



Mindful
Continuing Education

Classifying and Mediating Attention Problems in Youth



About this Packet

As the world around us is changing at an exponential rate, so must the way we approach attention problems. Over the coming decade, we all will be called upon to play a role in doing something about the many individuals who have trouble learning and performing effectively at school. In responding to this call, it will be essential to have a broad understanding of what causes attention problems and what society in general and schools in particular need to do to address such problems.

This packet serves as a starting point for increasing awareness of assessment and treatment of attention problems. Included are excerpts from a variety of sources, including government fact sheets and the classification scheme developed by the American Pediatric Association.

Symptoms are discussed in terms of degree of severity. Interventions described range from environmental accommodations to behavior management to medication. Because the intent is only to provide a brief overview, also included is a set of references for further reading and a list of agencies that provide information on attention problems and interventions.

I. Classifying Attention Problems:

***Keeping the Environment in Perspective as a Cause of
Commonly Identified Psychosocial Problems***



- A. The Label**
- B. Environmental Situations and Potentially Stressful Events**
- C. Attention Problems and Motivation**

I. Classifying Attention Problems ...

A. The Label

Attention Deficit Hyperactivity Disorder is a disorder that includes a persistent pattern of inattention and/or hyperactivity-impulsivity in a person. There are three subtypes of ADHD including: ADHD Predominantly Inattentive Type, ADHD Predominantly Hyperactive-Impulsive Type, and ADHD Combined Type. It is important to know that ADHD is a neurological disability and people with this disorder have underdeveloped frontal lobes in the brain. This region of the brain that is underdeveloped is responsible for planning, impulse control, attention, reasoning, and working memory.

Attention Deficit Hyperactivity Disorder (ADHD) is one of the most talked about yet misunderstood disabilities in the schools. It has been estimated that 3-5% of children truly have one form of ADHD, yet some schools have a much greater percentage with an ADHD diagnosis.

Some students identified with ADHD have been misidentified. There are several reasons that a student may be identified ADHD, but do not actually have this disorder. It is often the first response a teacher might have to a student who misbehaves. A lack of discipline can exasperate behaviors that look like ADHD. A slow learner might not be paying attention due to content over his or her head. A gifted student may be inattentive, because the material is too easy and the student may already understand a concept and not want to listen to the teacher explain it again. Anxiety or depression can cause inattention. It is difficult to differentiate these other factors between ADHD. Several things should be ruled out before a diagnosis is made.

Is it ADHD? Look at our chart to see instances of normal activity and instances of hyperactivity.

DSM-5 Criteria

ADHD: Predominantly Inattentive Type

(Formerly referred to as ADD)

For a diagnosis of ADHD, Inattentive Type, the following criteria must be met:

1. Student must have 6 or more of the following criteria to a significant degree for at least 6 months (possible examples with each).
 - **Student does not give close attention to details and frequently makes careless mistakes.**
 - *Grades suffer due to not watching the signs in math.*
 - *Student regularly completes the wrong assignment.*
 - **Student struggles with maintaining attention in tasks or play activities.**
 - *Child needs reminded it is her turn in the game almost every turn.*
 - *Child starts playing with something and suddenly abandons the first activity to begin something new.*
 - **Often, student does not seem to listen when spoken to directly.**
 - *Child may have a blank look on his face while directions are being given.*
 - *When asked a question, he routinely says "what?"*
 - **The student will often not follow through on instructions or fails to finish schoolwork, chores, or duties. (This is not due to oppositional behavior or failure to understand directions).**
 - *Child starts an assignment, gets distracted, and forgets to finish.*
 - *Half of the dishes have been washed.*
 - **Student often loses things necessary for tasks or activities.**
 - *Student often needs to borrow pencil or paper from other students.*
 - *Child routinely leaves the book needed to complete a homework assignment at school.*
 - **Student has difficulty with organization of tasks and activities.**
 - *Time management may be a concern.*
 - *Backpacks and desks are stuffed full of papers.*
 - **Student is easily distracted by stimuli in the environment.**
 - *Child does not listen to teacher when she is near a noisy fan.*
 - *Pictures on the wall may pull his attention away from the teacher.*
 - **Student is often forgetful in daily activities.**
 - *Child accidentally leaves homework at home on a regular basis.*
 - *The student's backpack is missing and she does not know if she left it at school, the bus, or her friend's house.*

1. For a diagnosis of ADHD, Hyperactive-Impulsive Type, the student must have 6 or more of the following criteria to a significant degree for at least 6 months:
 - **Student often fidgets with hands or feet or tends to squirm in seat.**
 - *Student sits on feet and changes positions frequently while seated.*
 - *Student often has a paperclip or some random item in his hand that he plays with.*
 - **Student often leaves seat in which remaining seated is expected.**
 - *Student walks to the other side of the classroom to tell a student something.*
 - *Student sharpens pencil frequently, gets drinks of water, and generally seems to be wandering around the room often.*
 - **Student often runs about or climbs excessively in situations in which it is inappropriate.**
 - *Parents have difficulty keeping child from running through aisles while shopping.*
 - *People comment about the child being "hyper."*
 - **Student often has difficulty playing or engaging in leisure activities quietly.**
 - *Even board games are not a quiet activity for the child.*
 - *Child makes noises as he draws.*
 - **Student is often "on the go" or often acts as if "driven by a motor."**
 - *Child plays constantly and goes from one activity to another.*
 - *Child does not engage in down time frequently.*
 - **Student often talks excessively.**
 - *One story reminds her of another story and then another...*
 - *Other people often don't have a chance to respond before the subject has been switched.*
 - **Student often blurts out answers before questions have been completed.**
 - *Student does not raise her hand in class.*
 - *Student answers a wrong question.*
 - **Student often has difficulty awaiting turn.**
 - *Student will play before his turn in a game.*
 - *Child has an extremely difficult time waiting in a line.*
 - **Student often interrupts or intrudes on others.**
 - *Child jumps into conversations when adults are talking.*
 - *Child interrupts parents on the phone.*

ADHD: Combined Type

For a diagnosis of ADHD, Combined Type, the student must have met criteria for both types of ADHD for at least 6 months.

Tools used to help diagnose ADHD

A psychologist, psychiatrist, or medical doctor can diagnose ADHD. A psychologist or psychiatrist can easily rule out other learning problems, where a medical doctor can rule out other medical conditions. Communication between professionals and a thorough evaluation is essential.

- Review of available information.
 - **Educational Data** – look for grades, discipline records, attendance (It is important to look for teacher comments or other records that indicate a consistent pattern of problems from the early grades that have continued.)
 - **Educational testing data** – cognitive and academic assessments are important to rule out a learning disability or other learning problems.
 - Medical records to ensure the problems are not related to another medical disorder.
 - Diagnostic Tools (See [SPED testing](#) for more complete information)
 - **Clinical Interview** – A professional will discuss the symptoms with the parent or the student and ask questions related to the DSM-IV criteria.
 - **Rating Scales** – A rating scale will often be provided to parents, teachers, and the students to obtain information from multiple sources. The scales may be specific to ADHD or be a global rating scale that can focus on a wide range of problems. These scales are useful because they help to quantify the degree of the problem by comparing the student's symptoms to other children of the same age and gender.
 - **Observation** – Watching the child in her natural environment can help a professional see if she is displaying characteristics associated with ADHD. This usually occurs in the classroom, but it is good to see a child across settings and in less structured events such as recess or lunch.

Treatment

ADHD is a neurological disorder, but with proper treatments and parenting techniques the symptoms can be more manageable.

Treatment is usually the most successful when multiple treatments are utilized across different settings. These include:

- Structured classroom management
- Educating parents with a focus on appropriate discipline and limit-setting
- Tutoring
- Behavioral therapy for the child
- Stimulant medication – Concerta, Ritalin, Adderall, Dexedrine (used to stimulate the frontal lobes in the brain to make them work more efficiently).

References

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th edition. Arlington, VA., American Psychiatric Association, 2013.

I. Classifyin Attention Problems ...

A. The Label (cont.)

Study Raises Questions About Diagnosis, Medical Treatment of ADHD

A CLA study shows that only about half of children diagnosed with attention-deficit hyperactivity disorder, or ADHD, exhibit the cognitive effects commonly associated with the condition.

The study also found that in populations where medication is rarely prescribed to treat ADHD, the prevalence and symptoms of the disorder are roughly equivalent to populations in which medication is widely used.

Part of the explanation may lie in the common method for diagnosing the disorder. ADHD is an extreme on a normal continuum of behavior that varies in the population, much like height, weight or IQ. Its diagnosis, and thus its prevalence, is defined by where health professionals “draw the line: on this continuum, based on the severity of the symptoms and overall impairment.

Researchers also found surprising results regarding the effectiveness of medicine in treating ADHD. In contrast to children in United States, youth in northern Finland are rarely treated with medicine for ADHD, yet the ‘look’ of the disorder—its prevalence, symptoms, psychiatric comorbidity and cognition—is relatively the same as in the U.S., where stimulant medication is widely used. The researches point out that this raises important issues about the efficacy of the current treatments of ADHD in dealing with the disorder’s long-term problems.

“The continuous nature of liability to ADHD requires that we examine more carefully what environmental pressures may be leading to impairment, instead of broadening our diagnostic classifications even further.”

Smalley SL, McGough JJ, Moilanen IK, Loo SK, Taanila A, Ebeling H et al (2007) Prevalence and psychiatric comorbidity of attention-deficit/hyperactivity disorder in an adolescent Finnish population. *J Am Acad Child Adolesc Psychiatry* 46:1575–1583

I. Classifying Attention Problems ...

A. The Label (cont.)

A large number of students are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters have trouble behaving in classrooms; only a small percent have attention deficit or a conduct disorder. In some schools, large numbers of students have problems learning; only a few have learning disabilities. Individuals suffering from true internal pathology represent a relatively small segment of the population. A caring society tries to provide the best services for such individuals; doing so includes taking great care not to misdiagnose others whose "symptoms" may be similar, but are caused by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in ineffective ways. A better understanding of how the environment might cause problems and how focusing on changing the environment might prevent problems is essential.

Labeling Troubled and Troubling Youth: The Name Game

She's depressed.

*That kid's got an attention deficit
hyperactivity disorder.*

He's learning disabled.

What's in a name? Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens despite the fact that the problems of most

youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

Diagnosing Behavioral, Emotional, and Learning Problems

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing *person* pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

Many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature *versus* nurture biases in thinking about problems, it helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

A Broad View of Human Functioning

Before the 1920's, dominant thinking saw human behavior as determined primarily by person variables, especially inborn characteristics. As behaviorism gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment (Bandura, 1978). However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables. This is both unfortunate and unnecessary -- unfortunate because such a view limits progress with respect to research and practice, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

Toward a Broad Framework

A broad framework offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum (referred to as Type I problems). At the other end are problems caused primarily by pathology

within the person (Type III problems). In the middle are problems stemming from a relatively equal contribution of environmental and person sources (Type II problems).

Diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the person (P)
E	(E<--->p)	P
Type I problems	Type II problems	Type III problems
<ul style="list-style-type: none"> caused primarily by environments and systems that are deficient and/or hostile problems are mild to moderately severe and narrow to moderately pervasive 	<ul style="list-style-type: none"> caused primarily by a significant <i>mismatch</i> between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology) problems are mild to moderately severe and pervasive 	<ul style="list-style-type: none"> caused primarily by person factors of a pathological nature problems are moderate to profoundly severe and moderate to broadly pervasive

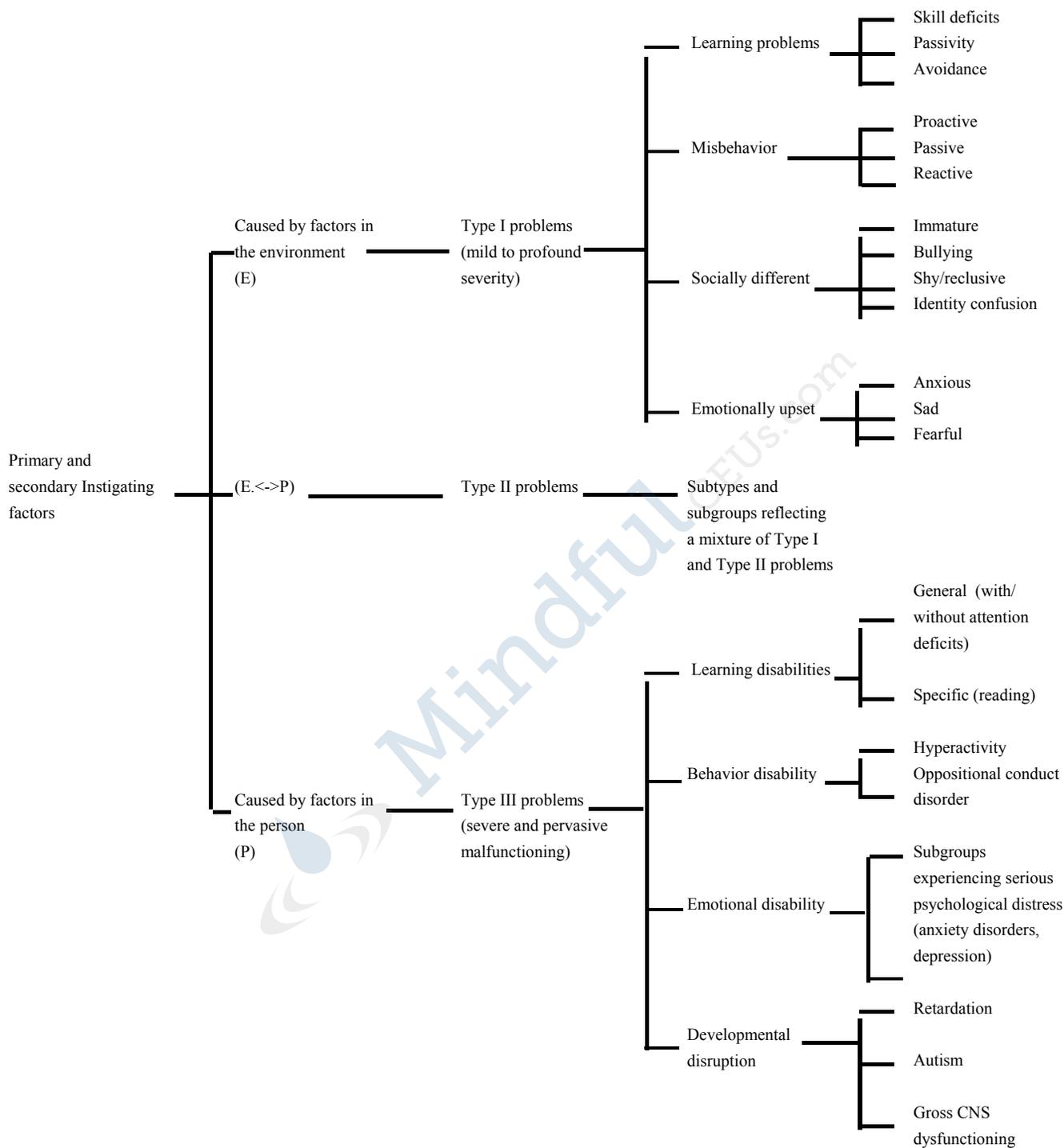
Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, or learning problems arising from serious internal pathology (e.g., structural and functional malfunctioning within the person that causes disorders and disabilities and disrupts development). Then subtypes might be differentiated within each of these categories. For illustrative purposes: Figure 2 presents some ideas for subgrouping Type I and III problems.

There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them. "To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.

Nicholas Hobbs

Figure 2: Categorization of Type I, II, and III Problems



Source: H. S. Adelman and L. Taylor (1993). Learning problems and learning disabilities. Pacific Grove. Brooks/Cole. Reprinted with permission.

Excerpt...

Who Receives a Diagnosis of Attention-Deficit/Hyperactivity Disorder in the United States Elementary School Population?

A total of 5.44% of children were reported to have received an ADHD diagnosis. Girls, black children, and Hispanic children were less likely to have the diagnosis even after controlling for other characteristics. Living with one's biological father was negatively associated with ADHD diagnosis. We also found regional variation in diagnosis with the western region of the United States having significantly lower instances of ADHD cases. Higher diagnosis rates were associated with having an older teacher, and lower rates were associated with having a white teacher, relative to a nonwhite teacher. In schools that were subject to stricter state-level performance accountability laws, we found higher odds of ADHD diagnoses, but we found no differences associated with larger class sizes or the presence of state laws that restrict school personnel from discussing ADHD treatment options with parents.

CONCLUSION: ADHD diagnosis is likely to be influenced by a child's social and school environment as well as exogenous child characteristics. Concerns that increased pressures for school performance are associated with increased ADHD diagnoses may be justified.

