ADHD
Attention Deficit-Hyperactivity Disorder
and
Learning Disabilities

P.A.D.D. Family Support Group,
Phone: 01-2883766

Members of INCADD
Irish National Council
of ADD/ADHD Support Groups

By Larry B. Silver, M.D.
ADHD: Attention Deficit-Hyperactivity Disorder and Learning Disabilities
by Larry B. Silver, M.D.

INTRODUCTION

Because of federal and state legislation-and initiatives by local school systems-you are increasingly likely to have in your classroom a child or adolescent with Attention Deficit Hyperactivity Disorder (ADHD) and/or Learning Disabilities (LD). Yet it is possible that your college or graduate school education did not cover this type of child; or you may need to be updated on the subject. As the classroom teacher, you can play a key role in helping children with ADHD and/or LD and their families. It is hoped that this booklet will aid you in understanding many aspects of such a child and how you can help him or her in the classroom and with other school-related activities. This booklet is only a guide. The child's doctor and the professional staff of your school system will help you with specific planning.

OVERVIEW OF THE PROBLEMS

Between 10 and 20 percent of all school-age children have learning disabilities. Of those with LD, about 20 to 25 percent also have ADHD. LD and ADHD are two separate problems; however, they occur together so frequently that it is useful to consider them related. In addition, most children and adolescents with LD and/or ADHD develop emotional, social, and family difficulties. These are the result of frustrations and failures experienced with family and peers and at school. They are not the cause of the academic problems but rather the consequence.
WHY DOES EVERYONE HAVE A DIFFERENT NAME FOR THIS CHILD?

As these children were recognized and studied, different names were applied to describe their condition. Many of these terms are still used by different professionals, sometimes confusing you and the parents. Prior to the 1940's, children who had difficulty learning or paying attention were considered either mentally retarded, emotionally disturbed, or culturally disadvantaged. The research of the 1940's identified a fourth group of children, those who had difficulty because of the way their nervous systems worked. Their problems were described as "neurologically based". Initially this disorder was called Minimal Brain Damage; later the name was changed to Minimal Brain Dysfunction. These terms referred to children with neurologically based academic problems, hyperactivity, a short attention span, impulsivity, and emotional problems. Since the 1940s, this group of problems has been a separate focus of study. First the neurologically based academic problems were identified and named to reflect the primary area of skill difficulty: dyslexia for reading problems, dysgraphia for writing problems, and dyscalculia for math problems. Later, the term Learning disability was applied to the types of learning difficulties that underlie the skill problems. Hyperactivity, distractibility, and impulsivity were initially called Hyperkinetic Disorder of Childhood (thus, the "Hyperactive child"). By 1980, the name had been changed to Attention Deficit disorder (ADD) to emphasize that the attentional problem was the major issue, not hyperactivity. In 1987, the name was changed again to reflect the reality that all of the problems were significant. The newest term is Attention Deficit-Hyperactivity Disorder (ADHD). The latest terms, therefore, are ADHD and LD. If the professionals you work with use others, do not be confused. They are not seeing a different problem;
they are merely using older terms to describe it. If a student in your classroom has ADHD and/or LD, he or she will probably have emotional problems (anger, sadness, anxiety, or disruptive behavior), social problems (immaturity, poor relationships with children his or her own age), and/or family problems. To understand this child or adolescent you must look at his or her difficulties from all angles to see how they affect every aspect of life - not just in school but with other children and with the family. It is clear that learning disabilities do not just interfere with reading, writing, and math. They affect, for example, recess and physical education - baseball, basketball, and hopscotch. They also may interfere with art, music, or related activities. Likewise, ADHD does not interfere with only classroom behavior; it affects peer-related behavior and family life as well. You must become knowledgeable about these students so that you can help them inside and outside the classroom. You must learn how to set up successful experiences for these students and how to maximize strengths rather than magnify weaknesses.

WHAT ARE LEARNING DISABILITIES?

To review the meaning of learning disabilities, it is useful to break down learning into its four steps. The first step is the process of recording information in the brain (input). Next, this information must be organized and understood (integration). Once recorded and understood, information must be stored, to be retrieved later (memory). Finally, information must be communicated from the brain to people or translated into action in the environment (output). Learning disabilities can occur in any of these four areas.
INPUT DISABILITIES

Information enters the brain through all five senses. In learning, the important ones are seeing (visual) and hearing (auditory). Input does not refer to the physical condition of the eye or ear, but rather to how the brain processes what is heard or seen. The term used for this central process of perceiving the world is perception. Thus, a child might have a visual or an auditory perception disability.

Visual Perception Disabilities: Your student might confuse visual inputs, reversing letters or have difficulty distinguishing “d” and “b” and “p” and “q”. “Was” might be read as “saw” or “dog” as “god”. This confusion might show up in written work, copying designs or in doing tasks that require the eyes to guide the hands (visual-motor task). A student with visual-motor problems might find it difficult to catch or hit a ball, do puzzles, use a hammer and nail, jump rope, etc. There are other types of visual perception problems. Some students might have trouble organizing their position in space or might confuse left and right. Others might have a “figure-ground” problem, the inability to focus on a particular thing rather than on the entire background. For example, when reading, they might skip words or lines. Judging distance is another visual perception task. A student might misjudge depth and bump into things or fall off a chair. He or she might seem careless or might knock a drink over because the distance is misjudged and the hand gets there too soon.

