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ATTENTION DEFICIT DISORDERS: MEETING INDIVIDUAL NEEDS: A PROGRAM DESIGNED TO INCREASE TEACHER EFFECTIVENESS AND PROMOTE STUDENT LEARNING

by

Elise R. Ecoff

A Practicum Report

Submitted to the Faculty of the Center for the Advancement of Education at Nova University in partial fulfillment of the requirements for the degree of Master of Science.

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Descriptors: Attention Deficit Disorders, Hyperactivity, Elementary Education, Teaching Methods, Teacher Training, Learning Strategies, Problem Solving.

This practicum addressed the problem classroom teachers face with increasing numbers of students in their classrooms who are diagnosed with or who exhibit the characteristics of an Attention Deficit Disorder (ADD). This practicum targeted a group of six elementary classroom teachers representing each grade level, who indicated high frustration levels due to lack of significant knowledge on Attention Deficit Disorders to participate in a multimodal inservice program. The inservice included lectures, guest speakers, audio and videotapes, role-plays, and group discussions. Success was measured by comparing pre and post implementation surveys, pre and post ADD inservice test scores, and pre and post use of the "Teacher's Report Form" (Thomas M. Achenbach, Ph.D). It was concluded that teachers can become more effective in working with ADD students through systematic instruction and collaboration.

Authorship Statement

I hereby testify that this paper and the work it reports are entirely my own. Where it has been necessary to draw from the work of others, published or unpublished, I have acknowledged such work in accordance with accepted scholarly and editorial practice. I give this testimony freely, out of respect for the scholarship of other workers in the field and in the hope that my work, presented here, will earn similar respect.

Elise R. Ecoff

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CHAPTER I

Purpose

The setting for this practicum is a twenty year old public elementary school located in an upper middle class suburb in South Florida. The school's current enrollment includes 768 students with an ethnic breakdown of: 622 White, 90 Black, 53 Hispanic and 3 Asian students. Due to the significant increase in enrollment over the past several years, many changes have occurred within the facility. These include the hiring of more staff and support personnel, increasing class size, greater noise levels, and obtaining portable classrooms.

The school was originally designed as an open school facility which, until the 1989-90 school year, had no walls. At present, the classrooms are predominantly closed in by partial walls and portable chalkboards which serve mainly as visual barriers which do not eliminate noise. Total school renovation is scheduled to begin at the end of the 1991-92 school year.

The school places high values on the social and emotional well-being of each child as well as each

child's intellectual growth. The school provides a variety of programs designed to fit the needs of the individual student. In addition to the basic education curriculum and special programs (art, physical education, music, media and computers), the school offers speech and language classes for the learning disabled, varying exceptionalities, and programs for the gifted. Additionally, support personnel provide individual and group counseling on relevant social issues such as substance abuse, divorce, wellness, self-esteem and conflict resolution. School staff work jointly with the Child Study Team (comprised of administrators and support staff) in identifying at-risk students. The team recommends prevention and intervention strategies and provides follow-up to assure student success.

The staff at this school is continuously involved in professional development. Of the 36 faculty members, many have earned or are working toward an advanced degree. Faculty and staff are active participants in county workshops, university courses, summer institute programs and professional conferences. Teachers are encouraged to share their knowledge and skills with their

colleagues during a "best practices" segment of bimonthly faculty meetings.

The target school has always enjoyed a very large and active parent group. Over 3,000 volunteer hours were spent by parents on various activities during the 1990-91 school year. This year however, there has been a noticeable decrease in parental participation. This has been attributed to the changing school population as well as difficult economic times. The PTA provides many enriching experiences and opportunities for students and faculty such as Meet the Masters Art Program and Superstars Math Program, cultural arts assemblies, classroom assistance and fund raising events. The PTA demonstrates its support of the faculty throughout the year by providing a teacher contingency fund, holiday luncheon, and teacher appreciation week activities.

The school staff provides a variety of curricular programs to enhance the education of all students. Some examples of these include career education, drug awareness education, multicultural education, Black History education and economics education. The school also holds an annual social-science fair.

Extra-curricular activities are an integral part of the school's daily life. A wide variety of clubs and activities are provided to meet the different interests of students. These activities include art, drama, and ecology clubs, chorus, safety patrols, student government, Teachers of Tomorrow, Just Say No and Young Astronauts.

The writer is a primary grade classroom teacher who began teaching at the target school six years ago. The writer is active in all facets of the school by serving as grade chairperson, inservice facilitator, Teachers of Tomorrow sponsor, PTA advisory representative, Focus 2000 representative, Curriculum Council representative, and discipline committee chairperson. The writer is well acquainted with faculty members, parents and students at the school.

Students with Attention Deficit Disorders (ADD) represent one of the most significant concerns for educators today. ADD is a disorder with which educators must become more knowledgeable since it affects from three to eight percent of the school-aged population (Copeland 1990). In 1987, the American Psychiatric Association compiled the following list of

characteristics of children with ADD. A child must exhibit at least eight of the fourteen characteristics for at least six months prior to the age of seven to be diagnosed with the disorder.

1. Often fidgets with hands or feet or squirms in seat (in adolescents may be limited to feelings of restlessness)
2. Has difficulty remaining seated when required to do so
3. Is easily distracted by extraneous stimuli
4. Has difficulty awaiting turn in games or group situations
5. Often blurts out answers to questions before they have been completed
6. Has difficulty following through on instructions from others (not due to oppositional behavior or failure of comprehension)
7. Has difficulty sustaining attention in tasks or play activities
8. Often shifts from one uncompleted activity to another
9. Has difficulty playing quietly
10. Often talks excessively
11. Often interrupts or intrudes on others
12. Often does not seem to listen to what is being said to him or her
13. Often loses things necessary for tasks or activities at school or at home
14. Often engages in physically dangerous activities without considering possible consequences (not for the purpose of thrill-seeking)

A survey (Appendix A:54) was given to classroom teachers at the target school along with the above list of characteristics of ADD children. One male and twenty-seven females responded to the survey. The respondents

range of teaching experience was from two to twenty-eight years with the mean average being 13 years. The results of the survey (Appendix B:57) were tabulated by each question as well as individual teacher score for the most informative results.

The responses to the first statement indicated that 94% of the respondents presently or in the past had a student who exhibited eight of the fourteen characteristics of ADD. Over 90% of the respondents admitted that they spend additional time with these students. Statements three, four and five related to knowledge about causes, teaching strategies and diagnosis of ADD. Eighty-nine percent or higher agreed or strongly agreed that they did not have enough knowledge in these areas. Only 19% disagreed with statement six, "I do not feel successful in my work with these students." Eighty-five percent of the respondents indicated that they felt frustrated working with ADD students due to their lack of knowledge about ADD. Every respondent agreed that information on ADD could help them become more successful with ADD students in the classroom. The survey results clearly indicated a need for a structured inservice

program designed to assist teachers in becoming more knowledgeable in all aspects of ADD.

Informal discussions with teachers reinforced the data from survey results. Teachers showed interest in learning more about ADD. Twenty-two teachers and support personnel indicated that they would be willing participants in a workshop on ADD.

After analyzing the data, the individual surveys were placed in order from lowest to highest number of points and the range, mean, median and mode were recorded. The lowest score by a respondent from each grade level, K-5 was chosen as the target representative from that grade. Lower scores indicated less knowledge about ADD and a higher frustration level. Each targeted teacher was asked to participate and all were in agreement. Biographical information on targeted population (Appendix E:69) was gathered to show the wide range of experiences of the target group.