I. Classifying Attention Problems ...

B. Environmental Situations and Potentially Stressful Events

The American Academy of Pediatrics has prepared a guide on mental health for primary care providers. The guide suggests that commonly occurring stressful events in a youngsters life can lead to common behavioral responses. Below are portions of Tables that give an overview of such events and responses.

Environmental Situations and Potentially Stressful Events Checklist

Challenges to Primary Support Group

- Challenges to Attachment Relationship
- Death of a Parent or Other Family Member
- Marital Discord
- Divorce
- Domestic Violence
- Other Family Relationship Problems
- Parent-Child Separation

Changes in Caregiving

- Foster Care/Adoption/Institutional Care
- Substance-Abusing Parents
- Physical Abuse
- Sexual Abuse
- Quality of Nurture Problem
- Neglect
- Mental Disorder of Parent
- Physical Illness of Parent
- Physical Illness of Sibling
- Mental or Behavioral disorder of Sibling

Other Functional Change in Family

- Addition of Sibling
- Change in Parental Caregiver

Community of Social Challenges

- Acculturation
- Social Discrimination and/or Family Isolation

Educational Challenges

- Illiteracy of Parent
- Inadequate School Facilities
- Discord with Peers/Teachers

Parent or Adolescent Occupational Challenges

- Unemployment
- Loss of Job
- Adverse Effect of Work Environment

Housing Challenges

- Homelessness
- Inadequate Housing
- Unsafe Neighborhood
- Dislocation

Economic Challenges

- Poverty
- Inadequate Financial Status

Legal System or Crime Problems

Other Environmental Situations

- Natural Disaster
- Witness of Violence

Health-Related Situations

- Chronic Health Conditions
- Acute Health Conditions

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics.

Common Behavioral Responses to Environmental Situations and Potentially Stressful Events

INFANCY-TODDLERHOOD (0-2Y)
BEHAVIORAL MANIFESTATIONS

- Illness-Related Behaviors**
N/A
- Emotions and Moods**
Change in crying
Change in mood
Sullen, withdrawn
- Impulsive/Hyperactive or Inattentive Behaviors**
Increased activity
- Negative/Antisocial Behaviors**
Aversive behaviors, i.e., temper tantrum, angry outburst
- Feeding, Eating, Elimination Behaviors**
Change in eating
Self-induced vomiting
Nonspecific diarrhea, vomiting
- Somatic and Sleep Behaviors**
Change in sleep
- Developmental Competency**
Regression or delay in developmental attainments
Inability to engage in or sustain play
- Sexual Behaviors**
Arousal behaviors
- Relationship Behaviors**
Extreme distress with separation
Absence of distress with separation
Indiscriminate social interactions
Excessive clinging
Gaze avoidance, hypervigilant gaze...

MIDDLE CHILDHOOD (6-12Y)
BEHAVIORAL MANIFESTATIONS

- Illness-Related Behaviors**
Transient physical complaints
- Emotions and Moods**
Sadness
Anxiety
Changes in mood
Preoccupation with stressful situations
Self -destructive
Fear of specific situations
Decreased self-esteem
- Impulsive/Hyperactive or Inattentive Behaviors**
Inattention
High activity level
Impulsivity
- Negative/Antisocial Behaviors**
Aggression
Noncompliant
Negativistic
- Feeding, Eating, Elimination Behaviors**
Change in eating
Transient enuresis, encopresis
- Somatic and Sleep Behaviors**
Change in sleep
- Developmental Competency**
Decrease in academic performance
- Sexual Behaviors**
Preoccupation with sexual issues
- Relationship Behaviors**
Change in school activities
Change in social interaction such as withdrawal
Separation fear
Fear of being alone
- Substance Use/Abuse...**

EARLY CHILDHOOD (3-5Y)
BEHAVIORAL MANIFESTATIONS

- Illness-Related Behaviors**
N/A
- Emotions and Moods**
Generally sad
Self-destructive behaviors
- Impulsive/Hyperactive or Inattentive Behaviors**
Inattention
High activity level
- Negative/Antisocial Behaviors**
Tantrums
Negativism
Aggression
Uncontrolled, noncompliant
- Feeding, Eating, Elimination Behaviors**
Change in eating
Fecal soiling
Bedwetting
- Somatic and Sleep Behaviors**
Change in sleep
- Developmental Competency**
Regression or delay in developmental attainments
- Sexual Behaviors**
Preoccupation with sexual issues
- Relationship Behaviors**
Ambivalence toward independence
Socially withdrawn, isolated
Excessive clinging
Separation fears
Fear of being alone

ADOLESCENCE (13-21Y)
BEHAVIORAL MANIFESTATIONS

- Illness-Related Behaviors**
Transient physical complaints
- Emotions and Moods**
Sadness
Self-destructive
Anxiety
Preoccupation with stress
Decreased self-esteem
Change in mood
- Impulsive/Hyperactive or Inattentive Behaviors**
Inattention
Impulsivity
High activity level
- Negative/Antisocial Behaviors**
Aggression
Antisocial behavior
- Feeding, Eating, Elimination Behaviors**
Change in appetite
Inadequate eating habits
- Somatic and Sleep Behaviors**
Inadequate sleeping habits
Oversleeping
- Developmental Competency**
Decrease in academic achievement
- Sexual Behaviors**
Preoccupation with sexual issues
- Relationship Behaviors**
Change in school activities
School absences
Change in social interaction such as withdrawal
- Substance Use/Abuse...**

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

I. Classifying Attention Problems ...

C. Attention Problems and Motivation

Many individuals with learning problems are described not only as learning disabled, but also as hyperactive, distractable, impulsive, behavior disordered, and so forth. Their behavior patterns are seen as interfering with efforts to remedy their learning problems, and the conclusion often is that such interfering behaviors have to be eliminated or minimized in order to pursue instruction. The focus has been on any actions of an individual that compete with instruction.

Besides trying to reduce the frequency of disruptive actions directly, programs have been designed to alter such behavior by improving

- impulse control
- selective attention
- sustained attention and follow-through
- perseverance
- frustration tolerance
- social awareness and skills

Variations in focus derive from the ways in which interfering behaviors are viewed. Some professionals see the problems as a skill deficiency and have tried to improve the situation through instruction. Others see the problem as a matter of control and have addressed it through the use of control techniques. For those children diagnosed as hyperactive or as having attention deficit disorders with hyperactivity, a number of controversial nonpsychoeducational interventions also have been advocated (such as the use of stimulant drugs or special diets to avoid chemical additives in food).

Current work in psychology has brought renewed attention to motivation as a central concept in understanding learning and attention problems. This work is just beginning to find its way into applied fields and programs.

Although motivation has always been a concern to those who work with learning problems, the stress is usually on how to use extrinsic to mobilize the learner and maintain participation. There is a recent emphasis on the relationship of learning problems to deficiencies in intrinsic motivation. The general content focus has been on

- increasing feelings of self-determination
- increasing feelings of competence and expectations of success
- increasing feelings of interpersonal relatedness
- increasing the range of interests and satisfactions related to learning

In response to concerns about deficiencies in intrinsic motivation, remedial activities have been directed at improving

- awareness of personal motives and true capabilities
- learning to set valued and appropriate goals
- learning to value and to make appropriate and satisfying choices
- learning to value and accept responsibility for choice

II. The Broad Continuum of Attention Problems

A. Developmental Variations

B. Problems

C. Disorders

D. Thinking About Differential Diagnosis

The American Academy of Pediatrics has produced a manual for primary care providers that gives guidelines for psychological behaviors that are within the range expected for the age of the child, problems that may disrupt functioning but are not sufficiently severe to warrant the diagnosis of a mental disorder, and disorders that do meet the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) of the American Psychiatric Association.

Just as the continuum of Type I, II, and III problems presented in Section IA does, the pediatric manual provides a way to describe problems and plan interventions without prematurely deciding that internal pathology is causing the problems. The manual's descriptions are a useful way to introduce the range of concerns facing parents and school staff. Therefore, these descriptions provide the bases for the following presentation of attention problems commonly seen in school settings.

In addition to using material from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* published by the American Academy of Pediatric throughout this packet, we also have incorporated fact sheets from major agencies and excerpted key information from journal articles to provide users with a perspective of how the field currently presents itself.

II. The Broad Continuum of Attention Problems

A. Developmental Variations: Behaviors within the Range of Expected Behaviors for That Age Group*

DEVELOPMENTAL VARIATION

Hyperactive/Impulsive

Variation

Young children in infancy and in the pre-school years are normally very active and impulsive and may need constant supervision to avoid injury. Their constant activity may be stressful to adults who do not have the energy or patience to tolerate the behavior.

During school years and adolescence, activity may be high in play situations and impulsive behaviors may normally occur, especially in peer pressure situations.

High levels of hyperactive/impulsive behavior do not indicate a problem or disorder if the behavior does not impair functioning.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy

Infants will vary in their responses to stimulation. Some infants may be overactive to sensations such as touch and sound and may squirm away from the caregiver, while others find it pleasurable to respond with increased activity.

Early Childhood

The child runs in circles, doesn't stop to rest, may bang into objects or people, and asks questions constantly.

Middle Childhood

The child plays active games for long periods. The child may occasionally do things impulsively, particularly when excited.

Adolescence

The adolescent engages in active social activities (e.g., dancing) for long periods, may engage in risky behaviors with peers.

SPECIAL INFORMATION

Activity should be thought of not only in terms of actual movement, but also in terms of variations in responding to touch, pressure, sound, light, and other sensations. Also, for the infant and young child, activity and attention are related to the interaction between the child and the caregiver, e.g., when sharing attention and playing together.

Activity and impulsivity often normally increase when the child is tired or hungry and decrease when sources of fatigue or hunger are addressed.

Activity normally may increase in new situations or when the child may be anxious. Familiarity then reduces activity.

Both activity and impulsivity must be judged in the context of the caregiver's expectations and the level of stress experienced by the caregiver. When expectations are unreasonable, the stress level is high, and/or the parent has an emotional disorder (especially depression ...), the adult may exaggerate the child's level of activity/impulsivity.

Activity level is a variable of temperament (...).The activity level of some children is on the high end of normal from birth and continues to be high throughout their development.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care*. (1996) American Academy of Pediatrics.

Note: Dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

II. The Broad Continuum of Attention Problems

B. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder.*

PROBLEM	COMMON DEVELOPMENTAL PRESENTATIONS
<p data-bbox="354 657 561 684" style="text-align: center;">Hyperactive/Impulsive</p> <p data-bbox="152 709 318 737">Behavior Problem</p> <p data-bbox="152 758 773 926">These behaviors become a problem when they are intense enough to begin to disrupt relationships with others or begin to affect the acquisition of age-appropriate skills. The child displays some of the symptoms listed in the section on ADHD predominantly hyperactive/impulsive subtype. However, the behaviors are not sufficiently intense to qualify for a behavioral disorder such as ADHD, or of a mood disorder (see section on Sadness and Related Symptoms), or anxiety disorder (see section on Anxious Symptoms).</p> <p data-bbox="152 951 773 1020">A problem degree of this behavior is also likely to be accompanied by other behaviors such as negative emotional behaviors or aggressive/oppositional behaviors.</p>	<p data-bbox="854 709 927 737">Infancy</p> <p data-bbox="854 737 1472 806">The infant squirms and has early motor development with increased climbing. Sensory underreactivity and overreactivity as described in developmental variations can be associated with high activity levels.</p> <p data-bbox="854 831 1008 858">Early Childhood</p> <p data-bbox="854 858 1472 905">The child frequently runs into people or knocks things down during play, gets injured frequently, and does not want to sit for stories or games.</p> <p data-bbox="854 930 1024 957">Middle Childhood</p> <p data-bbox="854 957 1472 1003">The child may butt into other children's games, interrupts frequently, and has problems completing chores.</p> <p data-bbox="854 1029 967 1056">Adolescence</p> <p data-bbox="854 1056 1472 1094">The adolescent engages in "fooling around" that begins to annoy others and fidgets in class or while watching television.</p>
	<p data-bbox="870 1167 1105 1194" style="text-align: center;">SPECIAL INFORMATION</p>
	<p data-bbox="854 1241 1472 1339">In infancy and early childhood, a problem level of these behaviors may be easily confused with cognitive problems such as limited intelligence or specific developmental problems (...). However, cognitive problems and hyperactive/ impulsive symptoms can occur simultaneously.</p> <p data-bbox="854 1365 1472 1432">A problem level of these behaviors may also be seen from early childhood on, as a response to neglect (...), physical/sexual abuse (...), or other chronic stress, and this possibility should be considered.</p>

* Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (1996). American Academy of Pediatrics.

Note: Dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

II. The Broad Continuum of Attention Problems

C. Disorders that Meet the Criteria of a Mental Disorder

DISORDER

Attention-Deficit/ Hyperactivity Disorder

Predominantly Hyperactive-Impulsive Type

This subtype should be used if six (or more) of the following symptoms of hyperactivity-impulsivity (but fewer than six symptoms of inattention [...]) have persisted for at least 6 months. They present before the age of 7 years. The symptoms need to be present to a significantly greater degree than is appropriate for the age, cognitive ability, and gender of the child, and the symptoms should be present in more than one setting (e.g., school and home).

Hyperactive-impulsive symptoms:

These symptoms must be present to a degree that is maladaptive and inconsistent with developmental level, resulting in significant impairment.

Hyperactivity

- often fidgets with hands/feet or squirms in seat
- often leaves seat in classroom or in other situations in which remaining seated is expected
- often runs about or climbs excessively in situation in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- often has difficulty playing or engaging in leisure activities quietly
- is often "on the go" or often acts as if "driven by a motor"
- often talks excessively

Impulsivity

- often blurts out answers before questions are completed
- often has difficulty awaiting turn
- often interrupts or intrudes on others

* Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (1996). American Academy of Pediatrics.

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COMMON DEVELOPMENTAL PRESENTATIONS

of the resource that is not included in this guide.

Infancy

The infant squirms frequently and has early motor development with excessive climbing. The infant has a hard time focusing on people or objects and squirms constantly. The infant does not organize purposeful gestures or behavior. The infant may show interest in gross motor activities such as excessive climbing but may also have difficulties in motor planning and sequencing (imitating complex movements). However, these behaviors are nonspecific and a disorder diagnosis is extremely difficult to make in this age group.

Early Childhood

The child runs through the house, jumps and climbs excessively on furniture, will not sit still to eat or be read to, and is often into things.

Middle Childhood

The child is often talking and interrupting, cannot sit still at meal times, is often fidgeting when watching television, makes noise that is disruptive, and grabs from others.

Adolescence

The adolescent is restless and fidgety while doing any and all quiet activities, interrupts and "bugs" other people, and gets into trouble frequently. Hyperactive symptoms decrease or are replaced with a sense of restlessness.

SPECIAL INFORMATION

Specific environmental situations and stressors often make a significant contribution to the severity of these behaviors, though they are seldom entirely responsible for a disorder-level diagnosis of these behaviors. Situations and stressors that should be systematically assessed include:

- Marital discord/divorce (...)
- Physical abuse/sexual abuse (...)
- Mental disorder of parent (...)
- Other family relationship problems (...)

Difficulties with cognitive/adaptive skills, academic skills, and speech and language skills often lead to frustration and low self-esteem that contribute to the severity of these behaviors. These conditions may also co-exist with ADHD and therefore should be systematically assessed.

DISORDER, CONTINUED

Predominantly Hyperactive-Impulsive Type, Continued

Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years. Some impairment from the symptoms is present in two or more settings (e.g., at school and at home). There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning. The symptoms do not occur exclusively during the course of an autistic disorder (see following differential diagnostic information), and are not better accounted for by another mental disorder (see following differential diagnosis information).

Combined Type

This subtype should be used if criteria, six (or more) symptoms of hyperactivity-impulsivity and six (or more) of the symptoms of the inattention (...), have persisted for at least 6 months.

Attention-Deficit/ Hyperactivity Disorder, NOS

(see DSM-IV Criteria ...)

COMMON DEVELOPMENTAL PRESENTATIONS CONTINUED

SPECIAL INFORMATION

Specific environmental situations and stressors often make a significant contribution to the severity of these behaviors, though they are seldom entirely responsible for a disorder-level diagnosis of these behaviors. Situations and stressors that should be systematically assessed include:

Marital discord/divorce, (...)
Physical abuse/sexual abuse, (...)
Mental disorder of parent, (...)
Other family relationship problems, (...)
Loss/bereavement, (...)

Difficulties with cognitive/adaptive skills, academic skills, and speech and language skills often lead to frustration and low self-esteem that both contribute to the severity of these behaviors. These conditions may also co-exist with ADHD and therefore should be systematically assessed.