Auditory Perception Disabilities: Some children have difficulty distinguishing subtle differences in sounds. Your student might misunderstand what you say and respond incorrectly, confusing words like “blue” and “blow” or “ball” and “bell”. Someone might ask, “How are you” and the child might answer, “I’m eight years old.” The “are” is heard as “old”. Difficulty with auditory “figure-
“ground” is another problem. A child might hear activity in the hall or other children talking in the room. You begin to speak to the class, but you might be well into what you are saying before the child realizes that it is your voice (the figure) to be listened to rather than the other sounds (the background). Such children appear to never pay attention, but if you call the child’s name first and make eye contact, you may see improvement. Some children cannot process sound inputs at a normal speed. Their slower processing of sound is called an auditory lag; they seem to miss part of what you are saying. You find that you intuitively speak slower if you want this child to understand.

INTEGRATION DISABILITIES

Once recorded, information must be placed in the correct order (sequencing), understood in the context in which it is used (abstraction), and integrated with all other information being processed (organization). Some children might have difficulty in one or more of these areas, but these problems may be primarily with either visual or auditory input. Thus, a student with auditory sequencing disability may do well with visual sequencing. Sequencing Disabilities: Your student might read or hear a story and understand it, but in retelling or writing the story, he or she may confuse the sequence of thoughts or events, starting in the middle, going to the beginning, and then to the end. The child might see “23” but write it as “32”. Spelling errors are common—all of the letters are there but in the wrong sequence. The child might be able to memorize a sequence such as the months of the year. But, if you ask what comes after September, he or she may not be able to use the sequence. Such children might find it necessary to start with January and word their way up to September in order to answer. Such a child might hit a ball but run to third base rather than first base. Abstraction Disabilities:
Most people understand the meaning of some words or phrases based on how the words are used. There is a difference in the meaning of the word "dog" if one says "the dog" or "you dog". Some children have difficulty understanding these differences. They appear to follow the literal meaning of the word. They misunderstand jokes, puns, and sayings. And, at times, they believe people are talking about them because they take what people say or do too literally.

Organization Disabilities: Some children can process each piece of information but have difficulty integrating the pieces into a whole picture. Perhaps they can answer the questions at the end of the chapter, but they're unable to explain what the chapter was about. They might do well on multiple-choice questions (where one has to recognize only pieces of information) but poorly on essay-type exams. These children might have difficulty organizing their lives. Their lockers or desks are a mess; their notebooks are crammed with papers in the wrong place; their lives are disorganized.

MEMORY DISABILITIES

Once information is recorded and integrated, it must be stored so that it can be retrieved later. In general, there are two types of memory: short-term and long-term. Short-term memory is what you remember as long as you are paying attention to it (for example, remembering a phone number from the information operator: you might forget it if someone talks to you before you dial the number). After many repetitions, you will retain the information; this is called long-term memory. It refers to repeated and stored information that you can retrieve by thinking about it. A student's short-term memory disability may affect visual inputs of information but not auditory, or vice versa. Such a child might go over a spelling list and have it down pat (he or she is attending to it); yet, the next morning it is forgotten.
You might explain a math concept in school and the child knows it (is attending to it) yet goes home that night and forgets how to do the problem. In contrast, this same child might remind you of something that he or she did two or three years ago in detail. There is no problem with long-term memory. However, he or she may need to go over something ten or more times to learn it, whereas a child without this problem might be able to learn it in three to five repetitions.

OUTPUT DISABILITIES

Information is communicated through words (language output) or through muscle activities such as writing, drawing, gesturing (motor output). Your student might have one or both of these output disabilities.

Language Disabilities: there are two types of oral language that we use, spontaneous (when we initiate a conversation) and demand (when someone asks us a question). With spontaneous language, we organize our thoughts and find the words we want before we speak. With demand language, we must do all of this as we speak. Your student might have a demand language disability. What is confusing is that when the child speaks (spontaneous language), he or she sounds normal. Yet, when asked a question (demand language) - "What did you do today?" "Will you answer question five?" - the child will respond with "huh?" or "What?" or ask you to repeat the question. If the child replies, he or she might ramble or have trouble finding the right words. Motor Disabilities: Your student might have difficulty using his or her large muscles (gross motor disability) or small muscles (fine motor disability). A child with gross motor problems may be clumsy, stumble, have trouble walking, running, climbing, or riding a bike. He or she might have difficulty with dressing, buttoning,
tying, or zipping. The child with fine motor disabilities will have difficulty coordinating a team of small muscles, such as those in his or her dominant hand when writing. Such children will have slow, poor handwriting. They will hold the pencil or pen differently and their hands will tire from the work needed to write. The child might say, "My hand does not work as fast as my head is thinking.

IN SUMMARY

It is important for you to understand these students' areas of learning disabilities as well as their abilities. You must appreciate how these disabilities interfere with academic and other school activities as well as with sports and relationships with other children. You must learn how to help your students build on their strengths rather than let them become frustrated by focusing on areas of weakness. If you are uncertain about a student's strengths and weaknesses, ask the special education professionals in your school system.

