

CHILD CARE

plus +

WINTER 1993

A Resource for Integrated Child Care Providers

Vol. 3, No. 2

+ Kids with Attention Deficit-Hyperactivity Disorder in Child Care? Yes!

Most of us feel we have cared for a child with an attention deficit at one time or another. They are the children we describe as easily distracted, especially active, impulsive, or even disruptive.

Years ago, specialists recognized a pattern of behavior common to these children. Over the years, various terms have been used to describe this disability--terms like hyperactive and attention deficit disorder. Although the term may change again, **Attention Deficit-Hyperactivity Disorder (ADHD)** is the term most commonly used today. The label is not as important as understanding how and why this diagnosis is made and how we can create responsive environments for young children with ADHD.

ADHD is not simply a descriptive term--it is a diagnosis. It can only be made by a clinician--physician, pediatrician, or psychologist--who specializes in childhood disorders. A number of professionals may be involved in diagnosing ADHD. A thorough medical and family history is required. Children are given physical examinations as well as medical, psychological, and educational tests.

ADHD is a developmental disorder with fourteen characteristic behaviors (see box). Diagnosis of ADHD is made when eight or more of the fourteen behaviors are identified. Behaviors must be inappropriate for the child's age (*difficulty remaining seated* means different behavior for a six-year-old than for a two-year-old), must begin before age seven, and persist for at least six months. It is possible some children may display these behaviors in reaction to situations like a divorce or a family move; however, in these cases, the behavior is typically short-term and clearly related to the event.

Here is what early childhood professionals can do to create a positive learning environment for a young child with ADHD:

To have ADHD, a child must exhibit:

1. at least 8 behaviors
2. inappropriate to age
3. before age seven
4. for at least 6 months

ADHD Behaviors

- often fidgets/squirms
- difficulty remaining seated
- easily distracted
- difficulty awaiting turn
- often blurts out answers
- difficulty following instructions
- difficulty sustaining attention
- often leaves uncompleted activities
- difficulty playing quietly
- often talks excessively
- often interrupts/intrudes
- often does not seem to listen
- often loses things
- often engages in unsafe activities

1. Learn about ADHD and about the child with ADHD in your program. Question parents and professionals.

2. Provide experiences appropriate for the child's interests and abilities--not too challenging or too easy. Children may enjoy and participate in particular activities; build upon their successes.

3. Establish a steady and predictable routine. Plan transitions between activities; talk about change--even minor change, like visitors--before it happens.

4. Be clear and calm about expectations. Be sure the child knows house rules; talk about expectations in a way that assumes the child will behave accordingly. Say firmly *it's time to go*

inside now rather than threaten *if you don't come inside right now* . . .

5. Give the child feedback about social interactions. Children may not accurately assess the impact of their behavior. Use short phrases to describe the feelings of other children/adults rather than saying *stop doing that!* Provide alternative options. You might say *you're making it hard for Ben and Jonna to play; I think that makes them sad*. Continue by suggesting an appropriate activity within Ben and Jonna's play or a separate activity.

6. Provide choices. Find alternative activities that are responsive to the child's needs and rewarding for the child. A cozy space with earphones and story tapes may provide welcome relief for a child when group activities get too demanding. On the other hand, large muscle equipment set up indoors may provide an alternative for a very active child.

7. Encourage and nurture the child's self-esteem. Children with ADHD frequently hear negative messages about their behavior and may seldom receive positive messages filled with warmth and praise. Make it a point to verbally and physically tell the child about the wonderful things he or she adds to your program!+

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+ FROM THE SOURCE: Teaming With Success

The characteristics which comprise Attention Deficit-Hyperactivity Disorder (ADHD) seem to be highly responsive to various treatments. However, the effectiveness of any treatment plan corresponds directly with the consistency with which the plan is conscientiously implemented across settings: home, child care, Grandma's house, Sunday school, or play group.

Since no single approach can accommodate most children diagnosed with ADHD, a service coordinator (the parent and/or a professional) is generally required to oversee coordination of needed services. The professional might be a pediatrician, pediatric neurologist, child psychiatrist or psychologist, or clinical social worker. Many types of professionals may have expertise in working with children diagnosed with ADHD. However, only a medical doctor may prescribe medications, if used.

Regardless of their professional orientation, the service coordinator for a child with ADHD needs to be well educated about the disorder as well as the various treatment strategies available. Essential qualities of this service coordinator include knowledge about the biological, social, environmental, and educational aspects of the disorder, as well as the ability to be helpful to the parent and child in whatever way possible.

