



The Community School  
of Bergen County

*For the child whose  
potential exceeds performance*

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### Who's Afraid of the 'H' Word?: Educating the Hyperactive Child

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The December 1993 cover of *New York* magazine pronounced loudly, "ADD, the Scariest Letters in the Alphabet." In July 1994, *Time* magazine's cover offered this story: "Disorganized? Distracted? Discombobulated? Doctors Say You May Have Attention Deficit Disorder." This article referred to adults. The subhead was, "It's not just kids who suffer from it." The article goes on to describe the experience of both children and adults who live "Life in Overdrive."

The clear intention of these articles is to alert the public to the hazards and pitfalls of this mysterious condition and also to commiserate with parents and adult 'victims' who find themselves in the ADHD predicament. And, incidentally, some information is actually offered

about how one can deal appropriately with this disorder.

Community School was just getting started when 'hyperkinesis' - the "H" word - was the definitive term for the syndrome we now know as ADHD. Our first enrollment, which numbered about 18 children, probably contained 16 hyperkinetics. In those days only classes for the emotionally disturbed would accept children whose behavior required therapeutic management. So, hyperactive children, frequently misdiagnosed, were referred to classes that were, in fact, highly unsuited to the needs of this particular population. We, on the other hand, recognized the concomitance of learning disabilities and hyperactivity right from the beginning and worked, both educationally and therapeutically, with these children.

The following assumptions, on which we based our program, seemed to prove true in clinical observation. One, assume that the child is highly motivated despite outward signs to the contrary. Two, provide structure within which the child can feel secure yet maintain in an environment that is not restrictive. In other words, establish firm limits, taking care never to allow enough rope for the child to trip on. Three, keep the teaching appropriate and stimulating. It was readily apparent that these children valued novelty and stimulation above all. When attention flagged, behavior deteriorated. When things got too quiet and studious, boredom set in. Our lessons were kept short, with frequent changes in activity. We strove to hold attention by using intrinsically motivating material, employing novelty in methods, and offering many and varied incentives.

We also began to experiment with two ideas new at the time: *Small Group Instruction* and *Time Out*. As to the first, our teachers observed how bored children got when working alone, period after period, on assigned exercises. We surmised that children would remain engaged longer if given a chance to interact and learn from each other in small homogeneous groups with teachers providing direct instruction. We also were tantalized by the possibilities of allowing children to walk around a bit every 40 minutes or so in a class change format. The experiments succeeded rather well.

Time Out proved effective. Wanting very much to stay in the group, which is where the action is, children, excluded because of misbehavior, learned the lesson that exclusion *will* be the consequence of failing to control. Social misbehavior resulted in social isolation. As we experimented with both instructional innovations and behavior modification techniques, things improved for our ADHD children. Community School became a happy place.

We have since learned much about ADHD. We know that the effective treatment of this disorder depends on accurate diagnosis, with the further understanding and clear identification of its subtypes and comorbidities. Three general subtypes are recognized. First is the inattentive group. The children in this group are characterized by difficulty in maintaining focus, daydreaming, forgetfulness and difficulty completing tasks. The second subtype is composed of children who present with hyperactivity/impulsivity syndrome. Recognized most frequently in boys, this type suggests behavior that tends to be aggressive and disruptive. Children in this group are highly distractible, often unable to sit still or work quietly. They usually have difficulty with social relations. The third subtype is a combination of the other two.

The range of symptoms within these subtypes is quite wide. Some of these children demonstrate hyperactivity combined with other disorders of a rather serious nature. Fortunately, however, only 15% to 30% of the children in the second and third subtypes is estimated to have problems such as Conduct Disorder, Oppositional Defiant Disorder, Anxiety Disorder, Depression and Chronic Irritability with Tantrums. Though small, this percentage is sufficient to cause great concern among parents, professionals and schools. It is important to understand that these psychiatric and neurological disorders require treatment apart from that employed for hyperactivity.

At the present time, child psychiatrists and pediatric neurologists are becoming increasingly sophisticated in using the wide range of new medicines at their disposal. The result has been more effective treatment for most of these children.

ADHD is a genuine handicap with profound social consequences. Consider the following behaviors and then imagine the conse-

quences a child might suffer if experiencing periods of some or even one of this large body of behaviors.

The flip side of the very active group is the lethargic or socially withdrawn variation. It, too, is ADHD, but 'hypo' instead of 'hyper.' A number of children show dramatic mood swings, which makes their behavior highly unpredictable. Classmates shun these 'manics' who cannot be relied upon to socialize properly. Others have sleep problems, disturbing both to the family and the child's ability to function in school. Some may engage in rapid fire speech that is characterized by quick changes of topic and increasing irrelevancy. Social conversation cannot be conducted under these circumstances, and classmates withdraw. Some may manifest exaggerated cheerfulness and unrealistic optimism. Learning disabilities, whether subtle or severe, are commonly present in most of these children.

Over the years we have not hesitated to enroll ADHD children at Community School, and our history reflects a fair representation of most of the subtypes, particularly for very young children when the diagnosis is not yet established. Our high school population, however, varies from this pattern since, if profound change has not occurred at adolescence, a different type of program is indicated.

Though we continue to be judiciously cautious and respectful of the challenges presented by the hyperactive child we, nevertheless, feel we have a primary obligation to use our skills, knowledge and expertise to offer treatment to these often rejected children. Classic hyperactivity at Community School, particularly at the lower level, is probably represented by approximately 40% of the children enrolled. Yet the atmosphere at both our schools is calm, quiet, orderly, studious and contained. Incidents of

overt discontrol are rare.