WHAT IS ATTENTION DEFICIT-HYPERACTIVITY DISORDER?

Three types of behavior characterize individuals with ADHD. Your student might demonstrate one, two or all three of these.

He or she might be hyperactive, distractible, and/or impulsive. Only one is necessary to be diagnosed as ADHD. For example, a child can be distractible and/or impulsive, but not hyperactive.

Hyperactivity: This child may not be running around the room or "climbing the walls". But he or she will appear to be in constant motion: fingers or feet tapping, legs swinging, or body wiggling in the chair. The child may be up and down at the desk or
doing several things at once when playing or working. It is important to understand that there can be two different types of hyperactivity. One, caused by a particular situation, may go away when the situation changes or the child learns to cope with the stress. The other, ADHD, is caused by neurological differences in the child's brain. The history of the problem helps the doctor decide if the hyperactivity, distractibility, and/or impulsivity is due to an emotional problem or to ADHD. Anxiety or depression can cause hyperactivity in children, adolescents, and adults, but this form of hyperactivity is not ADHD. If the behaviors began at a particular time in the child's life (for example, in third grade), think of anxiety. If the behaviors began after a life crisis (for example, parents' separation or divorce, birth of a sibling), think of depression. If the behaviors are chronic (present throughout the child's life) and pervasive (present throughout each day), the diagnosis is probably the neurologically based form of hyperactivity, or ADHD.

**Distractability:** We allow all input to enter our brain from all of our senses. We then monitor this input at a lower level of our brain, relaying only important information to the thinking part of the brain. Because of this ability, we can be in a noisy place yet hear perfectly our own name if it is called. We can drive home and suddenly realize that we were daydreaming and do not know how we got home (our brain screened important information and sent it to the necessary areas for reaction). Without this ability our mind would be cluttered with information. Some people have difficulty filtering out unnecessary inputs. They are easily distracted and have a short attention span. Others have problems with visual inputs - they may be distracted by the movements of people, cloud formations, or birds. Difficulty with sound inputs - people talking, car horns beeping, telephones ringing - is another
problem. As with hyperactivity, anxiety or depression can cause a person to be distractible. Again, if the problem has been chronic and is pervasive, it is most likely neurologically based, or ADHD. Impulsivity: Some children seem to have a short fuse. They do not stop to think before they act. They say something and are sorry they said it before they finish. They answer the teacher's questions before he or she finishes asking. They get angry and yell, throw, or hit. They do not learn from experience because they cannot pause long enough to reflect before they act. These children get into behavioral difficulties at home, with friends, and at school. As with hyperactivity or distractibility, anxiety or depression may cause a child to be impulsive. If the impulsivity has been chronic and pervasive, clinical evidence supports that it is neurologically based, or ADHD.

IN SUMMARY

If your student has ADHD, he or she might be hyperactive, distractible, and/or impulsive. Thus, it is possible that you might have a calm, underactive child who has been diagnosed as ADHD because he or she is distractible and/orimpulsive. It is important that this diagnosis be made by a trained professional and be established only if the behaviors are neurologically based - a conclusion usually based on the history of the problem and whether it has been chronic and pervasive. ADHD is not a learning disability. It is a related disorder often found in children who have learning disabilities. Treatment for ADHD will not correct any learning disabilities; they must be treated separately.
WHAT ARE THE EMOTIONAL, SOCIAL AND FAMILY PROBLEMS?

Often the ADHD and/or LD are missed by the school. Gradually, the child becomes frustrated and begins to fail, possibly getting into behavioral difficulties. Then, the school staff might call in the parents and explain that their child is not learning because of an emotional problem caused by family problems. It is essential that we distinguish between emotional, social, and family problems that cause academic difficulties - and emotional, social, and family problems resulting from a school difficulty that has been unrecognized or recognized and not fully treated. The cases are different: each child responds to an entirely different approach.

Emotional Problems: These problems are associated with academic difficulties. Often, friendship and family problems exist as well, these children feel frustrated. They experience failure and feel inadequate, bad, or dumb. Teachers and parents might call them lazy or bad for not doing better in school. Some may act out these feelings, becoming aggressive, getting into fights, or striking out impulsively. Others may internalize their feelings, becoming depressed, withdrawn, or showing a poor self-image. Still others may channel their feelings into their bodies developing headaches or stomachaches. If a child wakes up on a school morning with a stomachache and the parents let him or her stay home, only to find that by midmorning he or she is no longer sick, it is possible that the child was not playing games. He or she might have been anxious about going to school. The anxiety went away, as did the stomachache, with the realization that he or she did not have to face school. For some children, these bodily concerns may be more vague, with complaints of backaches or pains in their hands or legs. Other children handle their feelings by
learning to manipulate their world to avoid stressful situations - by becoming, for example, the "class clown". they know just what to do at the wrong time to the right person to disrupt a lesson plan or to be kicked out of class. If successful, they will avoid having to read or do math or whatever else they sense they cannot do well.