Most professionals and parents have found that effective treatment programs include parent/caregiver education, training in behavior management, and identification of specific modifications useful in home or group settings. When these strategies are combined, they serve to assist the child to have positive experiences and be successful. +

+ MAKING IT WORK: One Helpful Strategy

Group activities which require paying attention and sitting fairly still--such as circle time--are often difficult times for children with ADHD. While children need to learn to be attentive, we also want them to be successful and enjoy the process of learning. Here's one way to approach teaching a child these important skills at circle time.

Watch the child. What songs and finger plays does she enjoy? How long can she successfully engage in this activity before becoming disengaged? Tell her you know it's hard for her to stay with circle time. Describe the behavior you want from her; explain that you will help her learn to do it. Then brainstorm together an alternative activity for when she really needs to leave circle time--an activity which keeps her occupied without disrupting the group. The activity should be something she enjoys, but not something she would rather do than circle time. Tell her she may leave after her favorite song, *Old McDonald*. At that time, dismiss her with a smile and a nod; she can proceed quietly to her activity. Practice this a few times so you know she can be successful. The whole tone should be positive and fun, without shame or stigma.

Now, start with the length of time you previously observed she can remain engaged--however long (or short) that may be; sing *Old McDonald*, and let her leave. After circle time, talk to her about her success, and praise her efforts. When she's ready, GRADUALLY increase the time before singing *Old McDonald*. The increments should be large enough to help build skills, but small enough so she can do it. This strategy can be adapted to enable most children to stay engaged in almost any group activity. +

+ NOTES FROM HOME

MAYBE YOU KNOW MY KID!

(Reprinted with permission from *Maybe You Know My Kid* (1990) by M.C. Fowler. Carol Publishing Group: New York, NY.)

Maybe you know my kid. He's the one who acts before he thinks. It's usually upon some rash impulse that scares the living daylights out of me, like seeing how fast he can ride a big wheel down a long, steep, curvy hill. He's the one who says the first thing that comes to his mind. It's usually with a loud voice in a quiet crowd, and it makes me wish I could evaporate into thin air.

And he cannot remember a simple request. So I long for a trained parrot that can tell him ten times in five minutes 365 days a year to go upstairs, brush your teeth, get dressed and make your bed. He's the kid who scrapes his knee and screams so loud and long that I worry the neighbors think I am beating him. Then, just when I'm about to call the doctor, he eyes a monarch butterfly and chases it through the trees until it disappears, just like his hysterics of seconds before. He's the kid in school with ants in his pants who could do the work if he really tried. Or so we have been told over and over.

Maybe you know my kid really well. Maybe he reminds you of your own child or someone else's. But maybe you didn't know that children like this aren't really pain in the neck kids with lousy mothers. They are the children with Attention-deficit Hyperactivity Disorder, commonly called ADHD. Despite all that is known about ADHD, many children go undiagnosed. Instead they are misunderstood. Some are even blamed for behaviors which are the very features of this disorder. ADHD children act in a way that comes naturally to them. Thus, they are at the mercy of their disorder and its symptoms. Parents may suspect that all is not as it should be. But without knowledge and understanding of ADHD they are puzzled and worried by what they see.

I am one of the lucky mothers. I now understand why my son behaves the way he does. I know what to expect from him and how to manage his ADHD symptoms. I know when and where to go for help. I know now that the disturbing behaviors which appeared at various stages of his development were neither of his own doing nor my fault. If you are the parent of an ADHD child, I want you to know this too. +

+ SPOTLIGHT: CH.A.D.D.

Let me introduce you to a nation-wide organization called CH.A.D.D., Children with Attention Deficit Disorders. CH.A.D.D. is a non-profit, tax-exempt, parent-based organization providing support to families of children with attention deficit disorders and information to professionals. CH.A.D.D. maintains over three hundred and twenty-five chapters throughout the United States to provide services for children and adolescents with ADD (or ADHD).

As an organization, their primary objectives are:

1. To maintain a support group for parents who have children with ADD.
2. To provide a forum for continuing education of both parents and professionals about ADD.
3. To be a community resource for information about ADD.
4. To foster the objective that the best educational experiences should be available to children with ADD so that their specific difficulties will be recognized and appropriately managed within educational settings.

