's parent or parents.

Every parent will react somewhat differently to the diagnosis of ADHD. Some will feel frustrated and upset, others will be defensive and angry. Many will feel overwhelmed and seem unable to handle more problems. Denial is a common response that can occur in conjunction with blaming the school for all their child's problems (Parker, 1988). Some parents may feel very resentful toward the school if they have had little or no assistance in handling problems with their children before or after diagnosis of ADHD. Often parents will feel a great deal of stress and guilt about their child's home and school behavior (Freidman & Doyal, 1987). Still other parents will be happy to finally put a name to why their child is experiencing difficulty. Regardless of parents' reactions, a caring, knowledgeable counselor can help provide a supportive atmosphere for parents by listening to concerns about their

child. The counselor can help them to see that ADHD is a neurobiological problem and is not the result of parental failure (Bowley & Walther, 1992).

Counselors can help to educate parents about ADHD. This can be accomplished in several ways. Depending on the resources available, the counselor could direct parents to established parent training and support groups such as C.H.A.D.D. (Children with Attention Deficit Disorders), or professionals who work with parents individually. The counselor could also work with parents at the school by offering a parenting class about children with ADHD (Pond & Gilbert, 1990). The counselor could also develop an information and resource packet which could include materials about ADHD, a bibliography of appropriate books on ADHD, and a list of local sources of assistance.

Encouraging the parents to become involved in planning for their child's education and behavior management can help

parents learn more about ADHD and foster a home-school continuity for helping the child. The counselor can help to set up a daily goal card that is filled out by the student and teacher and sent home to the parents. Parents can monitor assignments, report difficulties, assist the teacher and counselor in modifying tasks, and provide home-based rewards for appropriate behavior and academic progress (Parker, 1988). Parent participation helps to facilitate consistency across settings, and promotes generalization of in-school gains to the home environment and vice versa (Barkley, 1990).

Teachers

Parents are not alone in their need for a better understanding of ADHD. The summary from the Bureau of Special Education Attention Deficit Disorder Study Group Iowa Department of Education, 1991) stated that "while ADHD is undefined in state and federal regulations as a specific handicapping condition, there is growing recognition of the

potential need for special education for at least some individuals with ADHD, and the need for educational accommodations for all of these individuals" (p. 12). Many teachers have not had specific training in how to make accommodations in their classroom for children with ADHD. The results of a study by Hawkins, Martin, Blanchard and Brady (1991), clearly indicated a gap between the amount of training educators receive in ADHD, and the prevalence of ADHD in the school population.

School is the place where ADHD problems often become apparent. According to Gordon (1991), the typical classroom is a terrible place for ADHD children because they are expected to do what they have trouble doing; attending, organizing, and controlling their actions for hours per day. Affected children benefit from an increased awareness of the characteristics and treatment of ADHD on the part of school personnel.

The counselor's first step in assisting teachers is helping to identify children with ADHD. School counselors cannot diagnose ADHD, but can become familiar with the signs and symptoms. The counselor could then make a tentative hypothesis of ADHD through observation of the child, and information from the teachers. Once ADHD is suspected, the elementary counselor can advise parents of the need for further examination and help direct them to the appropriate professionals (Bowley & Walther, 1992).

The next step in helping children experience success at school, is to educate teachers about the nature, course, outcome, and causes of ADHD. The school counselor is in a position to provide or facilitate inservice training for teachers so they can learn to work effectively with students having difficulty with attention problems (Desselle, 1989; Texas Education Agency, 1992).

Even though there are many ways in which a teacher can learn to structure a classroom to best meet the needs of the ADHD student, it is important for the school counselor to remember that teachers may become frustrated and possibly discouraged when trying to work with ADHD students (Freidman & Doyal, 1987). The counselor will not only need to be supportive of children and parents, but also of teachers as they struggle to deal with ADHD children. Validating the teacher's feelings and encouraging his or her efforts are as necessary as offering help with classroom accommodations and management strategies.

Conclusion

ADHD affects the behavior, education, emotional health, and social adjustment of millions of American children. Without appropriate intervention, these children are more likely to be at risk of dropping out of school, of being unemployed as adults, and of displaying antisocial behavior

(Barkley, 1990). On the other hand, early identification, accurate assessment, and consistent interventions and management techniques are necessary if these problems are to be addressed (Hawkins, Martin, Blanchard & Brady, 1991). The literature on ADHD stresses that the people involved in the care, treatment, and education of the child with ADHD work together and maintain a high level of communication. The elementary school counselor can help link the family, physician, and school, so that the child will have the best opportunity to avoid the cumulative effects of low self-esteem and chronic school failure (Bowley & Walther, 1992).

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