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

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II. The Broad Continuum of Attention Problems

D. Thinking About Differential Diagnosis

*Arguments About Whether Overdiagnosis of ADHD is a Significant Problem**

Attention Deficit Hyperactivity Disorder (ADHD) is one of the most commonly diagnosed mental disorder among children and adolescents. The Centers for Disease Control and Prevention (CDC) report a steady increase in prevalence, from 6.9% in 1997 to 9.5% in 2007.

With increased diagnoses has come widespread concern about the degree of overdiagnosis. This concern is compounded by related increases in use of medications to treat ADHD.

Over the years, prevalence has increased steadily with each new version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. Concerns have been expressed that prevalence will further increase with the latest version (DSM-5). The questions arise: Do ongoing refinements in the DSM and available assessment procedures enable better differential diagnosis? Do they overdiagnose ADHD?

Errors are common when diagnoses of ADHD are made. These include indicating a person has ADHD when they do not (designated as a false positive), indicating a person doesn't have ADHD when they do (designated as a false negative), or misclassifying the person's problem. In this respect, some argue that rising ADHD prevalence rates reflect many false positives; others argue the increases reflect a reduction in false negatives.

Those arguing that overdiagnosis is a significant problem suggest that:

- *Practitioners' Overdiagnose.* Both empirical and observational studies are cited as revealing that practitioners often diagnose ADHD despite limited assessment. For example, in a study of 1,000 clinicians assessing ADHD, only 15% reported regularly using information from multiple sources and settings; other studies have demonstrated false negatives resulting from gender and ethnic bias in the diagnosis process.
- *Conflicting Interests.* The relationship between medical/psychiatric diagnosticians and pharmaceutical companies is pointed to as the type of conflict of interest that contributes to ADHD overdiagnosis.
- *Criteria are Pathologically Biased.* Diagnostic criteria in the DSM have been described as blurring the line between behaviors that warrant diagnosis and behaviors that reflect a commonplace developmental trajectory. For instance, DSM-5 is seen as further widening the definition of ADHD with the inclusion of more behavioral descriptions and delays the maximum onset age to include late-onset diagnosis. The term "clinically significant" in previous editions is seen as having been revised into more lenient descriptions (e.g., behavior that "interferes with or reduces the quality of social, academic, or occupational functioning"). The concern is that changes in DSM may further increase ADHD diagnosis among individuals who display ADHD symptoms but who only manifest minor functional impairment.

- *Forces are at Work that Produce Uncritical Consumer Demand.* General and social networking media and ADHD organizations are seen as contributing to increasing demand, overdiagnosis, and overprescription. For example, a variety of websites promote initial home-diagnosis based on a small set of symptom-related questions. Relatedly, direct-to-consumer pharmaceutical advertising is seen as the type of mass promotion of ADHD that fuels demand for and overdiagnosis of ADHD along with overprescription of medication (e.g., a particular focus is on parents of students doing poorly at school).
- *Cognitive Biasing Factors.* Research emphasizes various cognitive biases that can lead observers to misattribute the source of problems and overestimate prevalence. For example, availability bias suggests there is a tendency to inflate the likelihood of an event based on a few salient examples. Confirmation bias suggests the tendency for one to become attached to an unconfirmed hypothesis and subsequently only attend to and seek information that support the hypothesis while disregarding and minimizing counter-evidence. Attribution bias suggests the tendency for observers to attribute an actor's (e.g., a student's) problem behavior to a stable, internal cause. Such biasing factors are seen as playing a role in disparate overdiagnosis of males, adolescents, and some racial groups.

Examples of efforts to counter such arguments point to:

- *Underlying biasing factors.* The claim is that biasing factors have reified the view that diagnostic rates are excessive. Such bias is seen as perpetuated by media through sensational portrayals of ADHD false positives that mislead people to believe that overdiagnosis is more prominent than it really is. Widely presented anecdotal accounts of children receiving unwarranted ADHD diagnosis along with aggressive pharmacological treatment are cited as misleading the public into overestimating the prevalence of false positives in ADHD. Moreover, the bias against ADHD diagnoses is seen as colluding with the tendency to overemphasize false positives, while deemphasizing estimates of false negatives. Furthermore, cognitive biases (e.g., information availability and confirmation) leading to judgments of overdiagnosis are viewed as reinforced by reports that overstate the case for overdiagnosis. In particular, mass promotion of the idea that ADHD overdiagnosed is seen as contributing to the tendency for people to become attached to an unconfirmed.
- *Improved diagnostic practices.* It is widely stressed that changes in DSM-5 are intended to and will reduce clinician subjectivity in the diagnostic process and increase diagnostic reliability by providing additional behavioral descriptions that include developmentally appropriate examples. It is also emphasized that just because many of the behaviors viewed as ADHD symptoms are commonplace is not a sound reason to question the validity of ADHD diagnoses.
- *About data related to race.* Claims of overdiagnosis due to racial factors are seen as ignoring findings that report racial minority children were less likely than their white peers to receive ADHD diagnosis across early to middle childhood. Related to this, data are referenced indicating racial differences in parental reports about ADHD symptoms in their children, with parents of racial minorities less likely to report such symptoms compared to parents of non-Latino whites.

About School Accountability Policy and ADHD Diagnosis

The U.S. has the highest rate of diagnosed ADHD -- 11% compared to a rate of around 5% in countries such as Brazil, China, and Europe. Variations within and across nations suggest the role of cultural and societal factors in determining rates of diagnosis. For example, in the U.S., cultural attitudes about special education labels such as ADHD and LD, and school accountability policies and pressures have been identified as playing a role in overdiagnoses. For example, in order to meet accountability standards and avoid being designated as low performing schools, districts try to exclude or at least ensure special accommodations for special education students in order to report higher test score averages.

In their 2014 book, *The ADHD Explosion*, Hinshaw and Scheffler discuss the impact of school accountability legislation as a major factor leading schools to increase their special education population. As a prime example, they focus on North Carolina, where school accountability legislation was enacted that specified rewards for schools performing up to a standard and penalized those that did not. The critical accountability measure was academic test scores. Hinshaw and Scheffler suggest that to maximize test scores schools sought to have underachieving students diagnosed and treated for ADHD so they would be put on “attention-enhancing” medications and/or receive testing accommodations. To back up this suggestion, they report research indicating a positive correlation between the increasing accountability demands and increases in ADHD diagnosis over the years.

Moreover, public schools in low-income communities are typically the most vulnerable when it comes to the negative impact of school-accountability policy. And indications are that the rate of increase in ADHD diagnosis is related to low socioeconomic students. Hinshaw and Scheffler report increases as high as 59% for ADHD diagnosis among youngsters from low-income homes after the launching of school accountability laws compared to a less than 10% increase among middle- and high-income children. Those who argue that overdiagnosis of ADHD is not a problem suggest that such a discrepancy is an indication of a long-standing failure to address ADHD among low-income populations. Hinshaw and Scheffler argue that the discrepancy is better explained by school accountability policy.

As a footnote to all this: In a recent interview with the *Los Angeles Times*, Scheffler made it clear that the current process for diagnosing ADHD depends heavily on the subjective judgments from parents, clinicians, as well as youngsters themselves. This reality alone makes false positive diagnoses of students a likelihood and provides a cautionary warning about the need to counter overdiagnoses.

II. The Broad Continuum of Attention Problems

D. Thinking About Differential Diagnosis (cont.)

Excerpted from U.S. Department of Education

Identifying and Treating Attention Deficit Hyperactivity Disorder A Resource for School and Home

A diagnosis of ADHD is multifaceted and includes behavioral, medical, and educational data gathering. One component of the diagnosis includes an examination of the child's history through comprehensive interviews with parents, teachers, and health care professionals. Interviewing these individuals determines the child's specific behavior characteristics, when the behavior began, duration of symptoms, whether the child displays the behavior in various settings, and coexisting conditions.

Collecting information about the child's ADHD symptoms from several different sources helps ensure that the information is accurate. Appropriate sources of information include the child's parents, teachers, other diagnosticians such as psychologists, occupational therapists, speech therapists, social workers, and physicians. It is also important to review both the child's previous medical history as well as his or her school records.

Excerpted from: CDC's Morbidity and Mortality Weekly Report (MMWR)

Increasing Prevalence of Parent-Reported Attention-Deficit/Hyperactivity Disorder Among Children --- United States, 2003 and 2007

Attention deficit hyperactivity disorder is a neurobehavioral disorder that typically begins in childhood and often persists into adulthood. ADHD is characterized by developmentally inappropriate levels of inattention and hyperactivity resulting in functional impairment in academic, family, and social settings. ADHD is the most commonly diagnosed neurobehavioral disorder of childhood with previous reports documenting increasing trends in prevalence during the past decade and increases in ADHD medication use. National estimates of the number of children reported by their parents to have ever been diagnosed with ADHD and the percentage of children with ADHD currently taking ADHD medications were published in 2005 using data from the 2003 National Survey of Children's Health. This report describes results from the second administration of NSCH in 2007, which indicated that the percentage of children aged 4 - 17 years with a parent reported ADHD diagnosis (ever) increased from 7.8% to 9.5% during 2003-2007, representing a 21.8% increase in 4 years. The findings in this report help to further characterize the substantial impact of ADHD on families.

Abstract

The association of attention deficit hyperactivity disorder with socioeconomic disadvantage: alternative explanations and evidence.

BACKGROUND: Studies throughout Northern Europe, the United States and Australia have found an association between childhood attention deficit hyperactivity disorder (ADHD) and family socioeconomic disadvantage. We report further evidence for the association and review potential causal pathways that might explain the link.

METHOD: Secondary analysis of a UK birth cohort (the Millennium Cohort Study, N = 19,519) was used to model the association of ADHD with socioeconomic disadvantage and assess evidence for several potential explanatory pathways. The case definition of ADHD was a parent-report of whether ADHD had been identified by a medical doctor or health professional when children were 7 years old.

RESULTS: ADHD was associated with a range of indicators of social and economic disadvantage including poverty, housing tenure, maternal education, income, lone parenthood and younger motherhood. There was no evidence to suggest childhood ADHD was a causal factor of socioeconomic disadvantage: income did not decrease for parents of children with ADHD compared to controls over the 7-year study period. No clinical bias towards labelling ADHD in low SES groups was detected. There was evidence to suggest that parent attachment/family conflict mediated the relationship between ADHD and SES.

CONCLUSION: Although genetic and neurological determinants may be the primary predictors of difficulties with activity level and attention, aetiology appears to be influenced by socioeconomic situation.

Excerpted from...

Evaluating the Evidence for and Against the Overdiagnosis of ADHD

Diagnostic inaccuracy. Some studies have shown that, for a significant number of children, an actual or suspected diagnosis of ADHD is disconfirmed after further assessment. For instance, Cotugno (1993) evaluated 92 children previously referred to a specialized ADHD clinic. He found that, after a comprehensive evaluation, only 22% of the children were given a primary diagnosis of ADHD and only 37% were given a secondary diagnosis of ADHD. Similarly, Desgranges, Desgranges, and Karshy (1995) found that 62% of clinic referrals for suspected ADHD were not confirmed as ADHD cases after further evaluation. One potential reason for the diagnostic inaccuracy is the variability in assessment procedures. Studies of assessment practices among psychologist and physicians suggest that a diagnosis of ADHD is often made without a comprehensive assessment. Handler and DuPaul (2005) found that a large majority of practicing psychologists did not regularly follow assessment procedures that are consistent with the best practice guidelines. Similarly, Wasserman and colleagues (1999) found that primary care physicians varied considerably in their assessment and diagnosis of childhood disorders. They found that physicians relied very heavily on interviews and most did not adhere to the DSM criteria or use standardized assessment tools. Although such variability in assessment procedures may provide fertile soil for overdiagnosis, it has not been empirically established that a failure to follow best practices for assessment invariably leads to more false positives than false negatives.

III. Interventions for Attention Problems

- A. Classroom Teaching and Accommodations**
- B. Managing Behavior**
- C. Treatments and Medications**
- D. Follow-up Treatment Research**



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III. Interventions for Attention Problems

A. Classroom Teaching and Accommodations

Teaching Students with ADD / ADHD



If you're a teacher, you know these kids: The one who stares out the window, substituting the arc of a bird in flight for her math lesson. The one who wouldn't be able to keep his rear end in the chair if you used Crazy Glue. The one who answers the question, "Who can tell me what the 6th Amendment guarantees?" with "Mrs. M, do you dye your hair?"

Students who exhibit ADD/ADHD's hallmark symptoms of inattention, hyperactivity, and impulsivity can be frustrating. You know the brainpower is there, but they just can't seem to focus on the material you're working hard to deliver. Plus, their behaviors take time away from instruction and disrupt the whole class.

Challenges of ADD / ADHD in the classroom

Think of what the school setting requires children to do: Sit still. Listen quietly. Pay attention. Follow instructions. Concentrate. These are the very things kids with ADD/ADHD have a hard time doing—not because they aren't willing, but because their brains won't let them. That doesn't make teaching them any easier, of course.

Students with ADD/ADHD present the following challenges for teachers:

- They demand attention by talking out of turn or moving around the room.
- They have trouble following instructions, especially when they're presented in a list.
- They often forget to write down homework assignments, do them, or bring completed work to school.
- They often lack fine motor control, which makes note-taking difficult and handwriting a trial to read.
- They often have trouble with operations that require ordered steps, such as long division or solving equations.
- They usually have problems with long-term projects where there is no direct supervision.
- They don't pull their weight during group work and may even keep a group from accomplishing its task.

Students with ADD/ADHD pay the price for their problems in low grades, scolding and punishment, teasing from peers, and low self-esteem. Meanwhile, you, the teacher, wind up taking complaints from parents who feel their kids are being cheated of your instruction and feeling guilty because you can't reach the child with ADD/ADHD.

What teachers can do to help children with ADD / ADHD

So how do you teach a kid who won't settle down and listen? The answer: with a lot of patience, creativity, and consistency. As a teacher, your role is to evaluate each child's individual needs and strengths. Then you can develop strategies that will help students with ADD/ADHD focus, stay on task, and learn to their full capabilities.

Successful programs for children with ADHD integrate the following three components:

- **Accommodations:** what you can do to make learning easier for students with ADD/ADHD.
- **Instruction:** the methods you use in teaching.
- **Intervention:** How you head off behaviors that disrupt concentration or distract other students.

Your most effective tool, however, in helping a student with ADD/ADHD is a positive attitude. Make the student your partner by saying, "Let's figure out ways together to help you get your work done." Assure the student that you'll be looking for good behavior and quality work, and when you see it, reinforce it with immediate and sincere praise. Finally, look for ways to motivate a student with ADD/ADHD by offering rewards on a point or token system.

Dealing with disruptive classroom behavior

To head off behavior that takes time from other students, work out a couple of warning signals with the student who has ADD/ADHD. This can be a hand signal, an unobtrusive shoulder squeeze, or a sticky note on the student's desk. If you have to discuss the student's behavior, do so in private. And try to ignore mildly inappropriate behavior if it's unintentional and isn't distracting other students or disrupting the lesson.

Classroom accommodations for students with ADD / ADHD

As a teacher, you can make changes in the classroom to help minimize the distractions and disruptions of ADHD.

Seating

- Seat the student with ADD/ADHD away from windows and away from the door.
- Put the student with ADD/ADHD right in front of your desk unless that would be a distraction for the student.
- Seats in rows, with focus on the teacher, usually work better than having students seated around tables or facing one another in other arrangements.

Information delivery

- Give instructions one at a time and repeat as necessary.
- If possible, work on the most difficult material early in the day.
- Use visuals: charts, pictures, color coding.
- Create outlines for note-taking that organize the information as you deliver it.

Student work

- Create a quiet area free of distractions for test-taking and quiet study.
- Create worksheets and tests with fewer items; give frequent short quizzes rather than long tests.
- Reduce the number of timed tests.
- Test the student with ADD/ADHD in the way he or she does best, such as orally or filling in blanks.
- Show the student how to use a pointer or bookmark to track written words on a page.
- Divide long-term projects into segments and assign a completion goal for each segment.
- Let the student do as much work as possible on computer.
- Accept late work and give partial credit for partial work.

Organization

- Have the student keep a master notebook, a three-ring binder with a separate section for each subject, and make sure everything that goes into the notebook has holes punched and is put on the rings in the correct section.
- Provide a three-pocket notebook insert for homework assignments, completed homework, and "mail" to parents (permission slips, PTA flyers).
- Color-code materials for each subject.
- Allow time for student to organize materials and assignments for home. Post steps for getting ready to go home.
- Make sure the student with ADD/ADHD has a system for writing down assignments and important dates and uses it.

Teaching techniques for students with ADD/ADHD

Teaching techniques that help students with ADD/ADHD focus and maintain their concentration on your lesson and their work can be beneficial to the entire class.