Social Problems: As mentioned earlier, the child's LD and/or ADHD does not just interfere with reading, writing, and math. The conditions affect sports, activities with other children, and family relationships - all aspects of life. It is not surprising that these children may not get along with children their own age. If they cannot do successfully what others do, they may choose to play with younger children or withdraw into the house. Some find that they are less likely to be embarrassed or experience failure if they control their world. They do only what they want to do, only the way they want to do it. They appear bossy or in need of being in control. For reasons we do not yet understand, some children, adolescents, and adults with LD and/or ADHD have difficulty recognizing social cues and using social skills. They miss the look on another person's face or the body language that suggests they are being annoying, and they blunder on. They may act inappropriately or seem immature and alienate others.

Family Problems: When one member of a family is hurting, everyone feels the pain. When a child experiences frustrations and failures, parents may also be frustrated trying to understand or help this child. As parents, they may feel like failures. Initially, they might have difficulty accepting that their child has a disability. they might deny the problem. But even when they have accepted it, they might still be angry that this happened or feel guilty about having caused it. It takes time to accept and
learn to live with each of these feelings. Brothers and sisters also may be affected. They may not have been informed about their sibling’s problems or the reason for everyone’s concern. Without facts, they might fantasize about the situation and worry: Is it my fault? Will I get it? Will he die? Some will be angry with the double standard: How come I have to make my bed and he doesn’t? How come when he does it he gets away with it, and when I do it I get punished? Others may feel guilty. They are told to be more understanding and accepting, yet they feel angry at the sibling’s behavior or at all the attention he or she gets.

IN SUMMARY

Unless the underlying LD and/or ADHD are recognized and treated, the emotional, social, and family problems may become worse. If these problems are treated by individual, behavioral, group, or family therapy without also addressing the reasons for the problems (the child’s disability), no progress will be made. You cannot put out a fire by blowing away the smoke. Nor can you help a child gain a better self-image when he or she is experiencing failure daily in school.

HOW DO YOU KNOW FOR SURE IF IT’S ADHD OR LD?

Because of the many types of possible learning and/or emotional problems a child or adolescent might have, it is best if the effort to pinpoint the cause is done by a team of professionals. This effort may take place in a doctor’s office or clinic, or in an educational, mental health, or other location. The child’s doctor may participate, directly, request the evaluations, or receive the results from the team, and help the parents to understand what was discovered. To review, learning disabilities are diagnosed through
studies by psychologists and special educational experts. The first studies assess the child’s intellectual ability and potential. The next assess the current level of achievement in each academic area. If there is a discrepancy between the child’s ability and performance, a third set of studies is done to clarify whether learning disabilities exist. If such disabilities are found, a speech pathologist might do further studies in the language areas. Or an occupational therapist might examine the sensory-motor and motor areas. Each school system has its own definition of LD; thus, a child might be diagnosed as LD by a professional or private team and not be recognized as such by the school. ADHD is identified primarily through evaluating the child’s history and from observations made by parents, teachers, and others. Again, the hyperactivity, distractibility, and/or impulsivity should be both chronic and pervasive for an ADHD diagnosis. As part of an evaluation for ADHD or LD, the doctor should do a complete physical examination. Other professionals might examine your child if your doctor feels it is needed. In some cases, a neurological examination may be necessary. An EEG (brain wave test) is not usually done unless there is a suggestion of a seizure disorder. A child psychiatrist or other mental health professional might evaluate the child to assess his or her level of psychological and social functioning and to uncover any emotional conflicts or stresses. Ideally, the full team should meet to discuss its findings and to establish a diagnosis and a treatment plan. One or more members of the team should meet with the classroom teacher to explain the findings, diagnosis, and treatment approaches. It is more likely, however, that one person from the team will meet with you about your role in working with this student.
WHAT CAN THE CLASSROOM TEACHER DO?

As you know, we are discussing a group of problems often found together. Children and adolescents can have LD and/or ADHD. Each is a different disorder. Most who have LD and/or ADHD develop emotional, social, and family problems secondary to (as a result of) these main problems. It is important that you assess which of these disorders your student has and which ones he or she does not have.

YOUR ROLE IN LEARNING DISABILITIES

Work with the student's special education team. You know the different types of learning disabilities and the terms used. Find out the areas where your child is learning disabled; also discover his or her learning abilities. You need to know these strengths so that you can help the child build on them. Work closely with the parents and your school professionals to develop the necessary interventions. Is the child receiving the best level of care? Some children respond best to being taught in a regular classroom and "pulled out" during the day for special educational help. Others do better in a special resource room from which they are "mainstreamed" into a regular classroom for part of the day. Still others need to be in a full-time, self-contained, special education program. The goal in each of these settings is to teach through your child's strengths while helping him or her to overcome or to make up for the disabilities. Since most learning-disabled children will become learning-disabled adolescents, it will be necessary to plan programs for each upcoming school year. Be sure that you understand the special educational studies done on the children in your class. Whenever possible, help them compensate for their disabilities by working on their weaknesses while building on their strengths. For example, if you have a child with fine motor disabilities but good
language strengths, you could call on this child to answer questions or discuss things in class but perhaps not ask him or her to write on the blackboard. Similarly, if you are going to put math problems or words on the board that have to be copied, you might photocopy them for this child. With written work, you might focus less on handwriting and more on content. Conversely, if you have a child with good motor skills but a demand language disability, you might ask him or her to write on the blackboard; or you might let this child volunteer to speak but not ask him or her a question in class. Always build on strengths rather than frustrate the child by focusing on weaknesses.