This practicum attempted to assist teachers who were frustrated because they lacked the knowledge and skill to effectively work with the increasing population of students with ADD. In working with ADD management,

effective communication among the teacher, student, and parents becomes essential.

The goal of this practicum project was to increase the knowledge and skill level of teachers about ADD to enable them to more effectively work with ADD students in the classroom. To achieve this goal the following objectives were proposed:

1. The participants, after completing the twelve-week inservice, would demonstrate a more positive attitude towards ADD, as evidenced by at least a 25% increase on the post implementation survey.
2. The participants, after completing the twelve week inservice, would show a 50% increase improvement in the understanding of ADD as evidenced by the pre and post ADD test. (Appendix D:66)
3. The participants, prior to attending the inservice, would completed the "Child Behavior Checklist" on a student demonstrating the characteristics of ADD. After completing the inservice and implementing the strategies learned, the participant would again complete the checklist. The "Child Behavior Checklist" would show a 15% decrease in externalizing and/or internalizing behavior.

4. The participants, after completing six weeks of the inservice, would design and implement an individual plan for a student demonstrating the characteristics of ADD. (Appendix F:72) After completing the twelve week inservice, the participants would analyze and evaluate the plan and share the results with the other participants.

CHAPTER II

Research and Solution Strategy

After extensive research on Attention Deficit Disorders, the writer recognized that in order to successfully assist ADD students in the classroom, teachers must be educated on all aspects of ADD in addition to teaching strategies. The classroom teacher must be knowledgeable in the following areas of ADD: historical perspective, causes, characteristics and diagnosis, and treatment and educational management. The acquisition of this knowledge, in conjunction with the sharing of classroom experiences, would result in an effective inservice program for teachers and would serve as a catalyst for positive classroom change.

The study of Attention Deficit Disorders in children has a rich and varied history. Its roots spread across many scientific disciplines including pediatrics, neurology, psychiatry, psychology and education (Parker, 1990). The first published report on children who exhibited hyperactivity was done by Still in 1902. Although this study is outdated, Still believed that

these children showed little "inhibitory volition," "lawlessness" and displayed a "defect in moral control" Still theorized that these factors were caused by biological factors and stressed the need for a special education environment for these children (Still, as cited by Barkley, 1990).

The prevailing opinion of the medical community from the early 1900's to 1960 was that brain damage caused the characteristics now described in ADD children (Barkley, 1990). This opinion derived from an encephalitis epidemic in 1917-1918. Children who survived the epidemic exhibited many of the characteristics of ADD. This lead to many studies on brain injuries resulting from birth trauma, measles, epilepsy and head injuries as well as studies of behavioral manifestation. Hyperactivity became accepted as a brain damage syndrome, even where evidence of damage was lacking. The disorder was treated through minimal stimulation classrooms or in residential centers. The prognosis was poor for such children (Barkley, 1990).

The 1960's and 1970's brought tremendous change in the prevailing opinions about the disorder. The movement turned away from the brain damage syndrome rationale

toward more specific cognitive, learning and behavioral disorders (Barkley, 1990; Greisbach, 1988). Diagnosis was based on observable and verifiable deficits. Environmental factors were considered as possible causes as well as brain neurotransmitter deficiencies. Stimulant medication, behavior modification, dietary management and parenting skills were all studied as treatments for the disorder (Barkley, 1990).

The 1980's brought the most significant changes in awareness, diagnosis and treatment of ADD (Barkley, 1990). In 1980 the American Psychiatric Association published the criteria for Attention Deficit Disorders with or without hyperactivity. These were later revised in 1987. Motivation became a factor to be studied in sustained attention difficulties (Barkley, 1990). Assessment tools such as the "Child Behavior Checklist" (Achenbach and Edelbrock, 1986) emerged as a more reliable and accurately normed rating scale. Many different approaches in treatments were developed and integrated for more effective results. Cognitive-behavioral techniques, child behavior management, parent training programs, social skills training and medical treatments were all studied (Barkley, 1990).

Despite the significant developments in the diagnosis and treatment of ADD, a major controversy arose. Many people became alarmed by the increased use of medication as a treatment for the disorder. Nevertheless, many parent and political action groups had formed to raise the level of awareness of all people in relation to ADD. Education is still necessary to eliminate the medication controversy.

ADD has become a major educational issue for the 1990's. In September 1991 the United States Department of Education sent a memo to all Chief School State Officers clarifying the policy addressing the needs of children with ADD within general or Special Education. The memo states:

> "The Department took the position that ADD does not need to be added as a separate disability category in the statutory definition since children with ADD who require special education and related services can meet the eligibility criteria under Part B" (of the Individual's with Disabilities Education Act) (Davila, MacDonald and Williams, 1991).

As educators and parents become more aware of the disorder, many questions will need to be answered. ADD will continue to be a major issue effecting education into the 21st Century.

ADD is the most studied of all psychopathologic disorders of childhood. Although its exact cause is unknown, recent research suggests that there is a metabolic dysfunction in the brain. However, it is likely that there is no one cause but rather a combination of various interacting biological and psychosocial factors (Weiss, 1990). Researchers have investigated several possible factors including: food allergies, fluorescent lighting, lead toxicity and abnormal fetus development. There is very little evidence, however, to substantiate many of these theories as common causes (Parker, 1988). Another theory is that of prenatal exposure to alcohol and cigarette smoke increases the risk of ADD. At this time, there is not enough evidence to support this theory (Brody, 1990).

The most popular theory regarding the cause of ADD in the majority of those diagnosed with the syndrome is a deficiency or imbalance of neurotransmitters (Copeland and Love, 1991; Parker, 1988; and Phelan, 1989). The neurotransmitters or brain chemicals affect the Reticular Activating Syndrome (RAS), the Reticular Formation and the frontal and central brain structures essential for attention and alertness. The RAS allows stimuli to enter

the brain; its function is one of a gatekeeper. When the RAS is deficient, too many stimuli enter the consciousness resulting in poor attention, concentration and other ADD characteristics (Copeland and Love, 1991).

The characteristics of ADD were first determined by the American Psychiatric Association in 1980. Revisions to the list were made in 1987 and are listed in Chapter Two of this proposal. The criteria for diagnosis is that the child must display at least eight of the fourteen characteristics prior to age seven for a period of at least six months.

The most common characteristics of ADD fall under these four categories: attention span/concentration, distractibility, impulse control, and motor overactivity (Greisbach, 1988). Within these larger categories lie many behaviors. Some of these are as follows; easily distracted, failure to follow through on instructions, inability to complete tasks, difficulty waiting turns, excessive talking, poor organizational skills, fidgeting, difficulty remaining seated and engaging in dangerous activities (McCall, 1989).

Undifferentiated ADD is a less publicized syndrome which can be equally frustrating for the child, parent

and teacher. In Undifferentiated ADD, the child is often underactive and lethargic. The child is usually not impulsive and does not display excessive motor activity. The child is, however, easily distracted, has difficulty attending and lacks the ability to concentrate (Copeland and Love, 1991).