Starting a lesson

- Signal the start of a lesson with an aural cue, such as an egg timer, a cowbell or a horn. (You can use subsequent cues to show much time remains in a lesson.)
- List the activities of the lesson on the board.
- In opening the lesson, tell students what they're going to learn and what your expectations are. Tell students exactly what materials they'll need.
- Establish eye contact with any student who has ADD/ADHD.

Conducting the lesson

- Keep instructions simple and structured.
- Vary the pace and include different kinds of activities. Many students with ADD do well with competitive games or other activities that are rapid and intense.
- Use props, charts, and other visual aids.
- Have an unobtrusive cue set up with the student who has ADD/ADHD, such as a touch on the shoulder or placing a sticky note on the student's desk, to remind the student to stay on task.

- Allow a student with ADD/ADHD frequent breaks.
- Let the student with ADHD squeeze a rubber ball or tap something that doesn't make noise as a physical outlet.
- Try not to ask a student with ADD/ADHD perform a task or answer a question publicly that might be too difficult.

Ending the lesson

- Summarize key points.
- If you give an assignment, have three different students repeat it, then have the class say it in unison, and put it on the board.
- Be specific about what to take home.

More help for ADD/ADHD in children

ADD/ADHD Help Center: Find ways to stay focused, turn chaos into calm, and manage the symptoms of distraction, hyperactivity, and impulsivity.

ADD / ADHD and School: Helping Children with ADHD Succeed at School

General Information for ADD / ADHD in Children and Teens: Signs and Symptoms of Attention Deficit Disorder in Kids

ADD / ADHD Parenting Tips: Helping Children with Attention Deficit Disorder

Treatment for ADD / ADHD in Children and Teens: Signs and Symptoms of Attention Deficit Disorder in Kids



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III. Interventions for Attention Problems

A. Classroom Teaching and Accommodations (cont.)

ADD / ADHD and School



School creates multiple challenges for kids with ADD/ADHD, but with patience and an effective plan, your child can thrive in the classroom. As a parent, you can work with your child and his or her teacher to implement practical strategies for learning both inside and out of the classroom. With consistent support, these strategies can help your child meet learning challenges—and experience success at school.

Setting up your child for school success

The classroom environment can be a challenging place for a child with ADD/ADHD. The very tasks these students find the most difficult—sitting still, listening quietly, concentrating—are the ones they are required to do all day long. Perhaps most frustrating of all is that most these children *want* to be able to learn and behave like their unaffected peers. Neurological deficits, not unwillingness, keep kids with attention deficit disorder from learning in traditional ways.

As a parent, you can help your child cope with these deficits and meet the challenges school creates. You can provide the most effective support: equipping your child with learning strategies for the classroom and communicating with teachers about how your child learns best. With support at home and teaching strategies at work in the classroom, there is no reason why kids with ADD/ADHD can't flourish in school.

ADD / ADHD and school: Tips for working with teachers

Remember that your child's teacher has a full plate: in addition to managing a group of children with distinct personalities and learning styles, he or she can also expect to have at least one student with ADD/ADHD. Teachers can do their best to help your child with attention deficit disorder learn effectively, but parental involvement can dramatically improve your child's education. You have the power to optimize your child's chances for success by supporting the work done in the classroom. **If you can work with and support your child's teacher, you can directly affect the experience of your child with ADD/ADHD in the classroom.**

There are a number of ways you can work with teachers to keep your child on track at school. Together you can help your child with ADD/ADHD learn to find his or her feet in the classroom and work effectively through the challenges of the school day.

ADD / ADHD school support strategy 1: Communicate with school and teachers

As a parent, you are your child's advocate. For your child to succeed in the classroom, it is vital that you communicate his or her needs to the adults at school. It is equally important for you to listen to what the teachers and other school officials have to say.

You can make communication with your child's school constructive and productive. Try to keep in mind that your mutual purpose is finding out how to best help your child succeed in school. Whether you talk over the phone, email, or meet in person, make an effort to be calm, specific, and above all positive—a good attitude can go a long way in communication with school.

- **Plan ahead.** You can arrange to speak with school officials or teachers before the school year even begins. If the year has started, plan to speak with a teacher or counselor on at least a monthly basis.
- **Make meetings happen.** Agree on a time that works for both you and your child's teacher and stick to it. Avoid cancelling. If it is convenient, meet in your child's classroom so you can get a sense of your child's physical learning environment.
- **Create goals together.** Discuss your hopes for your child's school success. Together, write down specific and realistic goals and talk about how they can be reached.

- **Listen carefully.** Like you, your child's teacher wants to see your child succeed at school. Listen to what he or she has to say—even if it is sometimes hard to hear. Avoid interrupting. Understanding your child's challenges in school is the key to finding solutions that work.
- **Share information.** You know your child's history, and your child's teacher sees him or her every day: together you have a lot of information that can lead to better understanding of your child's hardships. Share your observations freely, and encourage your child's teachers to do the same.
- **Ask the hard questions and give a complete picture.** Communication can only work effectively if it is honest. Be sure to list any medications your child takes and explain any other treatments. Share with your child's teacher what tactics work well—and which don't—for your child at home. Ask if your child is having any problems in school, including on the playground. Find out if your child can get any special services to help with learning.

ADD / ADHD school support strategy 2: Develop and use a behavior plan

Children with ADD/ADHD are capable of appropriate classroom behavior, but they need structure and clear expectations in order to keep their symptoms in check. As a parent, you can help by developing a behavior plan for your child—and sticking to it. Whatever type of behavior plan you put in place, create it in close collaboration with your child's teacher and your child.

Kids with attention deficit disorder respond best to specific goals and daily positive reinforcement—as well as worthwhile rewards. Yes, you may have to hang a carrot on a stick to get your child to behave better in class. Create a plan that incorporates small rewards for small victories and larger rewards for bigger accomplishments.

ADD / ADHD and school: Tips for managing symptoms

ADD/ADHD impacts each child's brain differently, so each case can look quite different in the classroom. Children with ADD/ADHD exhibit a range of symptoms: some seem to bounce off the walls, some daydream constantly, and others just can't seem to follow the rules.

As a parent, you can help your child with ADD/ADHD reduce any or all of these types of behaviors. It is important to understand how attention deficit disorder affects different children's behavior so that you can choose the appropriate strategies for tackling the problem. There are a variety of fairly straightforward approaches you and your child's teacher can take to best manage the symptoms of ADD/ADHD—and put your child on the road to school success.

Distractibility

Students with ADD/ADHD may be so easily distracted by noises, passersby, or their own thoughts that they often miss vital classroom information. These children have trouble staying focused on tasks that require sustained mental effort. They may seem to be listening to you, but something gets in the way of their ability to retain the information.

Helping kids who distract easily involves physical placement, increased movement, and breaking long work into shorter chunks.

- Seat the child with ADD/ADHD away from doors and windows. Put pets in another room or a corner while the student is working.
- Alternate seated activities with those that allow the child to move his or her body around the room. Whenever possible, incorporate physical movement into lessons.
- Write important information down where the child can easily read and reference it. Remind the student where the information can be found.
- Divide big assignments into smaller ones, and allow children frequent breaks.



Interrupting

Kids with attention deficit disorder may struggle with controlling their impulses, so they often speak out of turn. In the classroom or home, they call out or comment while others are speaking. Their outbursts

may come across as aggressive or even rude, creating social problems as well. The self-esteem of children with ADD/ADHD is often quite fragile, so pointing this issue out in class or in front of family members doesn't help the problem—and may even make matters worse.

Reducing the interruptions of children with ADD/ADHD should be done carefully so that the child's self-esteem is maintained, especially in front of others. Develop a "secret language" with the child with ADD/ADHD. You can use discreet gestures or words you have previously agreed upon to let the child know they are interrupting. Praise the child for interruption-free conversations.

Impulsivity



Children with ADD/ADHD may act before thinking, creating difficult social situations in addition to problems in the classroom. Kids who have trouble with impulse control may come off as aggressive or unruly. This is perhaps the most disruptive symptom of ADD/ADHD, particularly at school.

Methods for managing impulsivity include behavior plans, immediate discipline for infractions, and ways to give children with ADD/ADHD a sense of control over their day.

- Make sure a written behavior plan is near the student. You can even tape it to the wall or the child's desk.
- Give consequences immediately following misbehavior. Be specific in your explanation, making sure the child knows how they misbehaved.
- Recognize good behavior out loud. Be specific in your praise, making sure the child knows what they did right.
- Write the schedule for the day on the board or on a piece of paper and cross off each item as it is completed. Children with impulse problems may gain a sense of control and feel calmer when they know what to expect.

Fidgeting and hyperactivity

ADD/ADHD causes many students to be in constant physical motion. It may seem like a struggle for these children to stay in their seats. Kids with ADD/ADHD may jump, kick, twist, fidget and otherwise move in ways that make them difficult to teach.

Strategies for combating hyperactivity consist of creative ways to allow the child with ADD/ADHD to move in appropriate ways at appropriate times. Releasing energy this way may make it easier for the child to keep his or her body calmer during work time.

- Ask children with ADD/ADHD to run an errand or do a task for you, even if it just means walking across the room to sharpen pencils or put dishes away.
- Encourage the child to play a sport—or at least run around before and after school.
- Provide a stress ball, small toy, or other object for the child to squeeze or play with discreetly at his or her seat.
- Limit screen time in favor of time for movement.
- Make sure a child with ADD/ADHD never misses recess or P.E.

Trouble following directions

Difficulty following directions is a hallmark problem for many children with ADD/ADHD. These kids may look like they understand and might even write down directions, but then aren't able to do what has been asked. Sometimes these students miss steps and turn in incomplete work, or misunderstand an assignment altogether and wind up doing something else entirely.

Helping children with ADD/ADHD follow directions means taking measures to break down and reinforce the steps involved in your instructions, and redirecting when necessary. Try being extremely brief when giving directions, allowing the child to do one step and then come back to find out what they should do next. If the child gets off track, give a calm reminder, redirecting in a calm but firm voice. Whenever possible, write directions down in a bold marker or in colored chalk on a blackboard.

Medication for ADD/ADHD: What parents should know

Many schools urge parents to medicate children with attention deficit disorder, and you may feel unsure about what this means. While medication can help with the symptoms of ADD/ADHD, it is not a cure and comes with side effects. As a parent, you should weigh the benefits and risks of medications for ADD/ADHD before using them to treat your child.

ADD / ADHD and school: Tips for making learning fun

One positive way to keep your child's attention focused on learning is to make the process fun. Using physical motion in a lesson, connecting dry facts to interesting trivia, or inventing silly songs that make details easier to remember can help your child enjoy learning and even reduce the symptoms of ADD/ADHD.

Helping children with ADD/ADHD enjoy math

Children who have attention deficit disorder tend to be "concrete" thinkers. They often like to hold, touch, or take part in an experience in order to learn something new. By using games and objects to demonstrate mathematical concepts, you can show your child that math can be meaningful—and fun.

- **Play games.** Use memory cards, dice, or dominoes to make numbers fun. Or simply use your fingers and toes, tucking them in or wiggling them when you add or subtract.
- **Draw pictures.** Especially for word problems, illustrations can help kids better understand mathematical concepts. If the word problem says there are twelve cars, help your child draw them from steering wheel to trunk.
- **Invent silly acronyms.** In order to remember order of operations, for example, make up a song or phrase that uses the first letter of each operation in the correct order.

Helping children with ADD/ADHD enjoy reading

There are many ways to make reading exciting, even if the skill itself tends to be a struggle for children with ADD/ADHD. Keep in mind that reading at its most basic level made up of stories and interesting information—things that all children enjoy.

- **Read to children.** Read with children. Make reading cozy, quality time with you.
- **Make predictions or "bets."** Constantly ask the child what they think might happen next. Model prediction: "The girl in the story seems pretty brave—I bet she's going to try to save her family."
- **Act out the story.** Let the child choose his or her character and assign you one, too. Use funny voices and costumes to bring it to life.

How does your kid like to learn?

When children are given information in a way that makes it easy for them to absorb, learning is a lot more fun. If you understand how your child with ADD/ADHD learns best, you can create enjoyable lessons that pack an informational punch.

- **Auditory learners** learn best by talking and listening. Have these kids recite facts to a favorite song. Let them pretend they are on a radio show and work with others often.
- **Visual learners** learn best through reading or observation. Let them have fun with different fonts on the computer and use colored flash cards to study. Allow them to write or draw their ideas on paper.
- **Tactile learners** learn best by physically touching something or moving as part of a lesson. For these students, provide jellybeans for counters and costumes for acting out parts of literature or history. Let them use clay and make collages.

It's tough to enjoy learning when there is something undiagnosed standing in the way. In addition to ADD/ADHD, children may also be affected by learning disabilities. These issues make even the most exciting lessons extremely difficult for students. Like children with attention deficit disorder, children with learning disabilities can succeed in the classroom, and there are many ways you can help.

See [Learning Disabilities in Children](#).

ADD / ADHD and school: Tips for mastering homework

Sure, kids may universally dread it—but for a parent of a child with ADD/ADHD, homework is a golden opportunity. Academic work done outside the classroom provides you as the parent with a chance to directly support your child. It's a time you can help your child succeed at school where you both feel most comfortable: your own living room.

With your support, kids with ADD/ADHD can use homework time not only for math problems or writing essays, but also for practicing the organizational and study skills they need to thrive in the classroom.

Helping a child with ADD / ADHD get organized

With organization, it can help to get a fresh start. Even if it's not the start of the academic year, go shopping with your child and pick out school supplies that include folders, a three-ring binder, and color-coded dividers. Help the child file his or her papers into this new system.

- Establish a homework folder for finished homework.

- Check and help the child organize his or her belongings on a daily basis, including his or her backpack, folders, and even pockets.
- If possible, keep an extra set of textbooks and other materials at home.
- Help the child learn to make and use checklists, crossing items off as they are accomplished.
- Help organize loose papers by color coding folders and showing the child how to hole-punch and file appropriately.

Helping a child with ADD / ADHD get homework done and turned in on time

Understanding concepts and getting organized are two steps in the right direction, but homework also has to get done in a single evening—and turned in on time. Help a child with ADD/ADHD to the finish line with strategies that provide consistent structure.

- Pick a specific time and place for homework that is as free as possible of clutter, pets, and television.
- Allow the child breaks as often as every ten to twenty minutes.
- Teach a better understanding of the passage of time: use an analog clock and timers to monitor homework efficiency.
- Set up a homework procedure at school: establish a place where the student can easily find his or her finished homework and pick an appropriate and consistent time to hand in work to the teacher.

More help for ADD/ADHD in children

ADD/ADHD Help Center: Find ways to stay focused, turn chaos into calm, and manage the symptoms of distraction, hyperactivity, and impulsivity.

Treatment for ADD / ADHD in Children and Teens: Signs and Symptoms of Attention Deficit Disorder in Kids

ADD / ADHD Medications: Are ADHD Drugs Right for You or Your Child?

General Information for ADD / ADHD in Children and Teens: Signs and Symptoms of Attention Deficit Disorder in Kids

ADD / ADHD Tests & Diagnosis: Diagnosing Attention Deficit Disorder in Children and Adults

ADD / ADHD Parenting Tips: Helping Children with Attention Deficit Disorder

Teaching Students with ADD / ADHD: What Teachers Can Do to Help



III. Interventions for Attention Problems

A. Classroom Teaching and Accommodations (cont.)

Helping the Student with ADHD in the Classroom: Strategies for Teachers

Introduction

Affecting three to five percent of the population, Attention Deficit /Hyperactivity Disorder (ADHD) is one of the most common of the childhood behavior disorders. Associated with this disorder's core symptoms of inattention, hyperactivity and impulsivity are a variety of disruptive classroom behaviors (e.g., calling out, leaving seat, interrupting activities, etc.). Consequently, it is not surprising that these students are at risk for school failure.

Increased expectations for the use of classroom interventions for students with ADHD have been generated by Section 504 of the Vocational and Rehabilitation Act of 1973 and the Individuals with Disabilities Education Act (IDEA) of 1997. Section 504 has been used to require the development of general education accommodation plans. These plans are designed to ensure that the student with ADHD is provided a free and appropriate education. Among the recommended components of these plans are a variety of classroom interventions (including behavior management), with a special emphasis on environmental modifications. Similarly, the recent reauthorization of IDEA, with its requirements for functional assessments, should increase the frequency with which classroom-based behavioral interventions are considered for these students.

General behavior intervention suggestions

Classroom interventions for the student with ADHD should be based upon a solid foundation of general behavior intervention principles. While students with ADHD do have a core of common problems, this group is fairly heterogeneous. Thus, instead of focusing on ADHD symptoms, management should first directly target the specific problem behavior. Next, an alternative behavior, incompatible with the problem behavior, should be selected. It is important to keep both behaviors in mind. Not only do we want to make it clear to students what behavior is unacceptable (what we don't want them to do), but we also want to make it clear what behavior is acceptable (what we want them to do). These behaviors should be carefully defined so that the teacher will be able to accurately monitor them.