The same approach should be used for recess, crafts, and gym activities. Children with fine motor disabilities may have difficulty with sports that require skills in this area (baseball, basketball, etc.), but they may do well with sports that use gross motor abilities (soccer, hockey, swimming, etc.). If you are doing an art or crafts activity with drawing and cutting, don’t ask such children to do the fine cutting; they could, however, hand out the materials or squirt the glue. By knowing a child's strengths and weaknesses and by building on the strengths, a potential social or peer disaster could instead be a success. Parents need to do the same thing at home when selecting chores or seeking after-school activities. You can help by explaining their child’s strengths and weaknesses and by helping them learn how to choose the activities that build on these strengths rather than magnify the weaknesses.

YOUR ROLE IN ADHD

If the child’s doctor feels that the hyperactivity, distractibility, and/or impulsivity stem from a specific nervous-system-based disability, not anxiety or depression, he or she might prescribe medication. If a child in your classroom is placed on medication,
your observations are important. The child's doctor may want to discuss your observations to decide on the dosage or frequency of medication. Remember that some children are hyperactive; you will look for a decrease in these children's muscle activity. In distractible children, you will look for a decrease in distractibility and an increase in attention span. Still others are impulsive; in them you will look for an increase in reflectivity. Such medication will not necessarily help the learning disabilities; but it can make the child more available for learning. These medicines do not cure the ADHD. Instead, they appear to work by correcting for a lack of certain necessary brain chemicals in the nervous system. Parents should be aware that these medicines do not "drug" or "alter" the brain of the child. They make the child "normal" by correcting for a neurochemical imbalance. Either the child's own doctor or the school physician will discuss the prescribed medication with you, how it works, and its possible side effects. Be sure to ask questions so that you understand the medication. Since ADHD is a neurologically based disorder, it is important that children on medication take it as prescribed. The same hyperactivity, distractibility, and/or impulsivity that causes problems in school will cause problems at home, with other children after school, on weekends, or anytime. Medicine should be used when needed during school holidays and summer vacation, if the hyperactivity, distractibility, and/or impulsivity will prevent the individual from being successful or from behaving properly. Some doctors place children on "drug holidays", when they do not take medication, in order to avoid the development of long-term side effects. While research has shown that these time periods off medication are not necessary for most children, many doctors still continue to recommend "drug holidays".
YOUR ROLE WITH THE EMOTIONAL, SOCIAL AND FAMILY PROBLEMS

The emotional problems are due to the stresses this child or adolescent experiences. The first goal is to minimize these stresses. Often the emotional problems minimize or disappear once the school recognizes the LD and sets up a program to help, once the parents rethink their relationship based on their new knowledge - and, if needed, once medication is begun. In some cases, however, the emotional problems have become so ingrained, they continue to exist. Special mental health assistance may be needed in these situations. ADHD children usually respond best to structure and clearly defined expectations and limits. Sometimes, developing a system that lists acceptable and unacceptable behaviors along with rewards and consequences will work. You may want to seek help from your special services team if the behavioral problems are too disruptive or if they make the child unavailable for learning. If the emotional problems persist after the proper programs for the disabilities have been developed, the child might need therapy. If the child has internalized the problems, he or she might need individual, psychoanalytically oriented psychotherapy. He or she would see a therapist once or twice a week, and the parents also would receive counseling. And it is helpful for the therapist to communicate with you. If the problems are related more to the child's style of interacting with others, group therapy or a social skill learning group might be needed. If he or she has developed certain patterns of behavior, behavioral therapy might be recommended. If the difficulties are mainly concerned with family issues and interactions, family therapy might be appropriate. The social problems can best be addressed by helping the child experience
successes using the approaches discussed earlier. Sometimes social skills can be taught by a professional in a group setting.

**WHAT ABOUT THE FUTURE?**

LD and ADHD are disabilities that impact all aspects of life. For most children with LD, the disabilities will last a lifetime, whereas up to 50 percent of ADHD children will be so affected. With the right help, most LD children overcome or learn to compensate for the problems. They will progress in school and strive toward reaching their potential. There will be many programs available for them throughout school and after. But without the necessary help, they will fall behind and become increasingly unavailable for learning. They will continue to struggle and the families may be less than successful in helping their child. With the appropriate help, ADHD children can function without hyperactivity, distractibility, or impulsivity. They can develop confidence and a feeling of control and success. Your role is extremely important. For these special students to be successful in the classroom you must be informed. You must be this student’s advocate, actively seeking the recognition and help he or she needs. You must use your knowledge to maximize their academic and emotional growth. With your help, and by working with other professionals and the family, these children will overcome their disabilities and succeed in life as healthy, happy, productive people.
REMEMBER

1. LD and ADHD are related disorders but are not the same. Each must be diagnosed and separately treated.

2. Work with your special education team.

3. You must know all aspects of your student's disabilities and abilities. Only with this knowledge can you help.

4. Always build on strengths rather than magnify weaknesses.

5. Be assertive. Get the information and help you need from the professionals in your school system. Ask questions. Work with the parents to get the needed help. Work closely with the student's physician.