CH.A.D.D. grew out of one family's frustration. Slowly, after many efforts at discipline, dealing with guilt, professional analysis, and the endless search for the "best" day care or school, they learned many other people were trying to cope with the same problem--ADD. CH.A.D.D. was started in 1987 by parents of children with ADD and by professionals who had an interest in working with these children. News of CH.A.D.D. meetings spread quickly and soon chapters began to form nationwide. Each chapter holds monthly meetings where guest speakers present information on a variety of topics associated with ADD ranging from behavioral management, family interactions, medical management, and educational issues.

Child care providers and other teachers of young children can take advantage of the expertise found in organizations like CH.A.D.D. Here is a resource which may help you meet the needs of the families and children enrolled in your program.

Because they understand the frustration involved in seeking help for children,

CH.A.D.D. offers membership categories:

Family Membership \$30.00/year

Professional Membership \$60.00/year
International membership \$100.00/year
Organizational Membership* \$150.00/year
(*Designed for schools, educational and counseling centers, pediatric offices, and hospitals.)

Kids with ADD come in all sizes, shapes, and ages. They do not all have that mischievous "Dennis the Menace" look. They are not always just a blur of activity or a frenzy of excitement. Sometimes they're just sitting quietly for hours in front of the TV or seriously concentrating on the latest video game or teen magazine. Often, they are affectionate, caring, and well-behaved. Kids with ADD have a wonderful, joyous, spontaneous side to their personality, but they can also be a handful to raise.

Teachers often describe children with ADD as restless, inattentive, easily distracted, and overly impulsive. However, when they are particularly interested in something like a movie, television, or video game, kids with ADD have no trouble paying attention.

Of course, not all children who exhibit these symptoms do so as a result of an attention deficit disorder. Disorganized home or school environments, emotional difficulties within the child, or lack of motivation can cause similar symptoms. The difference for children with ADD is that under normal conditions, they lack the physical ability to control their behavior.

CH.A.D.D.'s mission is to better the lives of individuals with attention deficit disorders and those who care for them. Through family support and advocacy, public and professional education, and encouragement of scientific research, CH.A.D.D. works to ensure that those with attention deficit disorders reach their inherent potential.

For further information about ADD, contact:

CH.A.D.D.
499 N.W. 70th Avenue,
Suite 308
Plantation, FL 33317
(305) 587-3700

Parent volunteers respond to written inquiries and phone calls. Since they each have children with ADD themselves, they are very sensitive and knowledgeable.+



CH.A.D.D.
Children with Attention Deficit Disorders

"Parents Supporting Parents"

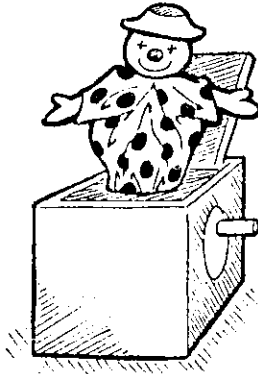
MEMBERSHIP BENEFITS

CH.A.D.D.ER, a semi-annual magazine
CH.A.D.D.er BOX, a monthly newsletter
ADD Teacher's Guide
Medical Management Guide
ADD Fact Sheet
ADD Information Booklet
Current CH.A.D.D. chapter meeting schedule

+ WHAT DO I DO WHEN . . .

QUESTION: *We have a four-year-old with ADHD in our child care program. He's a really bright, creative thinker but he often says things like "no one likes me," "I wish I would just disappear," and "I know I'm not going to be able to do that." Are we doing something wrong???*

ANSWER: It may not be that you are doing anything wrong. It may be that you are not doing the right things often enough. Does this little guy get frequent messages from caregivers that he is successful, effective, and competent?



Even though you may regularly have warm and positive interactions with the child, it is not uncommon for children with ADHD to have low self-esteem. This comes from their getting many more negative than positive messages from their environment. Your job is to try to balance these negative reminders with more constructive messages--both verbal and physical--to help the child understand and believe in his own value and importance.

Look for times during your day when you can add some of these positive messages. Perhaps you can give him an important role like feeding a pet. Make sure 1) it is a job the child can do, 2) that the job is important enough to be noticed, and 3) that his success is recognized.

Or try taking a moment or two at the end of the day to talk privately with the child about his day. Identify at least one terrific accomplishment that you and the child can proudly tell the child's parents. It may be an activity--he fed the fish or built a snow man--or an example of positively managing his own behavior--he held your hand on the neighborhood walk today. Follow through by

telling the parents about this accomplishment (and showing them the happy fish or the snow man) when they come to pick him up. +

(If you have a question about children with disabilities in child care settings, please send your question to CHILD CARE plus+.)