It is also important to ensure that the behavior intervention plan is based upon a careful functional assessment of behavior. Antecedents and consequences of both the problem and replacement behaviors need to be studied. Antecedents will suggest environmental changes that set up the student for success or failure. Analysis of consequences, on the other hand, will identify those environmental contingencies that serve to reinforce both desired and undesired behavior. The function of the problem behavior should guide intervention plans. For example, if the behavior is maintained by negative reinforcement (e.g., avoidance of an undesired task), then the intervention should ensure that this goal is not obtained by the problem behavior. At the same time the intervention should teach the student that the desirable behavior is a more effective way of obtaining the behavioral goal.

Environmental and instructional considerations

Task duration

To accommodate to the student's short attention span, academic assignments should be brief and feedback regarding accuracy immediate. Longer projects should be broken up into manageable parts. Short time limits for task completion should be specified and can be enforced with timers.

Direct instruction

Attention to task is improved when the student with ADHD is engaged in teacher-directed as opposed to independent seat-work activities. Also, the teaching of note-taking strategies increases the benefits of direct instruction. Both comprehension and on-task behavior improve with the development of these skills.

Peer tutoring

Class-wide peer tutoring provides many of the instructional variables known to be important in setting up students with ADHD for success. For example, it provides frequent and immediate feedback. When combined with a token economy, peer tutoring has been found to yield dramatic academic gains.

Scheduling

Based on evidence that the on-task behavior of students with ADHD progressively worsens over the course of the day, it is suggested that academic instruction be provided in the morning. During the after-noon, when problem solving skills are especially poor, more active, nonacademic activities should be scheduled.

Novelty

Presentation of novel, interesting, highly motivating material will improve attention. For example, increasing the novelty and interest level of tasks through use of increased stimulation (e.g., color, shape, texture) reduces activity level, enhances attention and improves overall performance.

Structure and organization

Lessons should be carefully structured and important points clearly identified. For example, providing a lecture outline is a helpful note-taking aid that increases memory of main ideas. Students with ADHD perform better on memory tasks when material is meaningfully structured for them.

Rule reminders and visual cues

The rules given to students with ADHD must be well defined, specific and frequently reinforced through visible modes of presentation. Well-defined rules with clear consequences are essential. Relying on the student's memory of rules is not sufficient. Visual rule reminders or cues should be placed throughout the classroom. It is also helpful if rules are reviewed before activity transitions and following school breaks. For example, token economy systems are especially effective when the rules for these programs are reviewed daily.

Auditory cues

Providing students with ADHD auditory cues that prompt appropriate classroom behavior is helpful. For example, use of a tape with tones placed at irregular intervals to remind students to monitor their on-task behavior has been found to improve arithmetic productivity.

Pacing of work

When possible, it is helpful to allow students with ADHD to set their own pace for task completion. The intensity of problematic ADHD behaviors is less when work is self paced, as compared to situations where work is paced by others.

Instructions

Because students with ADHD have difficulty following multi-step directions, it is important for instruction to be short, specific and direct. Further, to ensure understanding, it is helpful if these students are asked to rephrase directions in their own words. Additionally, teachers must be prepared to repeat directions frequently, and recognize that students often may not have paid attention to what was said.

Productive physical movement

The student with ADHD may have difficulty sitting still. Thus, productive physical movement should be planned. It is appropriate to allow the student with ADHD opportunities for controlled movement and to develop a repertoire of physical activities for the entire class such as stretch breaks. Other examples might include a trip to the office, a chance to sharpen a pencil, taking a note to another teacher, watering the plants, feeding classroom pets, or simply standing at a desk while completing classwork. Alternating seat work activities with other activities that allow for movement is essential. It is also important to keep in mind that on some days it will be more difficult for the student to sit still than on others. Thus, teachers need to be flexible and modify instructional demands accordingly.

Active vs. passive involvement

In line with the idea of providing for productive physical movement, tasks that require active (as opposed to passive) responses may help hyperactive students channel their disruptive behaviors into constructive responses. While it may be problematic for these children to sit and listen to a long lecture, teachers might find that students with ADHD can be successful participants in the same lecture when asked to help (e.g., help with audio-visual aids, write important points on the chalk board, etc.).

Distractions

Generally, research has not supported the effectiveness of complete elimination of all irrelevant stimuli from the student's environment. However, as these students have difficulty paying attention to begin with, it is important that attractive alternatives to the task at hand be minimized. For example, activity centers, mobiles, aquariums and terrariums should not be placed within the student's visual field.

Anticipation

Knowledge of ADHD and its primary symptoms is helpful in anticipating difficult situations. It is important to keep in mind that some situations will be more difficult for than others. For example, effortful problem solving tasks are especially problematic. These situations should be anticipated and appropriate accommodations made. When presenting a task that the teacher suspects might exceed the student's attentional capacity, it is appropriate to reduce assignment length and emphasize quality as opposed to quantity.

Contingency management: Encouraging appropriate behavior

Although classroom environment changes can be helpful in reducing problematic behaviors and learning difficulties, by themselves they are typically not sufficient. Thus, contingencies need to be available that reinforce appropriate or desired behaviors, and discourage inappropriate or undesired behaviors.

Powerful external reinforcement

First, it is important to keep in mind that the contingencies or consequences used with these students must be delivered more immediately and frequently than is typically the case. Additionally, the consequences used need to be more powerful and of a higher magnitude than is required for students without ADHD. Students with ADHD need external criteria for success and need a pay-off for increased performance. Relying on intangible rewards is not enough.

Use of both negative and positive consequences are essential when working with ADHD students. However, before negative consequences can be implemented, appropriate and rich incentives should first be developed to reinforce desired behavior. It is important to give much encouragement, praise and affection as these students are easily discouraged. When negative consequences are administered, they should be given in a fashion that does not embarrass or put down students. Also, it is important to keep in mind that the rewards used with these students lose their reinforcing power quickly and must be changed or rotated frequently.

Token economy systems

These systems are an example of a behavioral strategy proven to be helpful in improving both the academic and behavioral functioning of students with ADHD. These systems typically involved giving students tokens (e.g., poker chips) when they display appropriate behavior. These tokens are in turn exchanged for tangible rewards or privileges at specified times.

Response-cost programs

While verbal reprimands are sufficient for some students, more powerful negative consequences, such as response-cost programs, are needed for others. These programs provide mild punishment when problem behavior is displayed. For example, a student may lose earned points or privileges when previously specified rules are broken. There is evidence that such programming decreases ADHD symptoms such as impulsivity. A specific response-cost program found to be effective with ADHD students involves giving a specific number of points at the start of each day. When a rule is broken (a problem behavior is displayed), points are taken away. Thus, to maintain their points students must avoid breaking the rule. At the end of the period or day, students are typically allowed to exchange the points they have earned for a tangible reward or privilege.

Time-out

Removing the student from positive reinforcement, or time-out, typically involves removing the student from classroom activities. Time-out can be effective in reducing aggressive and disruptive actions in the classroom, especially when these behaviors are strengthened by peer attention. They are not helpful, however, when problem behavior is a result of the student's desire to avoid school work. The time-out area should be a pleasant environment and a student should be placed in it for only a short time. Time-out is ended based upon the student's attitude. At its conclusion a discussion of what went wrong and how to prevent the problem in the future takes place. While these procedures are effective with ADHD students, it is recommended that they be used only with the most disruptive classroom behaviors and only when there is a trained staff.

Summary

As students with ADHD are a heterogeneous group, there is no one intervention (or set of interventions) that will improve the classroom functioning of all of these students. Thus, it is suggested that classroom modifications be tailored to the unique needs of each student. In developing these modifications it is perhaps best to begin by examining how the classroom environment might be changed to set up the student with ADHD for success. The next step is to consider the implementation of a contingency management system designed to provide external incentives for appropriate classroom behaviors. In doing so it is important to remember that behavior management programs must be consistently applied. Further, it is essential to avoid excessive use of negative consequences (such as reprimands, time-out). In all cost programs, it is important to avoid the use of unrealistic standards that result in excessive point or privilege loss. Students must experience success. In other words, it is essential that students be frequently reinforced for what we want them to do, rather than simply punished for what we do not want them to do.

III. Interventions for Attention Problems

A. Classroom Teaching and Accommodations (cont.)

NASET ADHD SERIES

INTRODUCTION

Inattention, hyperactivity, and impulsivity are the core symptoms of Attention Deficit Hyperactivity Disorder (ADHD). A child's academic success is often dependent on his or her ability to attend to tasks and teacher and classroom expectations with minimal distraction. Such skill enables a student to acquire necessary information, complete assignments, and participate in classroom activities and discussions (Forness & Kavale, 2001). When a child exhibits behaviors associated with ADHD, consequences may include difficulties with academics and with forming relationships with his or her peers if appropriate instructional methodologies and interventions are not implemented.

There are an estimated 1.46 to 2.46 million children with ADHD in the United States; together these children constitute 3.5 percent of the student population (Stevens, 1997; American Psychiatric Association, 1994). More boys than girls are diagnosed with ADHD; most research suggests that the condition is diagnosed four to nine times more often in boys than in girls (Bender, 1997; Hallowell, 1994; Rief, 1997). Although for years it was assumed to be a childhood disorder that became visible as early as age 3 and then disappeared with the advent of adolescence, the condition is not limited to children. It is now known that while the symptoms of the disorders may change as a child ages, many children with ADHD do not grow out of it (Mannuzza, Klein, Bessler, Malloy, & LaPadula, 1998).

When selecting and implementing successful instructional strategies and practices, it is imperative to understand the characteristics of the child, including those pertaining to disabilities or diagnoses. This knowledge will be useful in the evaluation and implementation of successful practices, which are often the same practices that benefit students without ADHD.

Research in the field of ADHD suggests that teachers who are successful in educating children with ADHD use a three-pronged strategy. They begin by identifying the unique needs of the child. For example, the teacher determines how, when, and why the child is inattentive, impulsive, and hyperactive. The teacher then selects different educational practices associated with academic instruction, behavioral interventions, and classroom accommodations that are appropriate to meet that child's needs. Finally, the teacher combines these practices into an individualized educational program (IEP) or other individualized plan and integrates this program with educational activities provided to other children in the class.

NASET's ADHD Series is intended to provide educators with a step-by-step approach to the most effective methods of teaching students with ADHD. The ADHD Series was written to explain ADHD from the eyes of the teacher, so that, if a student in your class or school is diagnosed with this disorder, you can work effectively with the administrators, parents, other professionals, and the outside community.

We hope that ***NASET's ADHD Series*** will be helpful to you in understanding the key concepts of this disorder and how to be an effective educator when working with students diagnosed with Attention Deficit Hyperactivity Disorder.

III. Interventions for Attention Problems

A. Classroom Teaching and Accommodations (cont.)

Excerpted from U.S. Dept. of Education

Teaching Children with Attention Deficit Hyperactivity Disorder: Instructional Strategies and Practices

An Overall Strategy for the Successful Instruction of Children with ADHD

Teachers who are successful in educating children with ADHD use a three-pronged strategy. They begin by identifying the unique needs of the child. For example, the teacher determines how, when, and why the child is inattentive, impulsive, and hyperactive. The teacher then selects different educational practices associated with academic instruction, behavioral interventions, and classroom accommodations that are appropriate to meet that child's needs. Finally, the teacher combines these practices into an individualized educational program (IEP) or other individualized plan and integrates this program with educational activities provided to other children in the class. The three-pronged strategy, in summary, is as follows:

- **Evaluate the child's individual needs and strengths.**

Assess the unique educational needs and strengths of a child with ADHD in the class. Working with a multidisciplinary team and the child's parents, consider both academic and behavioral needs, using formal diagnostic assessments and informal classroom observations. Assessments, such as learning style inventories, can be used to determine children's strengths and enable instruction to build on their existing abilities. The settings and contexts in which challenging behaviors occur should be considered in the evaluation.

- **Select appropriate instructional practices.**

Determine which instructional practices will meet the academic and behavioral needs identified for the child. Select practices that fit the content, are age appropriate, and gain the attention of the child.

- **For children receiving special education services, integrate appropriate practices within an IEP.**

In consultation with other educators and parents, an IEP should be created to reflect annual goals and the special education-related services, along with supplementary aids and services necessary for attaining those goals. Plan how to integrate the educational activities provided to other children in your class with those selected for the child with ADHD.

III. Interventions for Attention Problems

B. Managing Behavior

Self-management procedures have been used in school settings to successfully reduce problem behaviors, as well as to reinforce appropriate behavior. A multiple-baseline across participants design was applied in this study to evaluate the effects of using a self-management procedure to enhance the classroom preparation skills of secondary school students with attention-deficit/ hyperactivity disorder (ADHD). Three male students enrolled in a public secondary school were selected for this study because teacher reports suggested that these students were insufficiently prepared for class and inconsistently completed assignments. The intervention involved training in self-management procedures focusing on the improvement of classroom preparation skills. Following the intervention, the training process was systematically faded. Results were consistent across the 3 participants in enhancing classroom preparation behaviors. Implications for practice and future research are discussed.

Five sixth-grade students diagnosed with attention-deficit/hyperactivity disorder (ADHD), taking psychostimulants for treatment of ADHD symptoms, and enrolled in a general education classroom participated in the study. Participants were taught self-management techniques to monitor academic performance, on-task behaviors, and disruptive behaviors. A multiple baseline design across students with intervention withdrawal embedded within each baseline was used to empirically assess the effectiveness of self-management. Self-management associated with increases of on-task behaviors and academic performance and with a decrease of disruptive behaviors when compared to other phases. Implications for practical application of the strategy in general education classrooms are discussed.

Objective: This study examined the feasibility and effectiveness of a behavioral parent training (BPT) group intervention implemented in an outpatient mental health setting in reducing child impairments and increasing parenting confidence in managing child behavior. **Method:** Parents of 241 children with ADHD participated in the eight-session parent group program, completing the Impairment Rating Scale (IRS) and a measure of parenting confidence at the first and last session. **Results:** Parents reported improvements in child behavior across all domains of the IRS, with the largest improvements in terms of overall impairment, parent-child relationship, and impact of child behavior on the family. Parents also reported increased confidence in managing their child's behavior. **Conclusion:** These findings suggest that brief BPT group programs administered to a diverse range of attendees in a typical outpatient setting result in improvements in functional impairments comparable with those produced in controlled studies, as well as improved parenting confidence.

III. Interventions for Attention Problems

C. Treatments and Medications

Attention Deficit/Hyperactivity Disorder (ADHD)

Persistent inattention and hyperactivity are two hallmark symptoms of Attention Deficit/Hyperactivity Disorder (ADHD). Please see the sections below for more information about these difficulties, as well as to learn about the best-supported treatment options.

What is ADHD?

Children and adolescents with ADHD show age-inappropriate levels of inattention, hyperactivity, and impulsivity. Symptoms of inattention include difficulty staying on task, distractibility, disorganization, and forgetfulness. Symptoms of hyperactivity and impulsivity, on the other hand, include interrupting the conversations or activities of others, acting without thinking, talking excessively, and running around when expected to sit quietly. These problems are usually apparent early in development (before age 7), are present in more than one setting (e.g., at home, at school, with peers), and typically follow a chronic course. As a result of their inattention and behavior problems, youths with ADHD often struggle academically and have difficulty getting along with their parents, teachers, and peers. More boys than girls tend to be diagnosed with ADHD.

Although most children and adolescents with ADHD experience problems in all three areas of inattention, hyperactivity, and impulsivity, some young people experience difficulty with sustained attention, disorganization, and forgetfulness, but do not display hyperactive or impulsive behavior. In such cases, problems can go unnoticed until middle school, when academic demands and the structure of the school day often require increased organization. A smaller number of youths (usually very young children) display hyperactive and impulsive behavior in the absence of attention problems. For these children, however, attention problems often emerge as they face increasing demands at school.

ADHD often co-occurs with **Oppositional Defiant Disorder**, **Conduct Disorder**, or a Learning Disorder.

As can be seen below, **behavioral approaches** and **organizational interventions** currently have the most research evidence for the treatment of children and adolescents with ADHD.