Schools play a unique and essential role in helping to diagnose ADD in children for a variety of reasons. First, children spend approximately 30 hours a week in school, making it an important setting for assessment. Second, schools provide substantial information on a variety of social and academic tasks observed by peers and adults. Third, teachers are most likely to notice the seriousness of the symptoms. Lastly, teachers have frequent contact with the children and base judgment on numerous observations in a natural environment (Atkins and Pelham, 1991).

There are numerous teacher rating scales used for the assessment of ADD. One such scale is the "Abbreviated Conners' Teacher Rating Scale" (C. Keith Conners, Ph.D). This rating scale is an easy to use checklist which fosters communication between the educational setting and the home or physician. The

"Abbreviated Conners'" has been criticized for not effectively selecting children with attention deficits, but identifying overactivity instead (Atkins and Pelham, 1991). Another teacher rating scale used to gather information on a child and help diagnose ADD is the "Child Behavior Checklist Teacher Report Form" (Thomas M. Achenbach Ph.D and Craig Edelbrock Ph.D). According to the authors, Achenbach and Edelbrock (1986), "The Teacher's Report Form (TRF) is designed to obtain teachers' reports of their pupils' problems and adaptive functioning in a standardized format." The TRF has been used extensively for research and has high validity and reliability properties.

Teacher rating scales are only one dimension in the diagnosis of ADD. The diagnosis requires the cooperation and teamwork of various professionals including: physicians, educators, guidance counselors, administrators, and psychologists (Achenbach and Edelbrock, 1986; Parker, 1989). These professionals, working together with parents, will evaluate the medical, educational, behavioral and psychological data to determine the most effective prescription for the child.

There is no one cure for ADD, however, these are a variety of treatments used to control or manage the behaviors associated with the disorder. The most prevalent treatments are: medication, behavioral therapy, cognitive therapy, psychological therapy and educational interventions. The writer feels that teachers should be familiar with each type of treatment, the rationale behind them and their documented effectiveness.

The most common type of treatment for ADD, medication, is also the most controversial. Three classes of drugs have been used with children diagnosed with ADD. These are antidepressants, tranquilizers, and stimulants (Friedman and Doyal, 1987).

Physicians have used tranquilizers to control impulsivity and overactivity but generally with poor results. The most commonly used tranquilizer is thioridazine (Mellaril). Valium and Librium have also been used as well as antihistamines such as Benadryl. Although there may be rare cases where tranquilizers have positive results, the majority of cases are not positively affected by this type of drug (Friedman and Doyal, 1987).

A category of antidepressants called tricylics have been successfully used with some children as an alternative to stimulant medication. Antidepressants such as imipramine and desipramine have many advantages, according to Gomez and Cole (1991).

> "Advantages include longer duration of action and the resultant feasibility of once daily dosing without symptom rebound or insomnia, greater flexibility in dosage, the readily available option of monitoring plasma drug levels and minimal risk of abuse of dependence."

The most widely prescribed medication therapy for ADD is stimulant medication. It is also, according to Henker and Whelan, as cited by Gomez and Cole (1991), "the most carefully studied treatment modality across the entire spectrum of childhood behavior problems." Approximately 70% to 80% of children who use stimulant medication respond favorably to this treatment. Stimulant medication decreases many of the symptoms associated with ADD including: motor activity, negativism and provocative behaviors while it increases attention span, concentration and goal-directed efforts in the school setting (Abikoff, 1985; Henker and Whelan, 1989; Johnson, 1988; Whelan et al., 1987) as cited by Gomez and Cole (1991).

The exact reason why stimulant medication is so effective with ADD children has been debated. One early theory, since proven false, was that stimulant medication actually acted as a sedative in children. Stimulant medication does not sedate children nor make them passive (Greisbach, 1989). In controlled doses, it stimulates the part of the brain that acts as the filtering mechanism to filter the outside stimuli. According to Friedman and Doyal (1987), "It stimulates an efficient system to work more efficiently. When the drug is working well, all it accomplishes is to make the child's nervous system work in a normal fashion." Greisbach (1989) found that:

> "Research has suggested that stimulant medications work by altering the ratio of neurochemical transmitters, specifically dopamine and norepinephrine, in certain areas of the brain. The net effect is stimulation of inhibitory systems so that the individual is less impulsive, distractive and hyperactive and is also more focused and attentive."

The most commonly used stimulant medication is methylphenidate (Ritalin). Less prescribed drugs in this class are Cylert and Dexadrine. Some children respond to all three medications while others may benefit from only one. Side effects do occur in some individuals and

usually wear off after several weeks of treatment: loss of appetite, insomnia, headaches, irritability and stomachaches. Some prolonged effects that indicate that the child may not be able to tolerate the medication are: depression, emotional liability, weepiness and lethargy (Greisbach, 1989).

The public controversy over the use of stimulant medication for the treatment of ADD has grown. The issue has been debated in newspapers, journals and on television. Baren (1989), a specialist in behavioral and developmental pediatrics states:

> "I firmly believe that stimulant medication for children and others with ADHD is an important part of the total treatment. Without this medication, many of these patients will be unable to perform at their optimal level in school, at home or in the community."

Others believe that there are still many unanswered questions relating to stimulant medications as treatments for ADD. One such issue is the psychological effects on the child who understands that he uses medication to control his behavior. Another issue that needs further exploration is the long term effects of medication on the ADD child and the potential for drug dependency (Gomez and Cole, 1991).

Behavior therapy or management is an important segment in the treatment of ADD. The goal of behavior management is to teach children the behaviors, values, goals and interpersonal skills that are deemed important and to diminish those which are not valued (Copeland and Love, 1990). This therapy involves parents and teachers working cooperatively to assist the child. Positive reinforcement and incentives are used to encourage expected behaviors; consequently, negative reinforcement and punishment are used to discourage unacceptable behaviors. Specific behaviors are targeted and monitored for change. Examples of these include paying attention to directions, raising hand before speaking and cooperating with classmates. The teacher records the child's behavior daily or weekly on a form or card to be reviewed by the parent. The parent provides positive or negative consequences based upon the child's performance (Parker, 1988). Behavior management is effective because it is easily implemented, flexible and understood by the child. It is also individualized for the specific needs of the child.

Cognitive therapy is another approach used with ADD children. Its main focus is on self guidance and

strategic problem solving skills. According to Abikoff (1991):

> "The expectation is that the enhancement and internalization of self-regulation cognitive skills should provide the youngster with ADHD with the means for more appropriate behavioral regulation, as well as facilitate academic functioning."

Research has proven however, that although well accepted in theory, cognitive therapy is not generally effective in helping ADD children cope with their disorder (Abikoff, 1991).

Psychological counseling and parenting classes are highly recommended as a necessary component for successful treatment of children with ADD and their families. The ADD child may have difficulty with siblings and frequently show much greater compliance to their father's instructions. The stress on the family unit makes professional counseling vital in treating ADD. ADD children may also benefit form individual counseling to build self esteem, and to better understand their behavior (Parker, 1988).

Greisbach (1989) states:

> "The most important interventions are educational. It is critical to ensure that the youngster is in the most appropriate classroom and school setting given his learning capabilities."