Children with Attention Deficit Disorders (C.H.A.D.D.)
1859 North Pine Island Road, suite 185
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1990, CIBA-GEIGY
Where do you get help? H.A.D.D. Formally known as Hyperactive Children's Support Group Ireland was established in 1980. In 1997 the group changed its name to include Attention Deficit Disorder with or without Hyperactivity and the objectives of the group are as follows:

* help and support children and their families.
* create a better understanding of the developmental difficulties children face because of Hyperactivity and ADD/ADHD
* ensure adequate resources are available to support the needs of children who are hyperactive and ADD/ADHD
* provide an information sharing and support network for families.
* improve diagnostic services.
* organise meetings/conferences/workshops
* provide a parent/professional link
* Encourage research into Hyperactive and ADD/ADHD

For further information please contact
or send a 9 x 6.5 72p stamped, self-addressed envelope to:

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(67) Dr. Brian Toone, Department of Psychiatry, Kings College Hospital, London SE5, U.K.


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(83) Dr. Geoff Kewley, Learning Assessment Centre, 2nd Floor, 44 Springfield Road, Horsham, West Sussex RH12 2PD, U.K. Telephone Number: 01403 240002. Fax Number: 01403 260900.

Professor Michael Fitzgerald.
GOAL CARD PROGRAM (I)Intermediate Grades One - Eight

Child's Name ___________________________ Teacher ___________________________
Grade _______________ School ___________________________ Home Room _____________

Goal Card

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<th>Week of</th>
<th>MON</th>
<th>TUE</th>
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Teacher's Initials

Rating Scales

N/A = Not Applicable
0 = Losing, Forgetting or Destroying Card
1 = Terrible 2 = Poor
2 = Poor 3 = Better
3 = Fair 3 = Good
4 = Good
5 = Excellent
Try For ______ Points

Child's Name ___________________________ Teacher ___________________________
Grade _______________ School ___________________________ Home Room _____________

Goal Card

<table>
<thead>
<tr>
<th>Week of</th>
<th>MON</th>
<th>TUE</th>
<th>WED</th>
<th>THU</th>
<th>FRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Paid attention in class</td>
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<tr>
<td>2. Completed work in class</td>
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<td>3. Completed homework</td>
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<tr>
<td>4. Was well behaved</td>
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<tr>
<td>5. Desk &amp; notebook neat</td>
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</table>

| Totals |     |     |     |     |     |

Teacher's Initials

Rating Scales

N/A = Not Applicable
0 = Losing, Forgetting or Destroying Card
1 = Terrible 2 = Poor
2 = Poor 3 = Better
3 = Fair 3 = Good
4 = Good
5 = Excellent
Try For ______ Points
**Conners' Abbreviated Teacher Rating Scale (ATRS)**

**CHILD'S NAME**

**COMPLETED ON**

**BY**

**INSTRUCTIONS:**
Please consider the last _____ (day, week, month) only in filling out the checklist. Check the appropriate box for each item: Not at all, Just a little, Pretty much, or Very much, which best describes your assessment of the child. Please complete all items.

<table>
<thead>
<tr>
<th>Observation</th>
<th>Degree of Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Restless or overactive</td>
<td>Not at all</td>
</tr>
<tr>
<td>2. Excitable, impulsive</td>
<td></td>
</tr>
<tr>
<td>3. Disturbs other children</td>
<td></td>
</tr>
<tr>
<td>4. Fails to finish things he start-good attention span</td>
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<tr>
<td>5. Constantly fidgeting</td>
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<tr>
<td>6. Inattentive, easily distracted</td>
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<tr>
<td>7. Demands must be met immediately-easily frustrated</td>
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<tr>
<td>8. Cries often and easily</td>
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<tr>
<td>9. Mood changes quickly and drastically</td>
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<tr>
<td>10. Temper outbursts, explosive and unpredictable behavior</td>
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</tr>
</tbody>
</table>

**Comments**

**Total Score:**

Reprinted with permission of C. Keith Conners, Ph.D.
The ADD Hyperactivity Workbook for Parents, Teachers, and Kids

ADAPT

Accommodations Help Students with Attention Deficit Disorders

Children and youth with attention deficit disorder (ADD) often have serious problems in school. Inattention, impulsiveness, hyperactivity, disorganization, and other difficulties can lead to unfinished assignments, careless errors, and behavior which is disruptive to one’s self and others. Through the implementation of relatively simple and straightforward accommodations to the classroom environment or teaching style, teachers can adapt to the strengths and weaknesses of students with ADD. Small changes in how a teacher approaches the student with ADD or in what the teacher expects can turn a losing battle into a winning one for the child.

Examples of accommodations which teachers can make to adapt to the needs of students with ADD are grouped below according to areas of difficulty.