Child & Adolescent ADHD

<p>Works Well What does this mean?</p>	<p>Behavior Therapy</p> <ul style="list-style-type: none"> • Behavioral parent training (BPT) • Behavioral classroom management (BCM) • Behavioral peer interventions (BPI) • Combined behavior management interventions • Organization training
<p>Works What does this mean?</p>	<ul style="list-style-type: none"> • Combined training interventions
<p>Might Work What does this mean?</p>	<ul style="list-style-type: none"> • Neurofeedback training
<p>Unknown/Untested What does this mean?</p>	<ul style="list-style-type: none"> • Cognitive training
<p>Not Effective What does this mean?</p>	<ul style="list-style-type: none"> • Social skills training

Example of ADHD

Kevin is a 7 year-old child whose mother and teacher are concerned has difficulties focusing and sustaining attention. Kevin's teacher notes that he often becomes distracted and rushes when completing tasks, talks excessively, and disrupts the class by interrupting the teacher and leaving his seat. Although he is clearly a bright child, these problems are beginning to interfere with his ability to complete tasks at school, particularly when he is expected to work independently. Additionally, Kevin's tendency to be over-exuberant and "budge in" to social situations has led to rejection among his classmates.

III. Intervention for Attention Problems

C. Treatments and Medications (cont.)

Excerpt from: NIMH's *What is Attention Deficit Hyperactivity Disorder (ADHD, ADD)?*

Treatments

Currently available treatments focus on reducing the symptoms of ADHD and improving functioning. Treatments include medication, various types of psychotherapy, education or training, or a combination of treatments.

Treatments can relieve many of the disorder's symptoms, but there is no cure. With treatment, most people with ADHD can be successful in school and lead productive lives. Researchers are developing more effective treatments and interventions, and using new tools such as brain imaging, to better understand ADHD and to find more effective ways to treat and prevent it.

Medications

The most common type of medication used for treating ADHD is called a "stimulant." Although it may seem unusual to treat ADHD with a medication considered a stimulant, it actually has a calming effect on children with ADHD. Many types of stimulant medications are available. A few other ADHD medications are non-stimulants and work differently than stimulants. For many children, ADHD medications reduce hyperactivity and impulsivity and improve their ability to focus, work, and learn. Medication also may improve physical coordination.

However, a one-size-fits-all approach does not apply for all children with ADHD. What works for one child might not work for another. One child might have side effects with a certain medication, while another child may not. Sometimes several different medications or dosages must be tried before finding one that works for a particular child. Any child taking medications must be monitored closely and carefully by caregivers and doctors.

Stimulant medications come in different forms, such as a pill, capsule, liquid, or skin patch. Some medications also come in short-acting, long-acting, or extended release varieties. In each of these varieties, the active ingredient is the same, but it is released differently in the body. Long-acting or extended release forms often allow a child to take the medication just once a day before school, so they don't have to make a daily trip to the school nurse for another dose. Parents and doctors should decide together which medication is best for the child and whether the child needs medication only for school hours or for evenings and weekends, too.

A list of medications and the approved age for use follows. ADHD can be diagnosed and medications prescribed by M.D.s (usually a psychiatrist) and in some states also by clinical psychologists, psychiatric nurse practitioners, and advanced psychiatric nurse specialists. Check with your state's licensing agency for specifics.

Trade Name	Generic Name	Approved Age
Adderall	amphetamine	3 and older
Adderall XR	amphetamine (extended release)	6 and older
Concerta	methylphenidate (long acting)	6 and older
Daytrana	methylphenidate patch	6 and older
Desoxyn	methamphetamine hydrochloride	6 and older
Dexedrine	dextroamphetamine	3 and older
Dextrostat	dextroamphetamine	3 and older
Focalin	dexmethylphenidate	6 and older
Focalin XR	dexmethylphenidate (extended release)	6 and older
Metadate ER	methylphenidate (extended release)	6 and older
Metadate CD	methylphenidate (extended release)	6 and older
Methylin	methylphenidate (oral solution and chewable tablets)	6 and older
Ritalin	methylphenidate	6 and older
Ritalin SR	methylphenidate (extended release)	6 and older
Ritalin LA	methylphenidate (long acting)	6 and older
Strattera	atomoxetine	6 and older
Vyvanse	lisdexamfetamine dimesylate	6 and older

*Not all ADHD medications are approved for use in adults.
NOTE: "extended release" means the medication is released gradually so that a controlled amount enters the body over a period of time. "Long acting" means the medication stays in the body for a long time.

Over time, this list will grow, as researchers continue to develop new medications for ADHD. Medication guides for each of these medications are available from the U.S. Food and Drug Administration (FDA).

What are the side effects of stimulant medications?

The most commonly reported side effects are decreased appetite, sleep problems, anxiety, and irritability. Some children also report mild stomachaches or headaches. Most side effects are minor and disappear over time or if the dosage level is lowered.

Decreased appetite. Be sure your child eats healthy meals. If this side effect does not go away, talk to your child's doctor. Also talk to the doctor if you have concerns about your child's growth or weight gain while he or she is taking this medication.

Sleep problems. If a child cannot fall asleep, the doctor may prescribe a lower dose of the medication or a shorter-acting form. The doctor might also suggest giving the medication earlier in the day, or stopping the afternoon or evening dose. Adding a prescription for a low dose of an antidepressant or a blood pressure medication called clonidine sometimes helps with sleep problems. A consistent sleep routine that includes relaxing elements like warm milk, soft music, or quiet activities in dim light, may also help.

Less common side effects. A few children develop sudden, repetitive movements or sounds called tics. These tics may or may not be noticeable. Changing the medication dosage may make tics go away. Some children also may have a personality change, such as appearing "flat" or without emotion. **Talk with your child's doctor if you see any of these side effects.**

Are stimulant medications safe?

Under medical supervision, stimulant medications are considered safe. Stimulants do not make children with ADHD feel high, although some kids report feeling slightly different or "funny." Although some parents worry that stimulant medications may lead to substance abuse or dependence, there is little evidence of this.

FDA warning on possible rare side effects

In 2007, the FDA required that all makers of ADHD medications develop Patient Medication Guides that contain information about the risks associated with the medications. The guides must alert patients that the medications may lead to possible cardiovascular (heart and blood) or psychiatric problems. The agency undertook this precaution when a review of data found that ADHD patients with existing heart conditions had a slightly higher risk of strokes, heart attacks, and/or sudden death when taking the medications.

The review also found a slight increased risk, about 1 in 1,000, for medication-related psychiatric problems, such as hearing voices, having hallucinations, becoming suspicious for no reason, or becoming manic (an overly high mood), even in patients without a history of psychiatric problems. The FDA recommends that any treatment plan for ADHD include an initial health history, including family history, and examination for existing cardiovascular and psychiatric problems.

One ADHD medication, the non-stimulant atomoxetine (Strattera), carries another warning. Studies show that children and teenagers who take atomoxetine are more likely to have suicidal thoughts than children and teenagers with ADHD who do not take it. **If your child is taking atomoxetine, watch his or her behavior carefully. A child may develop serious symptoms suddenly, so it is important to pay attention to your child's behavior every day.** Ask other people who spend a lot of time with your child to tell you if they notice changes in your child's behavior. Call a doctor right away if your child shows any unusual behavior. While taking atomoxetine, your child should see a doctor often, especially at the beginning of treatment, and be sure that your child keeps all appointments with his or her doctor.

Do medications cure ADHD?

Current medications do not cure ADHD. Rather, they control the symptoms for as long as they are taken. Medications can help a child pay attention and complete schoolwork. It is not clear, however, whether medications can help children learn or improve their academic skills. Adding behavioral therapy, counseling, and practical support can help children with ADHD and their families to better cope with everyday problems. Research funded by the National Institute of Mental Health (NIMH) has shown that medication works best when treatment is regularly monitored by the prescribing doctor and the dose is adjusted based on the child's needs.

Psychotherapy

Different types of psychotherapy are used for ADHD. Behavioral therapy aims to help a child change his or her behavior. It might involve practical assistance, such as help organizing tasks or completing schoolwork, or working through emotionally difficult events. Behavioral therapy also teaches a child how to monitor his or her own behavior. Learning to give oneself praise or rewards for acting in a desired way, such as controlling anger or thinking before acting, is another goal of behavioral therapy. Parents and teachers also can give positive or negative

feedback for certain behaviors. In addition, clear rules, chore lists, and other structured routines can help a child control his or her behavior.

Therapists may teach children social skills, such as how to wait their turn, share toys, ask for help, or respond to teasing. Learning to read facial expressions and the tone of voice in others, and how to respond appropriately can also be part of social skills training.

How can parents help?

Children with ADHD need guidance and understanding from their parents and teachers to reach their full potential and to succeed in school. Before a child is diagnosed, frustration, blame, and anger may have built up within a family. Parents and children may need special help to overcome bad feelings. Mental health professionals can educate parents about ADHD and how it impacts a family. They also will help the child and his or her parents develop new skills, attitudes, and ways of relating to each other.

Parenting skills training helps parents learn how to use a system of rewards and consequences to change a child's behavior. Parents are taught to give immediate and positive feedback for behaviors they want to encourage, and ignore or redirect behaviors they want to discourage. In some cases, the use of "time-outs" may be used when the child's behavior gets out of control. In a time-out, the child is removed from the upsetting situation and sits alone for a short time to calm down.

Parents are also encouraged to share a pleasant or relaxing activity with the child, to notice and point out what the child does well, and to praise the child's strengths and abilities. They may also learn to structure situations in more positive ways. For example, they may restrict the number of playmates to one or two, so that their child does not become overstimulated. Or, if the child has trouble completing tasks, parents can help their child divide large tasks into smaller, more manageable steps. Also, parents may benefit from learning stress-management techniques to increase their own ability to deal with frustration, so that they can respond calmly to their child's behavior.

Sometimes, the whole family may need therapy. Therapists can help family members find better ways to handle disruptive behaviors and to encourage behavior changes. Finally, support groups help parents and families connect with others who have similar problems and concerns. Groups often meet regularly to share frustrations and successes, to exchange information about recommended specialists and strategies, and to talk with experts.

III. Interventions for Attention Problems

D. Follow-up Treatment Research

Abstract from: Attention-deficit hyperactivity disorder, multimodal treatment, and longitudinal outcome: evidence, paradox, and challenge. Hinshaw, S.P., Arnold, L.E. and For the MTA Cooperative Group (2015). *Cognitive Science*, 6, 39–52.

Given major increases in the diagnosis of attention-deficit hyperactivity disorder (ADHD) and in rates of medication for this condition, we carefully examine evidence for effects of single versus multimodal (i.e., combined medication and psychosocial/behavioral) interventions for ADHD. Our primary data source is the Multimodal Treatment Study of Children with ADHD (MTA), a 14-month, randomized clinical trial in which intensive behavioral, medication, and multimodal treatment arms were contrasted with one another and with community intervention (treatment-as-usual), regarding outcome domains of ADHD symptoms, comorbidities, and core functional impairments. Although initial reports emphasized the superiority of well-monitored medication for symptomatic improvement, reanalyses and reappraisals have highlighted (1) the superiority of combination treatment for composite outcomes and for domains of functional impairment (e.g., academic achievement, social skills, parenting practices); (2) the importance of considering moderator and mediator processes underlying differential patterns of outcome, including comorbid subgroups and improvements in family discipline style during the intervention period; (3) the emergence of side effects (e.g., mild growth suppression) in youth treated with long-term medication; and (4) the diminution of medication's initial superiority once the randomly assigned treatment phase turned into naturalistic follow-up. The key paradox is that while ADHD clearly responds to medication and behavioral treatment in the short term, evidence for long-term effectiveness remains elusive. We close with discussion of future directions and a call for greater understanding of relevant developmental processes in the attempt to promote optimal, generalized, and lasting treatments for this important and impairing neurodevelopmental disorder.

Periodically, windows of opportunities arise for providing inservice at schools about mental health and psychosocial concerns, When such opportunities appear, it may be helpful to access one of more of our Center's *Quick Training Aids*.

Each of these offer a brief set of resources to guide those providing an inservice session. (They also are a form of quick self-tutorial and group discussion.)

Most encompass

- key talking points for a short training session
- a brief overview of the topic
- facts sheets
- tools
- a sampling of other related information and resources

*In compiling resource material, the Center tries to identify those that represent "best practice" standards, If you know of better material, please **let us know** so that we can make improvements.*

V. *A Few More Aids*



- A. **Questions Parents Ask**
- B. **Fidgety Students**
- C. **Tips for Parents of Youngsters with Attention Problems**

V. A Few More Aids

A. Questions Parents Ask and Some Concerns About Attention Deficit/Hyperactivity Disorder (ADHD)

This brief is designed for parents and highlights common questions and concerns surrounding Attention Deficit/Hyperactivity Disorder (ADHD). The contents are drawn from a variety of resources, all of which are cited in the list of references.*

Questions addressed are:

- *What do I do if my child is having problems at school?*
- *How do I know if it is ADHD?*
- *What is the best intervention for ADHD?*
- *What kind of help is available at school?*

In answering these questions, parents need to be aware of major concerns related to:

- diagnosis
- medication
- behavior control strategies

A Typical Scenario

Johnny is seven years old and is always on the go. He moves quickly from one activity to the next and talks incessantly. He often forgets to bring his homework home from school or, when he does remember, forgets to take his completed work back to school – resulting in many missing and incomplete assignments.

Johnny's mother, Mary, has always thought of Johnny as being full of energy and acknowledges that, at times, he can be a handful. He often climbs on the furniture in the house and seems to act without thinking. For example, last summer while attempting to climb the backyard tree Johnny slipped and fell, breaking his arm. Recently, Mary has been receiving more reports from Johnny's second grade teacher citing disruptive classroom behavior and inability to stay on task. Additionally, his inattention and activity seem to be affecting his grades and relationships with his peers.

The family wants to know what to do.

Question:

What do I do if my child is having trouble at school?

Talk to your child about his experiences with school. Find out: Does he like school and his teacher? If not, why? Is he interested in what he is learning? What are his favorite subjects, lessons, or activities? Does he feel confident that he can succeed in school? Encourage him to fully express his thoughts.

Talk with his teacher. Share what your child has told you. Find out: What does s/he thinks is causing the problems? What's already been tried to address the problems? What does s/he recommend?

Work with your child and the teacher to develop a plan for success. Based on what you all think is the root of the problem, plan ways to help establish a classroom and home environment where your child feels safe, respected, supported, and engaged in meaningful activities/lessons that are a good match for his motivation and capabilities. Consider specific accommodations that will enable success and reduce the need for disciplinary measures, thereby minimizing the need to assert control (which often increases rebellious behavior).

Strategies frequently discussed in the literature suggest (a) ensuring communications are delivered in ways that are clear, specific, concrete, and developmentally appropriate, (b) ensuring communications are understood by the child (especially those related to plans and expectations), (c) being clear about expectations and the value of accomplishing what is expected and the consequences of not doing so, (d) establishing appropriate routines, (e) providing specific and direct support and guidance and avoiding excessive use of questions, and (f) ensuring frequent feedback related to good and not so good outcomes (charting may be helpful).

Maintain the discourse with both your child and his teacher. Focus on what is going well and continue to modify plans to address any problems.

If problems continue, add on some specialized interventions. If the child is having learning problems, a natural adjunct is tutoring. If the problem is more about behavior than learning, a teacher may make environmental changes such as seating the child away from other students who are distractions and explicitly indicating the schedule and what is expected for the next period of time. Sometimes the student is paired with a peer buddy or mentor who can provide some extra support and guidance.

Teachers and parents often choose to introduce a behavior modification approach. This involves selective use of rewards and consequences. For example, young children are given gold stars or toy privileges for completing assignments in class, remembering to bring homework to and from school, or for completing chores at home. As consequences, the trend is to remove desired activities (e.g., loss of playtime until homework is finished).

If problems still continue, ask the school for a special education evaluation.

Question:

How do I know if it is ADHD?

There is no test or battery of tests that can say without a doubt that an individual has ADHD. It is important that the professional from whom you seek help thoroughly and carefully assesses your child and considers the degree to which the observed problems may be caused by an actual disorder or may be due to motivational factors. That is, a diagnosis of ADHD is only appropriate when ADHD-like symptoms cannot be explained by another cause.

Experts stress that the assessment should include separate interviews with you and your child (using approved rating instruments) asking about observed positive and negative functioning and possible causal factors for problems at home, at school, and in other settings. Information from the teacher also is important. Based on the assessment, the professional should clarify the different intervention options available.

It is not uncommon for a child to qualify for ADHD at their initial assessment but then fail to meet criteria when assessed later. To minimize false identifications, be sure to have periodic follow up evaluations to determine whether s/he still meets diagnostic criteria months and years later.

To see the criteria used for diagnosing ADHD, you can go to the federal Centers for Disease Control and Prevention's website -- <http://www.cdc.gov/ncbddd/adhd/diagnosis.html> .

Question:

What is the best intervention for ADHD?

Best is a relative term. There is no "quick fix" for ADHD! Researchers are still seeking interventions that will be highly effective for all children diagnosed as ADHD. Treatment depends on each individual child; there is no cookie-cutter technique. Each child and their behaviors are unique and no one intervention works for all. Whatever intervention is chosen must be tailored to your child, especially if your child's ADHD co-occurs with other problems or disorders such as learning problems and anxiety.