Educational management is essential for effective treatment of ADD. Educators have the ability and responsibility to assist ADD children to function at their highest level. An important technique for meeting this goal is infusing structure, routine and organizational skills into the children's daily lives. This will enable the children to internalize the structure necessary for future success (Copeland and Love, 1990). Eight steps were developed by Copeland and Love (1990) to introduce structure into the classroom. The authors note that structure is not synonymous with strictness which implies inflexibility. The teacher who utilizes structure must still recognize individual differences in all children, especially those with the disorder. The eight steps are:

1. Prepare lesson plans and make sure all materials are ready.
2. Spend the first fifteen minutes of every day organizing the children.
3. Color-code the students' books and materials.
4. Post the day's work on the board.
5. Have the ADD student keep an organized notebook. This should include pockets for work to be done, completed work and papers to save.
6. Orient the students again after lunch.
7. Spend ten minutes organizing at the end of the day.
8. Organize the ADD students' families. This includes explaining procedures for incomplete work and homework.

Behavioral management techniques are essential for creating a positive classroom environment in which learning can take place. Barkley (1990) developed seven principles for effective behavior management with ADD students:

1. Rules and instructions must be clear and brief and delivered through more visible modes of presentation.
2. Consequences (both positive and negative) must be immediate.
3. Consequences must be more frequent.
4. The consequences used with ADD children must be of higher magnitude than those used with normal children.
5. Positive reinforcement systems should be implemented one to two weeks prior to adding punishments.
6. Rewards must be changed frequently.
7. The management of ADD children requires planning ahead or anticipating possible problem situations.

Tangible rewards and token programs are an effective behavioral tool when used consistently. ADD children need the opportunity to earn frequent rewards. Praise, although valuable, is less effective without tangible rewards or privileges (Pfiffner, Rosen and O'Leary) as cited by Barkley (1990). Special privileges such as special games, computer time, helping the teacher and extra recess are especially effective.

Negative consequences include ignoring behaviors, reprimands, response cost and time-out. Ignoring

involves the contingent withdrawal of teacher attention upon the occurrence of inappropriate behavior (Barkley, 1990). Ignoring alone has not been found effective with ADD children. It has been recommended to use ignoring only in conjunction with other negative consequences.

Reprimands have been proven effective in studies when they are immediate, brief and unemotional. They are most effective when backed up with time out or loss of privileges. Reprimands appear to have a more powerful effect when delivered with eye contact and in close proximity to the child. It has also been determined that children respond better to teachers who deliver these effective reprimands at the beginning of the school year rather than to teachers who increase the severity as the year progresses (Barkley, 1990).

Response cost involves the loss of a privilege, point or reinforcer upon inappropriate behavior. It is often used with ADD children within a "token system." This program enables the child to earn tokens for appropriate behavior as well as lose tokens for inappropriate behavior. This is effective with ADD children because it places them in control of the amount of rewards they earn.

Time-out involves the withdrawal of positive reinforcement contingent upon inappropriate behavior. It can involve removal of any stimulus but usually involves the loss of adult or peer interaction. Time-out has specific criteria which must be fulfilled in order for the child to be removed from the setting. These include but are not limited to being quiet and cooperative for a predetermined length of time (Barkley, 1990). Time-out has been determined to be especially effective in reducing aggressive and disruptive action in the classroom.

There are many specific educational interventions that are effective with ADD children. The writer, after extensive research, has chosen to discuss thirteen strategies proven to be effective with ADD children. These were chosen based upon their ease of implementation, flexibility, and effectiveness with all children in the classroom. Special consideration was given to strategies that enhanced learning and promoted a positive classroom environment. These strategies are:

1. Placing the ADD child in the classroom. The ADD child should be placed in the least distracting spot in the classroom (Phelan, 1989). This is not necessarily

next to the teacher's desk where other children may be waiting for assistance. Many ADD children function well in the middle of the room when their view is that of other children working. Isolation has been found to be ineffective in many cases because it fosters feelings of inadequacy. Copeland and Love (1990) recommend that the teacher discuss desk placement with the child.

2. Teaching listening skills. ADD children tend to have developed poor listening skills and, therefore, need to be taught good listening skills. Oral repetition of directions, visual and auditory cuing and the use of tape recorders are all recommended strategies (Copeland and Love, 1990).

3. Establishing eye contact. The teacher should establish eye contact with the student before giving instructions. The teacher should always face the students. Giving directions while writing on the chalkboard is not conducive to learning (Copeland and Love, 1990; McCall, 1989; Parker, 1988; Phelan, 1989).

4. Varying voice tone and inflection. Research has proven that varying the tone of voice is the critical factor in attending, not volume. The teacher should move

around the classroom and use gestures to capture students' attention (Copeland and Love, 1990).

5. Emphasizing with color. Highlighting important directions on assignments is an effective strategy for the ADD student. The teacher should, when applicable, teach the child to use this strategy independently (Copeland and Love, 1990).

6. Creating study buddies. The use of peer tutors, group assignments or cooperative learning activities provide valuable academic and social skills lessons for the ADD child (Copeland and Love, 1990).

7. Dividing and organizing work. Work periods should be short and well structured (Copeland and Love, 1990). Folding a worksheet so the child focuses on one part is sometimes helpful (Phelan, 1989). Keeping only necessary materials on the desk works to eliminate distractors. The ADD student is more productive when only one or two assignments are given at a time. Frequent short breaks are useful (Copeland and Love, 1990; Phelan, 1989).

8. Using timers. The use of timers is not recommended as a management technique. Timers are often counterproductive because they become a distractor for

the student. The emphasis on quality not quantity is a much more productive strategy (Copeland and Love, 1990).

9. Allowing for physical movement. Allowing ADD students to move around the classroom when appropriate is beneficial (Phelan, 1989). Incorporating movement into lessons or activities can be beneficial for all students, especially those with ADD. Auditory drills with the students standing, exercising and moving help to eliminate behavioral disruptions (Copeland and Love, 1990).

10. Implementing a secret signal. The teacher should establish a secret non verbal signal with the student to assist in curtailing off task behavior (Phelan, 1989).

11. Implementing an assignment sheet. Daily assignment sheets are helpful in monitoring daily progress, keeping the student organized and fostering daily contact with parents (Copeland and Love, 1990; McCall, 1989; Parker, 1988; Phelan, 1989).

12. Capitalizing on strengths. It is vital for the teacher to help build self esteem in ADD children. One vehicle for this is to seek out the childrens' talents or interests and promote them (Parker, 1988; Phelan, 1989).

13. Reducing the frustration of writing. Almost 80% of ADD children have difficulty with writing. It is helpful for the teacher to determine what writing is necessary and to determine what other methods of communication can be infused. Shortening daily assignments is often vital. Other methods include the use of tape recorders, typewriters and computers (Copeland and Love, 1990).

The writer's belief that a teacher who is educated in all aspects of ADD will be more effective in the classroom was strengthened after extensive research on the subject. It is this belief that led the writer to develop a comprehensive inservice program which included all the components of ADD. The writer feels that learning by example is a powerful reinforcer. This philosophy was incorporated into the inservice program by the writer who demonstrated a variety of teaching methods, encouraged participant movement and involvement, offered frequent rewards, illustrated correct use of eye contact and vocal inflection and utilized study buddies. In addition to modeling effective teacher behaviors, the writer encouraged participants to work cooperatively to: brainstorm ideas and strategies, design individual

classroom plans tailored to the needs of their students, implement and monitor the plans and evaluate the plan's effectiveness. Participants were encouraged to share their successes and failures in an open forum in order to facilitate their own professional development as well as that of their colleagues.