+ RESOURCE REVIEW

Would you like help recognizing the symptoms of ADHD? Do you know what treatment is recommended? Mary Cahill Fowler provides some answers in *Maybe You Know My Kid: A Parent's Guide to Identifying, Understanding and Helping Your Child With Attention Deficit Hyperactivity Disorder* (1990, Birch Lane Press: New York, NY). In addition, this resource provides insights of nationally recognized practitioners in the field; readers get a clear, clinical explanation of how to deal with the problem. Sales/Distribution Offices 120 Enterprise Ave., Secaucus, NJ 07094. +

CHILD CARE plus+ is designed to enhance the integration of children with disabilities in child care settings by supporting care providers, parents, and community service providers including social workers, therapists, physicians, teachers, and administrators.

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+ AD/HD UPDATE: Attention Deficit/Hyperactivity Disorder

Since the Winter 1993 issue of *Child Care plus+* (Vol. 3, No. 2) on AD/HD was published, new diagnostic information about the disorder has been made available. The information in the newsletter is still quite accurate; only the diagnostic categories have changed.

Below you will find the new categories as they are defined in the *Diagnostic & Statistical Manual of Mental Disorders, Fourth Edition* (1994, American Psychiatric Association). This manual, referred to as *DSM-IV*, describes the ways that disorders such as AD/HD are diagnosed and distinguished from one another.

AD/HD is now divided into three subtypes according to the main features associated with the disorder: inattentiveness, impulsiveness, and hyperactivity. The three divisions or subtypes are:

- AD/HD Predominantly Combined Type (both Inattention & Hyperactivity),
- AD/HD Predominantly Inattentive Type, and
- AD/HD Predominantly Hyperactive-Impulsive Type.

These subtypes take into account that some children with AD/HD have little or no trouble sitting still or controlling their behavior, but may be "predominantly inattentive" and, as a result, have great difficulty getting or staying focused on a task or activity. Other children with AD/HD may be able to pay attention to a task but lose focus because they may be "predominantly hyperactive-impulsive" and, thus, have trouble controlling impulse and activity. The most prevalent subtype is the "combined type," which includes characteristics of both inattention and hyperactivity/impulsivity.

Symptoms of Inattention

The child habitually

- fails to give close attention to details or makes mistakes in schoolwork or other activities;
- has difficulty sustaining attention in tasks or play activities;
- does not seem to listen when spoken to directly;
- does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions);
- has difficulty organizing tasks and activities;
- avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework);
- loses things necessary for tasks or activities (such as toys, school assignments, pencils, books or tools);
- is easily distracted by extraneous stimuli;
- is forgetful in daily activities.

Symptoms of Hyperactivity

The child frequently

- ◆ fidgets with hands or feet or squirms in seat;
- ◆ leaves seat in classroom or in other situations in which remaining seated is expected;
- ◆ runs about or climbs excessively in situations in which it is inappropriate;
- ◆ has difficulty playing or engaging in leisure activities quietly;
- ◆ is "on the go" or acts as if "driven by a motor";
- ◆ talks excessively.

Symptoms of Impulsivity

The child repeatedly

- blurts out answers before questions have been completed;
- has difficulty awaiting turn;
- interrupts or intrudes on others (such as butting into conversations or games).

It is important to note that, in the *DSM-IV*, hyperactivity and impulsivity are not longer considered as separate features. Hyperactivity-impulsivity is a pattern stemming from an overall difficulty in inhibiting behavior.

The rest of the diagnostic criteria remain the same:

- ✓ symptoms must persist for at least six months and be inconsistent with expectations for the child's developmental level;
- ✓ symptoms must have been present before age 7 years;
- ✓ symptoms must be present in two or more settings (such as child care, social situations, home);
- ✓ there must be clear evidence of significant impairment in social, academic, or occupational functioning;
- ✓ symptoms are not better explained by another disorder—Schizophrenia, Psychotic Disorder, Anxiety Disorder, Clinical Depression

We would like to encourage readers to explore further the subject of AD/HD and to consult the materials and resources listed in this issue of the *Child Care plus+* newsletter.

REFERENCES

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, D.C.: Author.
- Fowler, M. (1994). *Briefing Paper: Attention-Deficit/Hyperactivity Disorder*. National Information Center for Children and Youth with Disabilities (NICHCY): Washington, D.C. 1-800-695-0285.