First of all, be sure that efforts are made both at home and in the classroom to address underlying problems. Work with your child's teacher to personalize his or her classroom and to enhance engagement. This includes providing more support and guidance and accommodations.

If problems persist and your child still qualifies for an ADHD diagnosis, currently the common interventions include medications, cognitive/behavior therapy, and education of parents, the child, and teachers about ADHD and how to manage it. Professionals tend to suggest use of combined interventions. While the American Academy of Pediatrics (AAP)

recommends combining medication and behavior therapy for school-age children and adolescents, they caution about the use of medication for preschool age children.

To maintain improvements, the trend is to recommend long-term intervention. Throughout, communicate closely with those who are helping you and your child and make sure that your child's progress and symptoms are continuously monitored. All intervention involves *ongoing transactions* (not a one-time visit for a prescription). Medication, in particular, must be closely monitored to assess effectiveness and watch for side effects. Remember: children respond differently to different interventions and do so differently at different ages. It may take several tries to "get it right."

Researchers stress that treatments for which there is little or no evidence of effectiveness for ADHD include: dietary management (like removing sugar, adding vitamins, minerals, elements, etc.), long term psychotherapy/psychoanalysis, biofeedback, play therapy, chiropractic treatment, or sensory-integration training.

Question:

What kind of help is available at school?

As noted in the previous responses, many steps can be taken at school to assist your child and enable his or her effective functioning. Your first role is to work with the teacher to plan and ensure that a range of promising strategies are introduced into daily classroom experiences. Focus first and foremost on ensuring the youngster is engaged in classroom learning. While all students can benefit from a personalized approach, such an approach is *essential* for students who are having difficulty at school.

If more help is needed, you will want to ask the school for a special education evaluation. *Schools are required by law to provide special accommodations and special assistance to students diagnosed as ADHD.*

Structure, consistency, motivating topics, and encouragement can go a long way in helping a student with ADHD to learn more effectively and to have better classroom behavior. The teacher should carefully structure and explain what is to be learned, how it relates to what has been learned previously, why it is worth learning, and how the student will be able to do it with an appropriate amount of effort and support. Examples of accommodations the school might be asked to try include: (a) working on hard concepts early in the day, (b) giving directions to one assignment at a time instead of to multiple tasks all at once, (c) simplifying instructions, (d) varying the pace and type of activity and structure, (e) dividing work into smaller units, (f) providing follow-up directions, (g) highlighting key points, (h) checking the student's assignments and giving a preview of the next lesson.

Concerns to Think About

There are three major concerns that arise around ADHD. The concerns reflect problems related to (1) diagnosis, (2) medication, and (3) behavior control strategies.

Concern About Diagnosing ADHD

It is important for everyone to understand that diagnosing ADHD is a far from perfect process. As a result, errors often are made, and there is concern about over-diagnosis.

❖ ***Diagnostic difficulty.*** ADHD-like behaviors can stem from many causes, not just a psychological dysfunction or disorder. Motivation is a key factor driving behaviors and should not be overlooked when a child is having difficulties in school.

Attention and activity vary in different situations (e.g., playing video games vs. doing homework) and among children of the same age. Inattention can result from many factors: an environment that is too challenging or not challenging enough, an unstructured upbringing, lack of sleep, poor nutrition, and much more. And, what is considered “normal” varies with age, stage of development, and situation. For example, what is a normal level of activity, attention, and impulsivity at five differs from what is expected of a ten-year-old. High activity during play sessions is common for elementary students, but is not appropriate in the classroom. When they are alone, youngsters tend to act differently than when they are with their peers.

Before going to school, a toddler may be seen as highly active; upon entering school, the behavior may be seen as a bit of a problem; around first or second grade, when the child is expected to pay attention for longer periods of time, take tests, and listen to lessons, s/he may be informally seen as ADHD and referred for evaluation.

Before seeking assessment for a diagnosable problem, it is important to consider if the child is motivationally uninvolved, avoidant, or both, rather than inattentive or hyperactive. A child who does not value school or learning, or who finds the material too hard and prefers to avoid it, will likely socialize in class, become easily distracted, or even act out.

❖ ***Misdiagnosis.*** Some individuals are diagnosed when they do not actually have ADHD, while others are not when such a diagnosis is appropriate. Research suggests that a range of factors may systematically influence diagnosis and that the criteria for diagnosing ADHD become less accurate for adolescents and adults.

The diagnostic guidelines for ADHD suggest comparison with the child’s *peers* rather than children of comparable age in their class. However, recent research reports that children who are the youngest in their class are more likely to be diagnosed with ADHD than the oldest in the class, even when these children are similar demographically. This effect may be due to the relative *immaturity* of younger children as contrasted with their older classmates

(cont.)

- ❖ **Over-diagnosis.** Another controversy surrounding ADHD is that of over-diagnosis. Given the rapidly rising number of ADHD diagnoses, it is not uncommon to hear accusations that the label is being assigned carelessly. Some cite examples of parents who “shop-around” for a doctor who will diagnose their child as ADHD in order to receive special help and accommodations at school. Others cite doctors who only engage in ten minute conversations with a parent and are ready to hand out a label and a prescription.

Much research has been conducted looking into this controversy. For example, gender difference in rates of diagnosis for boys and girls often are cited (i.e., many more boys are diagnosed with ADHD). The problem with these data is that girls are more likely to have inattentive symptoms which are readily ignored while boys are more likely to be hyperactive and disruptive and referred as potentially ADHD.

Two Major Concerns Related to Responding After Diagnosis

- ❖ **Medication.** Many concerns have been raised about children taking medication, especially now that preschool age children are being considered. Given that children often are on stimulant medication (e.g., Ritalin, Concerta, Adderall) for extended periods of time, there is particular concern about what the long term effects may be. (Immediate side effects can include headache, decreased appetite, insomnia, reduced growth, and in some cases, rare cardiovascular and psychiatric side effects).

As stimulant medications are very widely used, and often thought of as the first form of treatment for children diagnosed with ADHD, concern arises over whether the benefits outweigh the costs. Many studies conducted in laboratory settings show that medications are effective at reducing some ADHD symptoms. And combination medication and behavior therapy has been used to address a wider range of symptoms with lower doses of medication. But besides commonly reported side effects, controversy has arisen about whether medication is being used as a form of social control with little benefit for enhancing student learning. Moreover, some students feel oppressed and stigmatized by having to take medication. Finally, there is the increasing illegal acquisition of stimulant medication for substance abuse.

- ❖ **Behavior management techniques.** Concern has been raised that an over-reliance on behavior management may produce some immediate control over behavior, but it is unlikely to produce long lasting and generalizable learning. Moreover, it can undermine intrinsic motivation and produce a rebellious reaction. For example, if you reward your child with a sticker for bringing home his/her homework (with five stickers allowing him/her to pick out a toy from the store), s/he is likely to bring the homework as long as rewards are given. But don't expect that behavior to be maintained when the rewards stop. And, don't expect spontaneous improvements in learning and behavior at school. The need is to help your child experience school as a place where s/he wants to learn and is supported in pursuing activities s/he values and expects to attain with an appropriate amount of effort.

Summary

Attention Deficit/Hyperactivity Disorder (ADHD) is a legitimate disorder. Efforts, however, clearly need to be made to rule out other causes of the observed behavioral symptoms before labeling a child with ADHD. Motivation, especially, is a key factor to consider related to behaviors that are viewed as inattentive, impulsive, and hyperactive.

It is important to be certain that all major alternative explanations for your child's behavior be eliminated before a diagnosis of ADHD is made.

An important way to explore alternative explanations is to work with the teacher to formulate a personalized plan that will ensure your child feels safe, respected, meaningfully engaged, and supported at school and at home.

If that proves insufficient, work with the schools to add specific accommodations and supports that will enable success by addressing interfering factors.

If that still is insufficient, ask the school for a special education evaluation.

Should your child be diagnosed with ADHD, you should consider how to involve the youngster in decisions about what special interventions will be used.

With specific respect to medication, we know that some families want to try other interventions first and use medication as a last resort.

V. A Few More Aids

B. Fidgety Students

We hear from many teachers about this matter. Here are two recent requests:

(1) *I have several students who have a hard time sitting in their seats for instruction. Any suggestions?*

(2) *I have several students who are easily distracted, can't stay on task, need a lot redirection. ... Needless to say, they are having little success in the classroom. I have tried reinforcement, but it doesn't work. What other interventions would be appropriate?*

Rather than making it a control problem, let's assume that the students need some accommodations (e.g., standing up at times while working, periodically getting up at their seat for a few minutes break) and maybe some prosocial opportunities to move about (e.g., helping the teacher with some tasks).

Here are some immediate practices excerpted from variety of sources:

From Great Classroom Accommodations –

“Allow for extra movement. When given a choice, some students have trouble sitting at a table with feet on the floor to study homework. Indeed, when they had to study in a setting that didn't allow movement, their performance declined. I've seen classrooms where children are allowed to sit on low tables, or even under the tables, to read and write. The room was relatively quiet and orderly, even though there were a number of children with impulsivity and hyperactivity. You see, when the impulsivity and hyperactivity is accommodated, it tends to diminish with such accommodations.

Build a quiet corner. A soft rug, some beanbag chairs, make-due foam pillows in a back corner offers a more natural setting for leisure reading.

Study carrels offer privacy and personal space when needed. Carrels can be placed against the back wall or folding individual carrels can be constructed of hardboard and placed on the student's desk. Student can decorate as desired.

Preferential seating. Some students may perform better when seated near the teacher and where visual distractions are reduced. Others are so self-conscious when seated up front, it actually diminishes their performance. This has to be an individual call.”

From *Strategies for counselors and teachers*

“...Physical changes can help students who need physical activity. One straightforward accommodation is to provide desks: two desks in the front of the room, one on each side. Whenever a student needs physical activity, he or she simply moves to the other desk. Along with this, students are taught how to move from one desk to another (e.g., take all work/materials necessary, move directly to the new desk, don't speak to other students while making the move).

Another simple accommodation for students who need more physical activity is a standup desk – a desk that has been raised to approximately chest height, allowing the student to stand and work. This can be done quite simply by extending desk legs to the maximum or by placing the desk on blocks. Stand-up desks help allow for physical movement during independent work. Combining various types of seating arrangements may be desirable. For example, a child might have one normal desk, one stand-up desk, and one study carrel, each of which would be appropriate for different instructional activities.

For children who have difficulty remaining on-task, one effective accommodation is to have them work in study carrels. These are a simple, inexpensive means of greatly decreasing distractions. One potential problem with study carrels is that some students may perceive them as punitive, especially if they are used in conjunction with time-out. To avoid this problem, one clever teacher told her students that they could use carrels as a “special office.” Using the “office” was contingent upon appropriate behavior (“the office is only for working”). Students were allowed to put up a sign with their name when they used their “office,” and to sign up to reserve “office time,” and they were encouraged to move to their special office whenever they felt distracted.

Seating arrangements and instructional grouping also can affect students who have trouble sitting still because of proximity to other students who might pose potential distractions or unwittingly reinforce inappropriate behavior...”

From our Center: Be careful not to assume that fidgety students are ADHD. A few may be, but the reality is that fidgetedness is a common characteristic of a lot of individuals. Furthermore, many students are fidgety and increasingly so when they are not well engaged in learning in the classroom.

The danger with students who are not engaged is that they fill their time with behavior that not only is not productive, but often is disruptive, and this leads to negative encounters with the teacher and other school staff. In turn, this leads to a cycle of encounters that produce negative attitudes toward the teacher, school, and classroom learning. Thus, the first intervention concern for us is to “above all do no harm” with respect to the student's intrinsic motivation toward coming to school and for classroom learning (e.g., the youngster's feelings of competence, self-determination, relatedness to teacher and peers). To minimize threats to motivation, it is essential to personalize learning through accommodations that produce a good match to the student's interests and capabilities.

In this respect, one place to start is with ideas stemming from the literature on prereferral interventions and classroom accommodations designed to improve the match or "fit" between the classroom programs and the youngster's interests and capabilities.

Thus, over the long run, the best strategy to address this problem and a range of other behavior problems is to personalize learning. This tends to take care of most problems and then special assistance and accommodations can be reserved for those who really need it.

Some Immediate Things to Try

In general, the immediate need is to make changes to (a) improve the match between a youngster's program and his/her interests and capabilities and (b) try to find ways for her/him to have a special, positive status in class, at the school, and in the community. Talk and work with other staff in developing ideas along these lines.

- Add resources for extra support (aide, volunteers, peer tutors) to help the youngster's efforts to learn and perform. Create time to interact and relate with the youngster as an individual.
- Discuss with the youngster (and those in the home) why the problems are occurring.
- Specifically focus on exploring matters with the youngster that will suggest ways to enhance positive motivation.
- Change aspects of the program (e.g., materials, environment) to provide a better match with his/her interests and skills.
- Provide enrichment options (in and out of class).
- Use resources such as volunteers, aides, and peers to enhance the youngster's social support network.
- Specifically focus on exploring ways those in the home can enhance their problem-solving efforts.
- If necessary include other staff (e.g., counselor, principal) in a special discussion with the youngster exploring reasons for the problem and ways to enhance positive involvement at school and in class.

Note: The Center has a range of resources related to this topic.

***Classroom Problems: What Can I Do Right Away? A Learning Supports Practice Series for Teachers**

Often the best way to learn is by addressing a specific concern that needs an immediate response.

With this in mind, the Center is producing a series of resources focused on daily classroom dilemmas teachers experience and some initial ways to deal with such concerns. The emphasis is on engaging and re-engaging students in classroom learning.

As a school moves to develop a unified and comprehensive system of learning supports, this series can help augment professional development by providing a stimulus for discussion by teachers and other staff.

What can I do right away?

To date, this learning supports practice series for teachers includes the following topics:

- > *Bullying* – <http://smhp.psych.ucla.edu/pdfdocs/bullypn.pdf>
- > *Disengaged Students* – <http://smhp.psych.ucla.edu/pdfdocs/disengpn.pdf>
- > *Fidgety Students* – <http://smhp.psych.ucla.edu/pdfdocs/fidgetypn.pdf>
- > *Homework Avoidance* – <http://smhp.psych.ucla.edu/pdfdocs/homeworkpn.pdf>
- > *Students in Distress* – <http://smhp.psych.ucla.edu/pdfdocs/distresspn.pdf>
- > *Minimizing Referrals out of the Classroom* –
<http://smhp.psych.ucla.edu/pdfdocs/referralspn.pdf>
- > *Addressing Neighborhood Problems that Affect the School* –
<http://smhp.psych.ucla.edu/pdfdocs/neighpn.pdf>

V. A Few More Aids

C. Tips for Parents of Youngsters with Attention Problems



Life with a child with ADD/ADHD can be frustrating and overwhelming, but as a parent there is a lot you can do to help control and reduce the symptoms. You can help your child overcome daily challenges, channel his or her energy into positive arenas, and bring greater calm to your family. The earlier and more consistently you address your child's problems, the greater chance they have for success in life.

Helping your child with ADD/ADHD: What you need to know

Children with ADD/ADHD generally have deficits in *executive function*: the ability to think and plan ahead, organize, control impulses, and complete tasks. That means you need to take over as the executive, providing extra guidance while your child gradually acquires executive skills of his or her own.

Although the symptoms of ADD/ADHD can be nothing short of exasperating, it's important to remember that the child with ADD/ADHD who is ignoring, annoying, or embarrassing you is not acting willfully. Kids with ADD/ADHD want to sit quietly; they want to make their rooms tidy and organized; they want to do everything their parent says to do—but they don't know how to make these things happen.

Having ADD/ADHD can be just as frustrating as dealing with someone who has it. If you keep this in mind, it will be a lot easier to respond to your child in positive, supportive ways. With patience, compassion, and plenty of support, you can manage childhood ADHD while enjoying a stable, happy home.

ADD/ADHD and the family

Before you can successfully parent a child with ADD/ADHD, it's essential to understand the impact of your child's symptoms on the family as a whole. Children with ADD/ADHD exhibit a slew of behaviors that can disrupt family life:

- They often don't "hear" parental instructions, so they don't obey them.
- They're disorganized and easily distracted, keeping other family members waiting.
- They start projects and forget to finish them—let alone clean up after them.
- Children with impulsivity issues often interrupt conversations and demand attention at inappropriate times.
- They might speak before they think, saying tactless or embarrassing things.
- It's often difficult to get them to bed and to sleep.
- Hyperactive children may tear around the house or even do things that put them in physical danger.