CHAPTER III

Method

Pre-implementation

The writer began by applying to the Superintendent's Screening Committee of the local School Board for permission to conduct the practicum proposal at the targeted site. Once permission was granted, the writer then had to apply to the Human Resource Department for inservice credit for all participants. The Human Resource Department agreed to issue ten inservice points to participants who attended all sessions and scored 80 percent on the post test.

The writer was then able to offer the workshop to all faculty members. A combination of twenty-two teachers and support personnel, including the six targeted teachers, registered for the workshop. Preparation was a huge undertaking. Scheduling became an obstacle because of the large number of participants. After a group discussion, the participants agreed to meet on Mondays for one hour per week. The target group agreed to spend an additional half hour after each

session with the writer, to discuss feelings, experiences and observations.

Materials on ADD were then gathered from a variety of sources for each participant. A folder of these materials which included journal articles, local School Board materials, a pretest, a "Child Behavior Checklist" and an individualized education planning form was prepared for each participant. An agenda closely following the writer's practicum proposal time line, was prepared for the twelve week program. The preparation was difficult and time-consuming; however, it helped to make implementation smooth and uncomplicated.

Implementation Weeks One through Six

The writer began the first session by sharing the pre-implementation survey data. The participants were relieved to learn that they had similar thoughts and feelings about ADD students. This session set the tone for the entire workshop. The participants interacted and shared questions, feelings and classroom experiences, some for the first time. The writer explained the workshop objectives and reviewed the agenda with the participants. The writer requested input to shape future sessions and led a discussion on the characteristics of

ADD. The writer gave each participant a folder and answered questions about the workshop format.

The target group met briefly the first week to discuss their responsibilities. Each member agreed to keep a journal of thoughts and feelings about anything related to ADD. They also agreed to share their journals with the writer and the other members of the group. The writer also decided to keep a journal of incidents, impressions and feelings. The writer wanted to maintain a record of improvements and weak points as well as a sense of the attitudes of individual group members. The data provided information on the main areas of concern as well as items such as innovative ideas, classroom situations and participation levels.

The second and third weeks were consumed with the writer sharing knowledge in a variety of mediums about ADD. The participants first completed and scored the ADD pretest to diagnose their weak areas. The participants then viewed Phelan's "Attention Deficit Hyperactivity Disorder" Part I and II. This video explores the symptoms, causes and treatments of ADD. The writer stopped the video often to facilitate discussion and answer questions. The video offered some concrete

suggestions for teachers to implement in the classroom. The participants commented on those and shared personal experiences they had with ADD students with the group. The workshop climate was positive and a feeling of comraderie had formed.

The following two weeks were spent learning about the teacher's role in helping to assess ADD in students. The target schocl's Exceptional Student Education (ESE) Specialist, a workshop participant, shared knowledge and insight about the "Child Behavior Checklist" which all participants elected to use. The target group members were required to complete two of these instruments on a targeted student, one in week four and one just prior to workshop completion. Every participant, however, was eager to fulfill all of the requirements of the target group. Each participant completed the "Child Behavior Checklist" on a student exhibiting the characteristics of ADD, and learned how to score and gather information from it.

After careful reflection on the scores from the "Child Behavior Checklist", each participant was given the task of completing the individualized education plan. Strategies for working with ADD students were reviewed

and analyzed. Participants wrote and then shared their plan with the group, highlighting the rationale for the strategies they had chosen. The participants worked cooperatively, offered suggestions and opinions, and generated an enthusiasm that was contagious.

By the end of week five, the participants were filled with knowledge about ADD, had an individualized plan for working with an ADD student and found a cadre of co-workers with whom they could share experiences.

The midway point was spent doing an interim review with the participants. All participants responded positively to the informal review. One participant, not a target group member, had to withdraw from the workshop due to scheduling conflicts. The target group spent time sharing their journals and laughing with each other's experiences. All of the participants had implemented their plans. One participant saw great changes in the targeted student while others saw little change in one week. The participants agreed that their attitudes about ADD students had changed greatly; they felt more comfortable and less frustrated.

Implementation Weeks Seven through Twelve

The next two weeks were spent monitoring and making adjustments to the individualized education plans. At the end of the eighth week the first guest speaker, a local psychologist, came to the target site. The speaker presented information about ADD and shared experiences working with children, parents and teachers. The speaker is a founding member of CHADD a national support organization for parents of ADD children. The speaker brought a slide show which illustrated effective strategies for working with ADD students and also offered suggestions for conferencing and working with parents of ADD children. The vast knowledge and expertise shared by the speaker was appreciated by every participant.

The only ineffective resource utilized during the workshop appeared in the ninth week. The Copeland video "The School's Role in ADD" repeated much of the information presented in earlier sessions but in a lecture format. The writer turned it off midway through when it was obvious that the participants had lost interest. The writer facilitated a discussion on why the presentation did not hold the audiences' attention. The participants then brainstormed ways to present

information in a more interesting manner. Although unintended, the participants gained a list of exciting methods to use to present subject matter.

The tenth week offered the second guest speaker, a parent of an ADD child who is also a representative of an ESE Advisory Council for the local School Board. The speaker presented a great deal of information on ADD and shared personal experiences from a different perspective. The speaker explained ADD children's rights under Section 504 of the Rehabilitative Act of 1973. The speaker was an expert at generating questions from the audience and their enjoyment was obvious.

The last two weeks were spent reviewing all of the information presented, sharing results of the individualized education plans and administering post implementation evaluations. The participants each self-evaluated their plan and shared what was effective and what was ineffective. The writer did not need to take a direct lead in facilitating discussion. The participants' confidence in their ability to diagnose, offer suggestions and share experience was apparent and very gratifying to the writer.

The post implementation survey was administered during week eleven. Twenty participants completed the survey. One participant had to miss three sessions for personal reasons and could not complete the workshop. The total score of the six targeted teachers showed a dramatic change in attitude. (Appendix G:74) The range of scores on the pre-implementation survey was 16-24 with a mean of 20.5. The post implementation survey had a range from 40 to 49 points with a mean average of 45. The survey reflected what the writer saw happening. The participants' attitudes had become more positive as a result of receiving information, collaborating with colleagues, and sharing experiences.

The last week was spent gathering data and completing the necessary requirements for a County sponsored workshop. The ADD post test was given to determine gains in knowledge. The post test showed significant gains in understanding from each member of the targeted group. (Appendix H:79) Pretest scores from the group ranged from 65% to 80% while post test scores ranged from 95% to 100%. The participants expressed gratitude for the knowledge and a desire to continue to learn about ADD.

The Human Resource Department Inservice Workshop Evaluation was given to fulfill the requirements for inservice points. Although not part of the writer's objectives, it was gratifying to see that 94% of the participants rated the workshop excellent.

The target group completed the second "Child Behavior Checklist" during the last session. By this time the participants were proficient in scoring and evaluating the scores they had given. The scores on the instrument did not change dramatically for five of the six participants although all showed a decline in attention problems. (Appendix I:81) The group still expressed satisfaction in the knowledge and experience they had gained and felt certain it would only benefit all of their future students.

CHAPTER IV

Results

The writer evaluated the program through a variety of methods to determine if the objectives had been met. Four components were chosen to measure outcomes in the cognitive and affective domains as well as to develop excellent critical thinking skills. First, to measure a change in attitude, the writer compared scores on the pre and post implementation survey. Second, the writer also compared scores on the pre and post ADD test to determine the participants' increase in knowledge about ADD. Third, the writer, working with the participants, compared the initial and final scores on the "Child Behavior Checklist" to determine changes in the targeted students' behavior. Finally, the writer worked with the participants to determine if their individual plans were effective. This was done through observation and the use of the "Child Behavior Checklist".

