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AUTHOR	McEachern, Adriana Garcia
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ABSTRACT

This final report discusses the activities and outcomes of a project designed to train a cadre of school counseling students to work with culturally and linguistically diverse (CLD) students receiving special education services. The project was a pilot track under the Master of Science in Counselor Education, School Counseling program, at Florida International University in Miami. At the time the project was funded, the program required 54 semester hours for completion. Students selected to participate in the project were required to register for an additional 6 credits. These credits included the Education of Students with Exceptionalities course (3 credits) and 3 credits of independent research with a department faculty member. Trainees also agreed to complete field experiences in schools where they worked directly with students with disabilities. These field experiences consisted of a part-time practicum (105 hours) and a full-time internship (600 hours). The project trained and supported 23 school counseling students, with tuition scholarships and stipends. Seventeen of these have graduated and 14 are working as school counselors serving CLD students with disabilities. The students' research projects have resulted in publications, presentations, research papers, and research symposiums. The publications are included in the materials. (CR)

TRAINING PERSONNEL FOR THE EDUCATION OF INDIVIDUALS WITH DISABILITIES PROGRAM

GRANTS FOR PRESERVICE PERSONNEL TRAINING
CFDA 84.029G

PREPARATION OF RELATED SERVICES PERSONNEL

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March 31, 2002

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TRAINING SCHOOL COUNSELORS TO WORK WITH CULTURALLY AND LINGUISTICALLY DIVERSE EXCEPTIONAL EDUCATION STUDENTS FINAL REPORT

PROJECT DIRECTOR: Dr. Adriana G. McEachern Ph.D., L.M.H.C., N.C.C.
Associate Professor & Director,
Counselor Education Programs
Florida International University, Miami, Florida

DESCRIPTION OF THE PROJECT

The main goals of the project were as follows:

(1) To train a cadre of school counseling students to work with culturally and linguistically diverse (CLD) exceptional education students (ESE)

(2) To provide tuition scholarships and stipends to these trainees

(3) To provide internship opportunities for trainee students to work directly with diverse, exceptional education students, parents, and teachers by providing counseling and consultation services in the Miami and Broward County schools

(4) To provide opportunities for school counseling students to work directly with counseling and special education faculty on research projects.

(5) To disseminate the results of the project to school counselors, counselor educators, school, personnel, and other interested parties.

All Project goals were accomplished.

CONTEXT

The ESST Project was a pilot track under the M.S. in Counselor Education, School Counseling program at Florida International University, in Miami–known for its high enrollment of minority students. At the time the Project was funded, the program required 54 semester hours for completion. Students selected to participate in the project were required to register for an

additional 6 credits. These credits included EEX 6051, Education of Students With Exceptionalities (3 credits) and 3 credits of independent research (MHS 6910) with a department faculty member. Trainees also agreed to complete field experiences in schools wherein they worked directly with ESE students. These field experiences consisted of a part-time practicum (105 hours), and a full-time internship (600 hours). The main thrust of the Project was to increase the sensitivity of school counseling students to individual and cultural differences of ESE students attending our local schools and to increase their confidence and expertise when working with these populations. The aim was also to connect the student trainees with teachers, parents, and other school personnel that worked with diverse ESE students.

The impact of the Project have been many. The project has increased the number of trained school counselors with competencies to work with diverse, exceptional education students in a variety of ways such as improving self -esteem, increasing effective study habits, coping with anger and interpersonal conflicts, relating with teachers and school personnel, adjusting to their disabilities, identifying career goals. Students who have emotional, personal, social and academic issues may fall behind in student achievement if counseling interventions are not provided. Consequently, the services provided by school counseling trainees have impacted the student achievement, personal-social adjustment, and career goals of the diverse, students with disabilities they served. In addition, Project results have added to the research literature in the form of publications, research presentations at conferences and other venues, and promoted an increase in the level of awareness of the needs of students with disabilities on the local, state, and national arena.