The impact of ADD/ADHD on siblings

Because of these behaviors, siblings of children with ADD/ADHD face a number of challenges:

- Their needs often get less attention than those of the child with ADD/ADHD.
- They may be rebuked more sharply when they err, and their successes may be less celebrated or taken for granted.
- They may be enlisted as assistant parents—and blamed if the sibling with ADD/ADHD misbehaves under their supervision.
- As a result, siblings may find their love for a brother or sister with ADD/ADHD mixed with jealousy and resentment.

The impact of ADD/ADHD on parents

And, of course, having a child with ADD/ADHD affects parents in many ways:

- The demands of a child with ADD/ADHD can be physically exhausting.
- The need to monitor the child's activities and actions can be psychologically exhausting.
- The child's inability to "listen" is frustrating.
- The child's behaviors, and your knowledge of their consequences, can make you anxious and stressed.
- If there's a basic difference between your personality and that of your child with ADD/ADHD, you may find your child's behaviors especially difficult to accept.
- Frustration can lead to anger—and guilt about being angry at your child.

In order to meet the challenges of raising a child with ADD/ADHD, you must be able to master a combination of *compassion* and *consistency*. Living in a home that provides both love and structure is the best thing for a child or teenager who is learning to manage ADD/ADHD.

ADD/ADHD parenting tip 1: Stay positive and healthy yourself

As a parent, you set the stage for your child's emotional and physical health. You have control over many of the factors that can positively influence the symptoms of your child's disorder.

The power of a positive attitude

Your best assets for helping your child meet the challenges of ADD/ADHD are your positive attitude and common sense. When you are calm and focused, you are more likely to be able to connect with your child, helping him or her to be calm and focused as well.

- **Keep things in perspective.** Remember that your child's behavior is related to a disorder. Most of the time it is not intentional. Hold on to your sense of humor. What's embarrassing today may be a funny family story ten years from now.
- **Don't sweat the small stuff and be willing to make some compromises.** One chore left undone isn't a big deal when your child has completed two others plus the day's homework. If you are a perfectionist, you will not only be constantly dissatisfied but also create impossible expectations for your ADD/ADHD child.
- **Believe in your child.** Think about or make a written list of everything that is positive, valuable, and unique about your child. Trust that your child can learn, change, mature, and succeed. Make thinking about this trust a daily task as you brush your teeth or make your coffee.

When you take care of yourself, you're better able to take care of your child

As your child's role model and most important source of strength, it is vital that you live a healthy life. If you are overtired or have simply run out of patience, you risk losing sight of the structure and support you have so carefully set up for your child with ADD/ADHD.

- **Take care of yourself.** Eat right, exercise, and find ways to reduce stress, whether it means taking a nightly bath or practicing morning meditation. If you do get sick, acknowledge it and get help.
- **Seek support.** One of the most important things to remember in rearing a child with ADD/ADHD is that you don't have to do it alone. Talk to your child's doctors, therapists, and teachers. Join an organized support group for parents of children with ADHD. These groups offer a forum for giving and receiving advice, and provide a safe place to vent feelings and share experiences.
- **Take breaks.** Friends and family can be wonderful about offering to babysit, but you may feel guilty about leaving your child, or leaving the volunteer with a child with ADD/ADHD. Next time, accept their offer and discuss honestly how best to handle your child.

How pets can help kids with ADHD (and their parents)

If your home life feels chaotic, you may be reluctant to add a pet to the mix. But pets come with a host of benefits for you and your child. They can help teach your kid responsibility and get him or her outside. They can also inject some much-needed fun and help the whole family blow off steam. In fact, studies show that pets can protect you from depression, stress, and even medical problems.

Read: [The Health Benefits of Pets](#)

ADD/ADHD parenting tip 2: Establish structure and stick to it

Children with ADHD are more likely to succeed in completing tasks when the tasks occur in predictable patterns and in predictable places. Your job is to create and sustain structure in your home, so that your child knows what to expect and what they are expected to do.

Tips for helping your child with ADD/ADHD stay focused and organized

- **Follow a routine.** It is important to set a time and a place for everything to help the child with ADD/ADHD understand and meet expectations. Establish simple and predictable rituals for meals, homework, play, and bed. Have your child lay out clothes for the next morning before going to bed, and make sure whatever he or she needs to take to school is in a special place, ready to grab.
- **Use clocks and timers.** Consider placing clocks throughout the house, with a big one in your child's bedroom. Allow enough time for what your child needs to do, such as homework or getting ready in

the morning. Use a timer for homework or transitional times, such between finishing up play and getting ready for bed.

- **Simplify your child's schedule.** It is good to avoid idle time, but a child with ADHD may become more distracted and "wound up" if there are many after-school activities. You may need to make adjustments to the child's after-school commitments based on the individual child's abilities and the demands of particular activities.
- **Create a quiet place.** Make sure your child has a quiet, private space of his or her own. A porch or a bedroom work well too, as long as it's **not** the same place as the child goes for a time-out.
- **Do your best to be neat and organized.** Set up your home in an organized way. Make sure your child knows that everything has its place. Lead by example with neatness and organization as much as possible.

Avoid problems by keeping kids with attention deficit disorder busy!

For kids with ADD/ADHD, idle time may exacerbate their symptoms and create chaos in your home. It is important to keep a child with ADD/ADHD busy without piling on so many things that the child becomes overwhelmed.

Sign your child up for a sport, art class, or music. At home, organize simple activities that fill up your child's time. These can be tasks like helping you cook, playing a board game with a sibling, or drawing a picture. Try not to over-rely on the television or computer/video games as time-fillers. Unfortunately, TV and video games are increasingly violent in nature and may only increase your child's symptoms of ADD/ADHD.

ADD/ADHD parenting tip 3: Set clear expectations and rules

Children with ADHD need consistent rules that they can understand and follow. Make the rules of behavior for the family simple and clear. Write down the rules and hang them up in a place where your child can easily read them.

Children with ADD/ADHD respond particularly well to organized systems of rewards and consequences. It's important to explain what will happen when the rules are obeyed and when they are broken. Finally, stick to your system: follow through each and every time with a reward or a consequence.

Don't forget praise and positive reinforcement

As you establish these consistent structures, keep in mind that children with ADHD often receive criticism. Be on the lookout for good behavior—and praise it. Praise is especially important for children who have ADD/ADHD because they typically get so little of it. These children receive correction, remediation, and complaints about their behavior—but little positive reinforcement.

A smile, positive comment, or other reward from you can improve the attention, concentration and impulse control of your child with ADD/ADHD. Do your best to focus on giving positive praise for appropriate behavior and task completion, while giving as few negative responses as possible to inappropriate behavior or poor task performance. Reward your child for small achievements that you might take for granted in another child.

Kids with ADD/ADHD: Using Rewards and Consequences	
Rewards	Consequences
Reward your child with privileges, praise, or activities, rather than with food or toys.	Consequences should be spelled out in advance and occur immediately after your child has misbehaved.
Change rewards frequently. Kids with ADD/ADHD get bored if the reward is always the same.	Try time-outs and the removal of privileges as consequences for misbehavior.
Make a chart with points or stars awarded for good behavior, so your child has a visual reminder of his or her successes.	Remove your child from situations and environments that trigger inappropriate behavior.
Immediate rewards work better than the promise of a future reward, but small rewards leading to a big one can also work.	When your child misbehaves, ask what he or she could have done instead. Then have your child demonstrate it.
Always follow through with a reward.	Always follow through with a consequence.

ADD/ADHD parenting tip 4: Encourage movement and sleep

Physical activity can help your child with ADD/ADHD

Children with ADD/ADHD often have energy to burn. Organized sports and other physical activities can help them get their energy out in healthy ways and focus their attention on specific movements and skills.

The benefits of physical activity are endless: it improves concentration, decreases depression and anxiety, and promotes brain growth. Most importantly for children with attention deficits, however, is the fact that exercise leads to better sleep, which in turn can also reduce the symptoms of ADD/ADHD.

Find a sport that your child will enjoy and that suits his or her strengths. For example, sports such as softball that involve a lot of "down time" are not the best fit for children with attention problems. Individual or team sports like basketball and hockey that require constant motion are better options.

Children with ADD/ADHD may also benefit from martial arts training, tae kwon do, or yoga, which enhance mental control as they work out the body.



Better sleep can help your child with ADD/ADHD

Insufficient sleep can make anyone less attentive, but it can be highly detrimental for children with ADD/ADHD. Kids with ADD/ADHD need at least as much sleep as their unaffected peers, but tend not to get what they need. Their attention problems can lead to overstimulation and trouble falling asleep. A consistent, early bedtime is the most helpful strategy to combat this problem, but it may not completely solve it.

Help your child get better rest by trying out one or more of the following strategies:

- **Decrease television time** and increase your child's activities and exercise levels during the day.
- **Eliminate caffeine** from your child's diet.
- **Create a buffer time to lower down the activity level for an hour or so before bedtime.** Find quieter activities such as coloring, reading or playing quietly.
- **Spend ten minutes cuddling with your child.** This will build a sense of love and security as well as provide a time to calm down.
- **Use lavender or other aromas in your child's room.** The scent may help to calm your child.
- **Use relaxation tapes as background noise** for your child when falling asleep. There are many varieties available including nature sounds and calming music. Children with ADD/ADHD often find "white noise" to be calming. You can create white noise by putting a radio on static or running an electric fan.

The benefits of "green time" in kids with attention deficit disorder

Research shows that children with ADD/ADHD benefit from spending time in nature. Kids experience a greater reduction of symptoms of ADD/ADHD when they play in a park full of grass and trees than on a concrete playground. Take note of this promising and simple approach to managing ADD/ADHD. Even in cities, most families have access to parks and other natural settings. Join your children in this "green time"—you'll also get a much-deserved breath of fresh air for yourself.

ADD/ADHD parenting tip 5: Help your child eat right

Diet is not a direct cause of attention deficit disorder, but food can and does affect your child's mental state, which in turn seems to affect behavior. Monitoring and modifying what, when, and how much your child eats can help decrease the symptoms of ADD/ADHD.

All children benefit from fresh foods, regular meal times, and staying away from junk food. These tenets are especially true for children with ADD/ADHD, whose impulsiveness and distractedness can lead to missed meals, disordered eating, and overeating.

Eating small meals more often may help your child's ADD/ADHD

Children with ADD/ADHD are notorious for not eating regularly. Without parental guidance, these children might not eat for hours and then binge on whatever is around. The result of this pattern can be devastating to the child's physical and emotional health.

Prevent unhealthy eating habits by scheduling regular nutritious meals or snacks for your child no more than three hours apart. Physically, a child with ADD/ADHD needs a regular intake of healthy food; mentally, meal times are a necessary break and a scheduled rhythm to the day.

- Get rid of the junk foods in your home.
- Put fatty and sugary foods off-limits when eating out.
- Turn off television shows riddled with junk-food ads.
- Give your child a daily vitamin-and-mineral supplement.

To learn more, see [Nutrition for Children and Teens](#).

ADD/ADHD parenting tip 6: Teach your child how to make friends

Children with ADD/ADHD often have difficulty with simple social interactions. They may struggle with reading social cues, talk too much, interrupt frequently, or come off as aggressive or “too intense.” Their relative emotional immaturity can make them stand out among children their own age, and make them targets for unfriendly teasing.

Don't forget, though, that many kids with ADD/ADHD are exceptionally intelligent and creative and will eventually figure out for themselves how to get along with others and spot people who aren't appropriate as friends. Moreover, personality traits that might exasperate parents and teachers may come across to peers as funny and charming.



Helping a child with attention deficit disorder improve social skills

It's hard for children with ADHD to learn social skills and social rules. You can help your child with ADD/ADHD become a better listener, learn to read people's faces and body language, and interact more smoothly in groups.

- Speak gently but honestly with your child about his or her challenges and how to make changes.
- Role-play various social scenarios with your child. Trade roles often and try to make it fun.
- Be careful to select playmates for your child with similar language and physical skills.
- Invite only one or two friends at a time at first. Watch them closely while they play.
- Have a zero tolerance policy for hitting, pushing and yelling in your house or yard.
- Make time and space for your child to play, and reward good play behaviors often.

More help for ADD/ADHD in children

ADD/ADHD Help Center: Find ways to stay focused, turn chaos into calm, and manage the symptoms of distraction, hyperactivity, and impulsivity.

Help for ADD / ADHD at home

ADD / ADHD in Children: Signs and Symptoms of Attention Deficit Disorder in Kids

ADD / ADHD Treatment in Children: Signs and Symptoms of Attention Deficit Disorder in Kids

ADD / ADHD Medications: Are ADHD Drugs Right for You or Your Child?

ADD / ADHD Tests & Diagnosis: Diagnosing Attention Deficit Disorder in Children and Adults

Help for ADD / ADHD at school

ADD / ADHD and School: Helping Children with ADHD Succeed at School

Teaching Students with ADD / ADHD: What Teachers Can Do to Help

VI. Keeping Attention Problems in Broad Perspective



Some people believe that the reason they are good readers is because they were taught by a phonetic approach. Others believe they are good readers because they were taught with a language experience or a combination approach. Indeed, most good readers seem to advocate for whatever method they think worked for them.

Our reading of the research literature, however, indicates that almost every method has *not* worked for a significant number of people. For *a few*, their reading problems stem from unaccommodated disabilities, vulnerabilities, and individual developmental differences. For many, the problems stem from socioeconomic inequities that affect readiness to learn at school and the quality of schools and schooling.

If our society truly means to provide the opportunity for all students to succeed at school, fundamental changes are needed so that teachers can personalize instruction and schools can address barriers to learning. Policy makers can call for higher standards and greater accountability, improved curricula and instruction, increased discipline, reduced school violence, and on and on. None of it means much if the reforms enacted do not ultimately result in substantive changes in the classroom and throughout a school site.

Current moves to devolve and decentralize control may or may not result in the necessary transformation of schools and schooling. Such changes do provide opportunities to reorient from "district-centric" planning and resource allocation. For too long there has been a terrible disconnection between central office policy and operations and how programs and services evolve in classrooms and schools. The time is opportune for schools and classrooms to truly become the center and guiding force for all planning. That is, planning should begin with a clear image of what the classroom and school must do to teach all students effectively. Then, the focus can move to planning how a family of schools (e.g., a high school and its feeders) and the surrounding community can complement each other's efforts and achieve economies of scale. With all this clearly in perspective, central staff and state and national policy can be reoriented to the role of developing the best ways to support local efforts as defined locally.

At the same time, it is essential not to create a new mythology suggesting that every classroom and school site is unique. There are fundamentals that permeate all efforts to improve schools and schooling and that should continue to guide policy, practice, and research.

For example:

- The curriculum in every classroom must include a major emphasis on acquisition of basic knowledge and skills. However, such basics must be understood to involve more than the three Rs and cognitive development. There are many important areas of human development and functioning, and each contains "basics" that individuals may need help in acquiring. Moreover, any individual may require special accommodation in any of these areas.
- Every classroom must address student motivation as an antecedent, process, and outcome concern.
- Remedial procedures must be *added* to instructional programs for certain individuals, but only after appropriate nonremedial procedures for facilitating learning have been tried. Moreover, such procedures must be designed to build on strengths and must not supplant a continuing emphasis on promoting healthy development.
- Beyond the classroom, schools must have policy, leadership, and mechanisms for developing school-wide programs to address barriers to learning. Some of the work will need to be in partnership with other schools, some will require weaving school and community resources together. The aim is to evolve a comprehensive, multifaceted, and integrated continuum of programs and services ranging from primary prevention through early intervention to treatment of serious problems. Our work suggests that at a school this will require evolving programs to (1) enhance the ability of the classroom to enable learning, (2) provide support for the many transitions experienced by students and their families, (3) increase home involvement, (4) respond to and prevent crises, (5) offer special assistance to students and their families, and (6) expand community involvement (including volunteers).
- Leaders for education reform at all levels are confronted with the need to foster effective scale-up of promising reforms. This encompasses a major research thrust to develop efficacious demonstrations and effective models for replicating new approaches to schooling.
- Relatedly, policy makers at all levels must revisit existing policy using the lens of addressing barriers to learning with the intent of both realigning existing policy to foster cohesive practices and enacting new policies to fill critical gaps.

Clearly, there is ample direction for improving how schools address barriers to learning. The time to do so is now. Unfortunately, too many school professionals and researchers are caught up in the day-by-day pressures of their current roles and functions. Everyone is so busy "doing" that there is no time to introduce better ways. One is reminded of Winnie-The-Pooh who was always going down the stairs, bump, bump, bump, on his head behind Christopher Robin. He thinks it is the only way to go down stairs. Still, he reasons, there might be a better way if only he could stop bumping long enough to figure it out.



Mindful
Continuing Education

“This course was developed from the public domain document: Attention Problems: Intervention and Resources (2015) – Center for Mental Health in Schools at UCLA.”