The writer's belief that effective classroom change could only occur if the attitudes of teachers about ADD were improved was the cornerstone of the practicum

proposal. The teachers needed to feel properly prepared to work with ADD students in order to help them be successful. As the teachers learned more about ADD, their attitudes improved. It was apparent that the educators who attended the workshop faithfully were receptive to changing their own behaviors. The sharing of experiences, strategies, successes and failures enabled the group to learn from each other and to become an invaluable support system. By sharing the knowledge and strategies the writer researched, the group felt empowered and motivated to make changes in their classrooms.

The attitudinal survey was given twice during the program. The pre-implementation survey results (Appendix C:61) reflected the targeted groups frustration about their lack of knowledge about ADD and effective strategies used with ADD students. The target group did not feel successful when working with ADD students and were looking for assistance. The response to statement two revealed that five of the six target teachers spent additional time with ADD students. All six of the teachers indicated the need for information on strategies used with ADD students. Five of the six teachers agreed

that they felt frustrated when working with ADD students. Perhaps the most alarming statistic from the pre-implementation survey was the response to question nine. Five of the six teachers believed that ADD students were less successful and productive academically than their classmates. However, the post-implementation survey illustrated significant changes in the ideas and opinions of the target group, possibly indicating a greater understanding of the problem as well as a desire to do something about it. The response to statement two showed that the target group still spent additional time with ADD students. However, only one member of the target group indicated the need for more information on strategies used with ADD students. Five of the six teachers indicated that they no longer felt frustrated when working with ADD students. The number of target group members who believed that ADD students were less successful and productive academically than their classmates was reduced by three. Weekly discussions showcased the participants gradual change in attitudes. By the midpoint oral review, the participants felt more relaxed, less frustrated and eager to continue the program. The proposal objective which indicated each

participant would demonstrate a more positive attitude towards ADD by an increased score of 25% on the post attitudinal survey was met by each participant. Additionally, each participant agreed that they had more confidence in their ability to work with ADD children and assist other teachers with challenging classroom situations.

The workshop participants were exposed to a tremendous amount of material about ADD. Weekly reviews were done orally to ensure participants understanding of concepts. Participants voluntarily engaged in their own research and brought materials to meetings to share with others. As the participants began to take control of their own learning, their confidence increased. This impacted the workshop positively, by empowering each participant to take risks, ask questions and solve problems independently. The guest speakers brought information and shared experiences which enhanced the participants learning. Participants were directed to analyze the effectiveness of teaching strategies and report back to the group. The writer was able to monitor the groups learning during the weekly meetings and the sharing of journals.

The written measurement of knowledge was the use of the pre and post ADD test. The same test was given twice. The first time was just prior to the beginning lecture and then again after the last meeting. Each participant demonstrated at least a 20 percent increase in knowledge about ADD on the post test. Further, each participant was given the opportunity to discuss what they had learned and all felt more knowledgeable about ADD. Finally, each participant was given references throughout the workshop for future inquiry if desired.

The purpose of designing this workshop for teachers was to enable them to implement knowledge and strategies learned into their classrooms, thereby improving the quality of education for all students. Measuring this, however, was a difficult talk. Each teacher completed two "Teacher Report Forms" on a student exhibiting the characteristics of ADD. One was completed at week five while the other was done at the last workshop session. The final scores reflected a wide variety of differences among the targeted teachers results. Each teacher indicated some positive changes in behavior although the changes varied in degree. All scores revealed a decrease in attention problems; however, the numbers ranged from

one to fifteen points. The differences were attributed to the severity of the attention problems as well as individual differences in teachers completing the form. The experience level of the teacher was not considered to be a valid factor in the differences of scores. Teacher One, who has twelve years of teaching experience, indicated significant changes in the targeted student's behavior. Teacher Two, a second year teacher, indicated little change in the targeted student's behavior. Teacher five, a twenty-six year veteran, revealed little change in the targeted student's behavior while Teacher Six, a nine year teacher, indicated large changes in the targeted student's behavior. Due to the inconsistency of the scores, the teachers experience level could not be utilized to explain these differences. The group discussed a wide variety of factors which may have caused the disparity of scores. The group analyzed the scores and felt that the time attributed to the differences. The second "Teacher Report Form" was completed at the end of the school year. The group felt that student behavior was greatly affected by the ending of a school year. The scores did reflect some individual gains in coping with attention problems but fell short of meeting the proposal

objective. The group expressed satisfaction in what they had learned. One member felt that if the program had started at the beginning of the year, the results might have been higher. The writer agreed with this valid point.

In order to create change in the classroom, each teacher designed an individualized education plan for a targeted student at week six. The teacher chose three strategies to implement and monitor for the duration of the workshop. From week seven on the plans were discussed, evaluated and modified weekly. The writer facilitated the discussions, but allowed the participants to work together to analyze the successes and failures of certain strategies. Each participant kept weekly anecdotal notes in their journals and enthusiastically shared experiences with each other. Participants noted that some strategies worked well for a week or two but needed to be rotated often. The participants presented a final oral evaluation of their plan explaining what they found to be successful and why. Each group member felt that this was their favorite activity and the one they gained the most from. They felt strongly that their analytical, evaluative and creative abilities were

strengthened significantly. They also expressed positive feelings about working together as a team.

The entire project reflected group cooperation, professionalism and self-evaluation. Although some of the outcome objectives were not attained numerically, the processes represented by each objective flourished. The teachers had no education about ADD prior to the workshop, so it is the opinion of the writer that the practicum was successful because all of the participants made significant gains in knowledge and understanding. Other unmeasurable skills were learned including better collaboration, improved listening skills, and the ability to analyze and generate solutions for difficult classroom situations.

CHAPTER V

Recommendations

It is intended that this inservice be implemented at the beginning of the school year for teachers. Allowing for modifications, suggestions and criticisms the basic format will be utilized for future programs. It is also intended to expand the inservice program to include neighboring schools or any interested teacher. Additionally, the writer will pursue mandatory ADD education for all new teachers through the Professional Orientation Program of the Human Resource Department.

ADD education will be infused into faculty meetings through the school's discipline committee of which the writer is chairperson. Weekly discipline committee meetings will continue to reserve time for faculty members to discuss discipline problems and share ideas and suggestions. Materials from the inservice program will be placed in the school's professional library for future reference. The writer will be available to help any colleague work more effectively with ADD students.

Future programs can include special presentations for parents, administrators, paraprofessionals and support personnel. The more informed educators become, the more students they will reach. A continuation of the program throughout the educational system is of critical importance. This program has acted as a catalyst in the targeted site, for reaching a growing population of students and helping to better meet their educational needs. If given the support it deserves, the program can continue to improve the quality of education for all students.

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APPENDIX A

Teacher Survey

PRE/POST IMPLEMENTATION SURVEY

Answer the following questions using the number values listed below. Indicate your response by circling the number which best represents your feelings.

1 - Strongly Agree, 2 - Agree, 3 - Not Sure, 4 - Disagree, 5 - Strongly Disagree.