**Inattention**

- place student in quiet area
- seat student near good role model
- seat student near window
- increase time between desk changes to promote assignmnet work
- assign assignments of written work to be completed with time allowance
- ensure long assignments into smaller parts so student can see the work
- assist student in selecting short-term goals
- give assignments one at a time to avoid work overload
- return fewer correct responses for praise
- reduce amount of homework
- instruct student in self-monitoring using charts
- written instructions with oral instructions
- provide near earplugs in classrooms
- give clear, concise instructions
- work to involve student in lesson presentation
- allow student to stay on task, i.e., private signal

**Motor Activity**

- have student to stand at times while writing
- provide opportunity for seat breaks, i.e., run, stretch, etc.
- provide breaks between assignments
- supervise closer during transition times
- require student to check own work, if performance is elevated and careless
- give extra time to complete tasks, especially on tests with low motor tempo
- provide reassurance and encouragement
- frequently compliment positive behavior
- avoid assigning work in non-threatening manner if student shows nervousness
- review instructions when giving new assignments to make student understand
- compose directions to make sure student understands
- look for opportunities for student to display leadership role in class
- conference frequently with parent to keep student on track and in school
- provide frequent check for homework
- give more time talking to students who seem bent up or display large anxiety
- point out in class or in anger, encourage student to verbalize, and to use calming behavior. Emphasis on stress relief in getting angry

**Academic Skills**

- set up behavior contract with student
- monitor behavior of others
- hand raising calling out
- call on only when hand is raised in appropriate manner
- praise student if hand raised to answer question

**Compliance**

- praise compliant behavior
- ignore minor misbehavior
- use token reinforcement
- set up behavior contract with student
- set up behavior contract with student
- monitor behavior of others
- hand raising calling out
- call on only when hand is raised in appropriate manner
- praise student if hand raised to answer question

**Socialization**

- provide appropriate behavior
- monitor social interactions
- set up social behavior goals
- role play situations
- pump appropriate social behavior
- other verbally or with pictures
- encourage cooperative learning skills in other subjects
- provide small group social role playing
- allow student to take leadership role in group
- assign social responsibilities to student in small group or others observe studies in a positive light

Page 84

*Attention Deficit Accommodation Plan for Teaching*

Hedy C. Parker, Ph.D.
### GOAL CARD PROGRAM (P)rimary

#### PRESCHOOL & KINDERGARTEN

**CHILD'S NAME** ___________________________ **TEACHER** _______________________

**WEEK OF** ____________________________

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1 = TRY HARDER

2 = BETTER

3 = GREAT JOB

My GOAL IS TO GET ____ POINTS

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### GOAL CARD PROGRAM (P)rimary

**CHILD'S NAME** ___________________________ **TEACHER** _______________________

**WEEK OF** ____________________________

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My GOAL IS TO GET ____ POINTS
The ADD Hyperactivity Workbook for Parents, Teachers, and Kids

Home Token Program

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Imipramine (Tofranil)

Imipramine is a Tricyclic antidepressants (TCA) along with Amitriptyline, Desipramine, Clomipramine and Nortriptyline, and is licensed for the treatment of depression although their efficacy in children and adolescence is still in doubt. Imipramine is also licensed for the treatment of bed wetting in children. They have however shown clinical efficacy in the treatment of hyperkinetic disorders, improvement is rapid and often as striking as with stimulants. They are thought to act by increasing the availability of neurotransmitters, especially serotonin and noradrenaline.

They may have particular value in children with co-existing mood disorders, a family history of mood disorder and response to antidepressants, associated bed wetting, tic disorder, obsessive symptoms and when Ritalin has not been effective or has had adverse effects, for example insomnia. In addition in older children where Ritalin may be associated with abuse potential.

Dosage: Tablets/syrup (Imipramine)
2-3.5 mg/kg in two to three divided doses, in order to minimise the cardiotoxicity. Initial dose in 10-15 year old 25mg increasing as necessary by 10-25 mg increments.

Side Effects:
Common and transient: Sedation
Dry mouth, difficulty passing urine, dyspepsia, constipation.
Rare: Decreased seizure threshold therefore caution if history of epilepsy. May also cause elated mood in susceptible people. Cardiac arrhythmias.
These tablets are potentially fatal in overdose and all medication should be kept out of reach of all children.

Monitoring:
Baseline ECGs need to carried out before treatment and after the dosage has risen above 3mg/kg. (stop the medication if the ECG shows Heart rate >130/min, QRS interval > 50% plus baseline, PR interval > 0.21 sec) For this reason they are generally regarded as second line treatment for hyperkinetic disorder.

Medication is always in addition to others treatment modalities and needs to be reviewed on a yearly basis to see if your child still needs medication.
Please fill in the side effect rating scale and you can discuss these with the doctor on your next visit.

If you are worried or would like advice please call ____________________________
on ____________________________

Information discussed with parents/guardian
Signed ____________________________ Date ____________________________
(Please enter copy into child’s file)
Clonidine (Catapres)

Clonidine is an anti-hypertensive drug and it is used to treat high blood pressure. In recent times clonidine has been found to be effective in treating children with hyperkinetic disorder. As yet however, it is not licensed for use in this condition in Britain. It is particularly useful in children who have hyperkinetic disorder along with any of the following:

- Tic disorders
- Extreme overactivity
- Oppositional or conduct disorders
- Hyperactivity
- A poor response to stimulant drugs

Clonidine is often used on its own or in combination with stimulant drugs (eg. Ritalin) when problems arise such as rebound effects, difficulty sleeping or bedtime difficulties, low frustration tolerance, impulsiveness and emotional swings. However, combination therapy needs particularly close specialist medical supervision, including regular cardiac monitoring.

**Dosage:** (tablets) Usually start with 25 micrograms at night increasing by 25 microgram increments to 100-200 micrograms if tolerated. Withdrawal should be gradual to avoid hypertensive reaction.