The great question is, how do we achieve such a happy result. How do we treat hyperactive children? To be effective, treatment must be embedded in natural settings such as the home and the school. The treatment program has three essentials - structure, limits and consequences. All three must be present consistently both at home and at school. After expectations are made absolutely clear (structure and limits), consequences are defined in a practical behavior modification contract. Contracts are used extensively in our school, and, in many cases, in the home as well.

The following histories demonstrate several important principles of treatment that must be considered to assure successful outcomes. The *first* is that proper treatment begins with diagnosis. Several years ago a young couple seeking placement described their child as having a "relatedness disorder." Several years earlier, the child had begun treatment with a private therapist for help in developing socially aware and appropriate behavior. Anxiety was thought to be a contributing factor. The symptoms were seen early on and the problems were of long duration. Though intellectually gifted and academically talented, school had become an issue. Ongoing problems in control and in maintaining limits, plus difficult interactions with classmates, provoked an emotionally based diagnosis, and the family was advised to seek an alternate special education placement.

Though a bit apprehensive, we accepted the child, reasoning that our program's flexibility allowed us to try several approaches that had not been used before. We also saw the high intellect as a strength we could exploit. Within just a few weeks of the new school term we were impressed by the unmistakable presence of hyperactivity - the H word.

ADHD as a diagnosis was nowhere mentioned in the case record. Egocentricity and disinhibition, however, were prominent. We alerted the family and the clinician. We recommended a neurological evaluation. We requested consideration of a trial on psychostimulants. Ritalin, the most commonly used was prescribed. Response to the earliest minimal dose was encouraging, and the dosage was gradually increased to a modest but effective level.

Life changed dramatically for this child at home and at school. Teachers and parents could only marvel at the degree of improvement in adjustment and production. The talent and intellect were being used creatively. There were progressive accomplishments, and social relatedness improved greatly. This child was able to maintain positive social interactions for an extended period of time and to remain comfortable within the limits set by the classroom teacher.

Principle number *two* reminds us that time and patient therapeutic management heal. A nine-year old enrolled in our Primary 3 class presented with all the symptoms of ADHD, a specific learning disability, and a history of oppositional behavior. Like most of our children, this child was bright, likable, well-meaning and highly motivated to achieve academic success and peer acceptance. Problems usually surfaced around rejection and frustration. Perfectionistic tendencies manifested in extreme competitiveness and inability to accept loss. The child, a good athlete, had particular trouble in the gym when he lost a play or a teammate lost the game. Resistance to participation in all requirements of the daily instructional program was an ongoing problem for the teacher.

Both the child and family were in private counseling, receiving professional help in home management. Home was a problem, and the school situation was troubling. The parents asked us to provide in-school counseling, hoping that this strategy would help to bring about compliance. The child refused to go to the therapist. Bribes and punishments were to no avail. THE CHILD REFUSED TO GO. Even threatened loss of the treasured gym period was ineffective.

A plan of action requiring implementation in small steps was initiated. It would need three participants - the classroom teacher, the crisis intervention coordinator and the principal. A contingency contract was drawn up that defined a minimal standard for compliance. Consequences were clear and inevitable. Implementation was swift and consistent. Trust, however, had to be built up. The desirable rewards of extra gym and time to play a game with a selected classmate were provided immediately upon compliance with a particular demand in the contract. A conflict or commotion in the gym inevitably resulted in loss of the next gym period. The teacher was consistent. Time Outs were imposed for infractions according to the contract. The child was denied the valued company of his friends in this consequence; it was quite painful. The teacher was patient. Things began to improve. Writing assignments were increasingly undertaken without a battle. The gym situation calmed down. Our demands for accepting frustration increased incrementally and the staff was encouraged. By the end of the school year improvement was great enough for a recommendation of advancement to the next level. The gains have been maintained, and the child continues to have

a good experience. In this case, sufficient time, faith and the appropriate management of the challenge by a highly skilled, sensitive and competent staff did the magic.

Our last example demonstrates the absolutely essential *need* to establish an effective pharmacological treatment, with consistent administration of the program, and a close and ongoing coordination among the doctor, the school and the family. With all parties cooperating in monitoring the results and agreeing how and when adjustments will be made, a successful outcome might be anticipated. The child involved presented with an extreme example of hyperactivity with the common associated learning disabilities in the area of literacy.

Previous experiences with medication were unsuccessful, (as the child appeared to be a non-responder.) The parents sought placement when the child was put on home instruction for unmanageable behavior in the regular second grade classroom. Fortunately for all, the child was placed in our school with a determined, tenacious, highly knowledgeable, competent and loving teacher. It was clear almost immediately that control could not be established through structure and consequences alone without the help of a good pediatric neurologist. After some doctor shopping, the parents settled on an excellent specialist who was known to maintain close contact with the school.

Because Ritalin was contraindicated, the psychostimulant Dexedrine was tried. Even with the initial small dose, results were positive. Once again, however, consistent administration became an issue. Nevertheless, the teacher persisted, the doctor persevered and the parents ultimately cooperated with the therapeutic program, gradually increasing the dose to the optimal level for productive classroom performance. Hyperactivity is still, of course, quite apparent; but academic concentration and peer relations have improved sufficiently to assure a happy, successful, well-related child. The aggressive, overpowering behavior is no longer in evidence. The child is a well-integrated member of the class, participates in all activities, enjoys friendly social relations with classmates and seldom requires periods of time out. The consistent following of an appropriate medical regimen and the regular contact with the supervising physician have turned the trick.

In short, hyperactivity, the 'H' word, need not frighten us into inaction or defeatism, nor should it condemn children to social and academic failure. With the sensible practice of good management techniques, outside medical and clinical intervention and, most especially, insightful, skilled, caring and courageous school personnel, ADHD children can be provided a happy, productive school experience.