1.	I have/had one or more students who exhibit at least 8 of the 14 characteristics of Attention Deficit Disorders (ADD) (DMS-RIII)	1 2 3 4 5
2.	I spend additional time working with these students.	1 2 3 4 5
3.	I need to know about the causes of ADD.	1 2 3 4 5
4.	I need to know about the teacher's role in assessing ADD.	1 2 3 4 5
5.	I need to know more about methods/ strategies used with ADD students.	1 2 3 4 5
6.	I do not feel successful when working with these students.	1 2 3 4 5
7.	I feel frustrated in my work with these students.	1 2 3 4 5
8.	I feel uncomfortable when talking with parents about ADD.	1 2 3 4 5
9.	ADD students are less successful and productive academically than their classmates.	1 2 3 4 5
10.	I do not understand how medication affects ADD students.	1 2 3 4 5
11.	I am unsure of the difference in characteristics between ADHD and	

	Undifferentiated ADD.	1 2 3 4 5
12.	Information on ADD could help me to be more successful with ADD students.	1 2 3 4 5
13.	There is a need for ADD education for educators and parents right now.	1 2 3 4 5

Personal Comments:

APPENDIX B

Total Group Survey Results

PRE-IMPLEMENTATION SURVEY RESULTS

28 TEACHERS

1. I have/had one or more students who exhibit at least 8 of the 14 characteristics of Attention Deficit Disorders (ADD) (DMS-RIII).

   Strongly Agree 79%
   Agree 14%
   Not Sure 7%
   Disagree 0%
   Strongly Disagree 0%

2. I spend additional time working with these students.

   Strongly Agree 79%
   Agree 17%
   Not Sure 4%
   Disagree 0%
   Strongly Disagree 0%

3. I need to know about the causes of ADD.

   Strongly Agree 50%
   Agree 39%
   Not Sure 4%
   Disagree 7%
   Strongly Disagree 0%

4. I need to know about the teacher's role in assessing ADD.

   Strongly Agree 61%
   Agree 30%
   Not Sure 0%
   Disagree 0%
   Strongly Disagree 0%

5. I need to know more about methods/strategies used with ADD students.

   Strongly Agree 71%
   Agree 29%

Not Sure 0%
Disagree 0%
Strongly Disagree 0%

6. I do not feel successful when working with these students.

Strongly Agree 25%
Agree 29%
Not Sure 29%
Disagree 11%
Strongly Disagree 8%

26 Teachers completed survey

7. I feel frustrated in my work with these students.

Strongly Agree 31%
Agree 54%
Not Sure 12%
Disagree 0%
Strongly Disagree 3%

8. I feel uncomfortable when talking with parents about ADD.

Strongly Agree 8%
Agree 40%
Not Sure 6%
Disagree 24%
Strongly Disagree 12%

One teacher did not answer

9. ADD students are less successful and productive academically than their classmates.

Strongly Agree 27%
Agree 42%
Not Sure 19%
Disagree 9%
Strongly Disagree 3%

10. I do not understand how medication affects ADD students.

Strongly Agree 19%
Agree 35%
Not Sure 19%
Disagree 19%
Strongly Disagree 8%

11. I am unsure of the difference in characteristics between ADHD and Undifferentiated ADD.

Strongly Agree 19%
Agree 35%
Not Sure 12%
Disagree 27%
Strongly Disagree 8%

12. Information on ADD could help me to become more successful with ADD students.

Strongly Agree 58%
Agree 42%
Not Sure 0%
Disagree 0%
Strongly Disagree 0%

13. There is a need for ADD education for educators and parents right now.

Strongly Agree 88%
Agree 4%
Not Sure 4%
Disagree 4%
Strongly Disagree 0%

Three surveys were incomplete. The total used for those was 25.

Mean 24

Median 23

Mode 16 and 21

Range of scores 16-41

APPENDIX C

Target Group

PRE-IMPLEMENTATION SURVEY RESULTS

6 TARGETED TEACHERS (One from each grade level, K-5)

1. I have/had one or more students who exhibit at least 8 of the 14 characteristics of Attention Deficit disorders (ADD) (DMS-RIII)

   Strongly Agree IIII (4)
   Agree I (1)
   Not Sure I (1)
   Disagree
   Strongly Disagree

2. I spend additional time working with these students.

   Strongly Agree III (3)
   Agree II (2)
   Not Sure I (1)
   Disagree
   Strongly Disagree

3. I need to know about the causes of ADD.

   Strongly Agree IIII (4)
   Agree I (1)
   Not Sure
   Disagree I (1)
   Strongly Disagree

4. I need to know about the teacher's role in diagnosing ADD.

   Strongly Agree IIII (4)
   Agree II (2)
   Not Sure
   Disagree
   Strongly Disagree

5. I need to know more about methods/strategies used with ADD students.

   Strongly Agree IIIII I (6)
   Agree

Not Sure
Disagree
Strongly Disagree

6. I do not feel successful when working with these students.

Strongly Agree II (2)
Agree II (2)
Not Sure II (2)
Disagree
Strongly Disagree

7. I feel frustrated in my work with these students.

Strongly Agree III (3)
Agree II (2)
Not Sure I (1)
Disagree
Strongly Disagree

8. I feel uncomfortable when talking with parents about ADD.

Strongly Agree
Agree IIIII (5)
Not Sure I (1)
Disagree
Strongly Disagree

9. ADD students are less successful and productive academically than their classmates.

Strongly Agree I (1)
Agree IIII (4)
Not Sure I (1)
Disagree
Strongly Disagree

10. I do not understand how medication effects ADD students.

Strongly Agree
Agree III (3)
Not Sure III (3)
Disagree

Strongly Disagree

11. I am unsure of the difference in characteristics between ADHD and undifferentiated ADD.

Strongly Agree I (1)
Agree IIII (4)
Not Sure
Disagree
Strongly Disagree

12. Information on ADD could help me to be more successful with ADD students.

Strongly Agree IIIII (5)
Agree I (1)
Not Sure
Disagree
Strongly Disagree

13. There is a need for ADD education for educators and parents right now.

Strongly Agree IIIII I (6)
Agree
Not Sure
Disagree
Strongly Disagree

INDIVIDUAL SURVEY RESULTS

Pre-Implementation Survey

TOTAL USED: 6

RANGE: 16-24
MEAN AVERAGE: 20.5
MODE: 21
MEDIAN: 21

TEACHER ONE	21 OUT OF 65 TOTAL POINTS	32%
TEACHER TWO	16 OUT OF 65 TOTAL POINTS	25%
TEACHER THREE	21 OUT OF 65 TOTAL POINTS	32%
TEACHER FOUR	23 OUT OF 65 TOTAL POINTS	35%
TEACHER FIVE	24 OUT OF 65 TOTAL POINTS	37%
TEACHER SIX	18 OUT OF 65 TOTAL POINTS	28%

APPENDIX D

ADD Test

ADD Pre/Post Test

DIRECTIONS: Read each statement. Indicate your response by circling T if the statement is TRUE, F if the statement is FALSE.