**Monitoring:**

Baseline Blood Pressure is required.

**Side effects**

The most important potential side effect is **lowering of blood pressure** (fainting and dizziness). This can be minimised by starting the drug at low doses and increasing it gradually. Suddenly stopping the medication may cause a rebound increase in blood pressure. This may be very serious and therefore it is important to stop the drug slowly under medical supervision. Although the risk of either of these side effects may be small, it is very important to follow the doctor's advice closely and not to alter the medication without first speaking with your doctor or the child psychiatrist.

Other side effects are:

- Dry mouth
- Headache
- Dizziness
- Constipation
- Feeling high
- Sleepiness
- Restless at night
- Depression
- Fluid retention
- Rash
- Feeling sick
- Slow pulse
- Feeling unusually sensitive to cold

Most of these side effects are mild and often pass off on their own after a short time. Please fill in the side effect rating scale and you can discuss these with the doctor on your next visit.

If you are worried or would like advice please call ____________________________

Information discussed with parents/guardians
Signed ____________________ Date __________________________
DEXAMPHETAMINE (Dexedrine)

Background information: Dexamphetamine is a central nervous system stimulant, a class of medication most commonly used in the treatment of hyperkinetic disorder (Attention deficit/hyperactivity disorder). It is thought to act by its effect on the part of the brain responsible for maintaining attention and arousal (The Reticular activating system). It is associated with improving hyperactivity, restlessness, impulsivity, aggression and socially inappropriate behaviour in many children. Dexamphetamine is licensed for use in children over 5 years.

Dosage: Short acting tablets administered by mouth (Dexamphetanine Sulphate 5 mg). Dexamphetamine starts to work after 20 minutes and lasts about 5 hours. Because of this the effective dosage will need to be repeated every 4-5 hours to maintain the positive effects during the waking hours. We commonly start with 2.5mg twice a day and increase at weekly intervals by 2.5-5 mg until the desired effect is reached. Some older children may need up to a total of 40mg. (Maximum =0.5-1.0 mg/kg per day)

Side effects:
Although many are listed not all occur in any one person and will be monitored closely by your doctor to minimise the effects.
Common: Loss of appetite, nausea
Less common: weight loss, abdominal pain
Rare but serious: Dizziness, mood changes and very rarely psychosis, abnormal loike movements, clinically significantly raised blood pressure and heart rate.
Most of these side effects are mild and often pass off on their own after a short time. Please fill in the side effect rating scale and you can discuss these with the doctor on your next visit. Dexamphetamine interacts with some medicines-please tell us, if your child is on any.

Monitoring: Any decision to commence the medication will have been made based on accounts of your child’s performance at school, home and assessment centre. After a six-week period significant improvements are seen and treatment continued we will review the child to see if medication is still required. We also recommend monitoring the child’s height, weight and blood pressure every three months.

If you are worried or would like advice please call ____________________________
on ____________________________

Information discussed with parents/guardians
Signed ____________________________ Date ____________________________ (Please enter copy into child’s file)
METHYLPHENIDATE (RITALIN)

Background information: Methylphenidate is a central nervous system stimulant, a class of medication most commonly used in the treatment of hyperkinetic disorder (Attention deficit/hyperactivity disorder). It is thought to act by its effect on the part of the brain responsible for maintaining attention and arousal. (The Reticular activating system). It is associated with a reduction in hyperactive, restless and impulsive behaviour in many children. The large volumes of research in the medical literature show that methylphenidate is effective and probably the most dependable medication for the treatment of children with hyperkinetic disorder. Methylphenidate is licensed for use in children over 6 years.

Dosage: Short-acting tablets administered by mouth (Ritalin 10 mg). We commonly start with 5 mg twice a day (morning and lunchtime) and increase at weekly intervals by 5 mg until the desired effect is reached (usually no more than a total dose of 45 mg). Methylphenidate starts to work after 20 minutes and lasts about 3-4 hours. Because of this, the effective dosage will need to be repeated every 3-4 hours to maintain the positive effects during the waking hours. Some children benefit from medication three times a day.

Side effects:
Although many are listed not all occur in any one person and they will be monitored closely by your doctor.
Common: Loss of appetite, nausea
Less common: weight loss, abdominal pain
Rare but serious: Dizziness, mood changes and very rarely psychosis, abnormal tic-like movements, clinically significantly raised blood pressure and heart rate.

Most of these side effects are mild and often pass off on their own after a short time. Please fill in the side effect rating scale and you can discuss these with the doctor on your next visit. Methylphenidate interacts with some medicines—please tell us, if your child is on any.

Monitoring: Any decision to commence the medication will have been made based on accounts of the child’s performance at school, home and assessment centre. If after a six-week period significant improvements are seen and treatment continued we will review your child to see if medication is still required.
Because methylphenidate may occasionally cause changes in the number of some of the cells which circulate in the blood we recommend each child has one blood test (full blood count) before starting treatment and one after three months. We also recommend monitoring the child’s height, weight and blood pressure every three months.

If you are worried or would like advice please call ________
on________

Information discussed with parents/guardians
Signed ___________________________ Date ____________ (Please enter copy into child’s file)