1.	Add affects three to eight percent of school-aged children.	T	F
2.	To be diagnosed with ADD, a child must exhibit at least six of the fourteen characteristics for six months prior to the age of seven.	T	F
3.	ADD is a form of brain damage.	T	F
4.	ADD is caused by environmental factors.	T	F
5.	There are two types of attention disorders.	T	F
6.	Hyperactivity is a characteristic of every child with an attention disorder.	T	F
7.	A medical examination is the only information needed to diagnose ADD.	T	F
8.	Tranquilizers are the most effective medications for ADD.	T	F
9.	Ritalin, a stimulant medication, decreases many of the symptoms of ADD.	T	F
10.	Stimulants used in treating ADD produce some side effects which usually wear off after a few weeks.	T	F
11.	A strict, rigid teacher is best for the ADD student.	T	F
12.	A structured classroom hinders the		

	ADD student.	T	F
13.	Praise is the most effective behavioral tool used with ADD students.	T	F
14.	Ignoring inappropriate behavior is very effective with ADD students.	T	F
15.	Token behavior systems work well as a classroom management system	T	F
16.	Assignment sheets should only be used with intermediate grade level students.	T	F
17.	Timers are not recommended for use with ADD students.	T	F
18.	Isolating the ADD student from the rest of the class improves concentration.	T	F
19.	Emphasize quality of work, not quantity.	T	F
20.	Children with ADD always outgrow it by adulthood.	T	F

APPENDIX E

Biographical Data

Biographical Data

Teacher One

Female

Teaching Assignment	:	Kindergarten
Years of Experience	:	12
Grade Levels Taught	:	K, 1st, Pre-Kindergarten
Years at Target Site	:	4
Education	:	Bachelor of Science in Elementary and Early Childhood Education, Master of Science Early Childhood. Certified in ESOL

Teacher Two

Female

Teaching Assignment	:	First Grade
Years of Experience	:	2
Grade Levels Taught	:	1st
Years at Target Site	:	2
Education	:	Bachelor of Arts in Elementary Education, Certified in Early Childhood Education.

Teacher Three

Female

Teaching Assignment	:	Second Grade
Years of Experience	:	6
Grade Levels Taught	:	1st, 2nd, 3rd, 7th
Years at Target Site	:	2
Education	:	Bachelor of Science in Elementary Education, Master of Science Elementary Education. Certified in Early Childhood Education.

Teacher Four

Female

Teaching Assignment	:	Third Grade

Years of Experience	:	5
Grade Levels Taught	:	K, 1st, 2nd, 3rd
Years at Target Site	:	2
Education	:	Bachelor of Science in Elementary Education. Certified in Early Childhood Education and ESOL

Teacher Five

Female

Teaching Assignment	:	Fourth Grade
Years of Experience	:	26
Grade Levels Taught	:	4th, 5th, 6th
Years at Target Site	:	18
Education	:	Bachelor of Arts in Elementary Education, Certified in ESOL

Teacher Six

Female

Teaching Assignment	:	Fifth Grade
Years of Experience	:	9
Grade Levels Taught	:	3rd, 4th and 5th
Years at Target Site	:	9
Education	:	Bachelor of Science in Elementary Education. Certified in ESOL

APPENDIX F

Individualized Education Plan

Individualized Education Plan
for student exhibiting the characteristics of an
Attention Deficit Disorder

During the second half of this inservice program, I will implement the following strategies with my targeted student.

1.

2.

3.

I will monitor this plan and reevaluate the plan's effectiveness weekly.

Teacher's Name _____

Grade Level _____

APPENDIX G

Post Implementation Survey Results

POST IMPLEMENTATION SURVEY RESULTS

6 TARGETED TEACHERS (One from each grade level, K-5)

1. I have/had one or more students who exhibit at least 8 of the 14 characteristics of Attention Deficit Disorders (ADD) (DMS-RIII)

   Strongly Agree IIII (4)
   Agree II (2)
   Not Sure
   Disagree
   Strongly Disagree

2. I spend additional time working with these students.

   Strongly Agree IIIII (5)
   Agree I (1)
   Not Sure
   Disagree
   Strongly Disagree

3. I need to know about the causes of ADD.

   Strongly Agree
   Agree
   Not Sure
   Disagree II (2)
   Strongly Disagree IIII (4)

4. I need to know about the teacher's role in diagnosing ADD.

   Strongly Agree
   Agree
   Not Sure
   Disagree I (1)
   Strongly Disagree IIIII (5)

5. I need to know more about methods/strategies used with ADD students.

   Strongly Agree I (1)
   Agree
   Not Sure

Disagree II (2)
Strongly Disagree III (3)

6. I do not feel successful when working with these students.

Strongly Agree
Agree
Not Sure
Disagree III (3)
Strongly Disagree III (3)

7. I feel frustrated in my work with these students.

Strongly Agree
Agree I (1)
Not Sure
Disagree IIII (4)
Strongly Disagree I (1)

8. I feel uncomfortable when talking with parents about ADD.

Strongly Agree
Agree
Not Sure
Disagree II (2)
Strongly Disagree IIII (4)

9. ADD students are less successful and productive academically than their classmates.

Strongly Agree
Agree II (2)
Not Sure
Disagree
Strongly Disagree IIII (4)

10. I do not understand how medication effects ADD students.

Strongly Agree
Agree
Not Sure
Disagree II (2)
Strongly Disagree IIII (4)

11. I am unsure of the difference in characteristics between ADHD and undifferentiated ADD.

Strongly Agree
Agree I (1)
Not Sure
Disagree II (2)
Strongly Disagree III (3)

12. Information on ADD could help me to be more successful with ADD students.

Strongly Agree II (2)
Agree III (3)
Not Sure I (1)
Disagree
Strongly Disagree

13. There is a need for ADD education for educators and parents right now.

Strongly Agree IIIII (5)
Agree I (1)
Not Sure
Disagree
Strongly Disagree

INDIVIDUAL SURVEY RESULTS

Post Implementation Survey

TOTAL USED: 6

RANGE: 40 - 49
MEAN AVERAGE: 45
MODE: 45
MEDIAN: 45

TEACHER ONE	49 OUT OF 65 TOTAL POINTS	75%
TEACHER TWO	45 OUT OF 65 TOTAL POINTS	69%
TEACHER THREE	40 OUT OF 65 TOTAL POINTS	61%
TEACHER FOUR	45 OUT OF 65 TOTAL POINTS	69%
TEACHER FIVE	45 OUT OF 65 TOTAL POINTS	69%
TEACHER SIX	46 OUT OF 65 TOTAL POINTS	70%

APPENDIX H

Pre and Post ADD Test Scores

Pre and Post ADD Test Scores

	Pre Test Scores	Post Test Scores
TEACHER ONE -	80%	100%
TEACHER TWO -	70%	95%
TEACHER THREE -	70%	95%
TEACHER FOUR -	70%	100%
TEACHER FIVE -	80%	100%
TEACHER SIX -	65%	100%

APPENDIX I

"Teacher Report Form" Results

"TEACHER REPORT FORM" RESULTS

	Teacher One	Teacher Two	Teacher Three	Teacher Four	Teacher Five	Teacher Six
Initial TRF Internalizing Behavior	3	11	41	33	18	2
Initial TRF Externalizing Behavior	47	7	14	37	22	26
Initial TRF Attention Problems	26	18	25	32	27	23
Second TRF Internalizing Behavior	3~	11~	13↓	21↓	24↑	0↓
Second TRF Externalizing Behavior	34↓	7~	43↑	36↓	22~	9↓
Second TRF Attention Problems	21↓	17↓	14↓	30↓	26↓	8↓

KEY
↑ Behavior Increased
↓ Behavior Decreased
~ Behavior Did Not Change