DESCRIPTION OF HOW GOALS WERE ACCOMPLISHED

The goals were accomplished in a variety of ways. Recruitment of students was conducted by using the ESST Project webpage, www.fiu.edu/~edpsy/Mcgrant, that was developed, by soliciting assistance from department faculty who made announcements in class regarding the Project, by developing and disseminating a Project Brochure, and by providing an Orientation for Trainee students every semester to review the Project goals, activities, and accomplishments. Support from administrators in the Miami-Dade and Broward County schools was crucial; therefore, regular meetings were held to discuss the Project goals, processes, and progress with them. The Counselor Education Advisory Committee was also used as a catalyst to solicit support for Project activities. On-going program evaluations, evaluations of interns, clinical instructors, and progress toward Project goals were conducted throughout. The Internet and on-line resources were used to disseminate project research and activities along with publications in refereed and non-refereed publications and presentations at national, state, and local conferences and meetings.

PROBLEMS ENCOUNTERED AND PROBLEM RESOLUTIONS

Only a few problems were encountered. Initially, the Project entailed recruiting students who had completed half of the program's credit hours, but this cause difficulty in recruitment; therefore, more flexibility was built into the recruitment process thus allowing for more students to be eligible to apply. The first year of the Project was spent recruiting as opposed to funding students. Consequently, not all Project funds had been spent by the end of the 3rd year, and a one-year extension was requested and approved.

Some problems were encountered internally with the Office of Financial Aid for trainees

who were receiving Project assistance and who were also on Financial Aid. These students tuitions were credited instead of being credited to the Project were credited to their Financial Aid. This resulted in scholarship monies being returned to the grant. Consequently, refunds had to be given to students necessitating additional paperwork on our part. The problem here is that FIU's computer systems are outdated, and the Financial Aid system does not communicate with the Comptroller's Office and vice versa. FIU is currently updating its computer system to avoid these problems from occurring in the future.

I learned that four years are needed to adequately complete a Project such as this one as it typically takes two years for students to complete the program, and the first year of the Project is spent coordinating, getting out information, developing materials etc. I also learned that collaboration and developing partnerships within the University, in the schools, and in the community are critical for program success. I learned you have to stay on top of everything and follow-up to assure activities and deadlines are met.

PROJECT OUTCOMES AND RESULTS

Project Trainees

The ESST Project has trained and supported with tuition scholarships and stipends, **23** school counseling students; **17** of these have graduated; **14** of them are working in the Miami-Dade County or Broward County schools as school counselors and are serving diverse, exceptional students in some capacity. Six trainees are currently enrolled and completing internships. Project trainees were comprised of 20 females and 3 males; 13 Hispanics, 2 African Americans, 2 African Caribbeans (Haiti & Jamaica); and 6 of Anglo European descent.

The Project also supported **4** graduate assistants with stipends while the College of

Education provided a 9 credit tuition waiver. Two of the grad assistants graduated with specialists degrees in school psychology (one is completing her internship and the other is working as a school psychologist in Broward County); the other male grad assistant completed the Masters in Special Education and is teaching in Miami-Dade County; the current grad assistant is completing the Masters in mental health counseling and will be interning this summer. **The total number of graduate students supported by the Project was 27.**

Project trainees have served over 2000 elementary and secondary school exceptional education students while engaged in field experiences in the Miami-Dade County and Broward County schools. These schools were predominantly in urban settings and had student populations that were very racially and ethnically diverse. During the Project years, Project trainees served **378** students in individual counseling, **245** in group counseling, **1414** in classroom guidance instruction, and have provided individual and group consultation to **177** parents of students with disabilities and **104** exceptional education teachers.

Project trainees also worked with department faculty on independent research projects during their participation. This work has resulted in 3 publications in refereed counseling or psychological journals, 2 manuscripts accepted and under revisions, the ESST Project Research Journal (a compilation of several research papers completed by students), 16 presentations at national, regional, state, or local conferences, 10 research papers, 2 Research Symposiums conducted at the University, 4 email research briefs sent nationally to counselors, counselor educators, and other interested individuals, the ESST Project webpage that reported research results, and several newsletter articles. One of the projects, *The Relationship Between Depression and Anxiety in Students With Learning Disabilities,* has obtained external funding. The following

is a list of the research projects, publications, presentations, and symposiums.

Publications

McEachern, A.G., & Bornot, J. (2001). Gifted students with learning disabilities: Implications and strategies for school counselors. *Professional School Counselor, 5,* 34-41.

Del Valle, P., McEachern, A. G., Chambers, H. D. (2001). Using social stories with autistic children. *Journal of Poetry Therapy, 4,* 187-197.

McEachern, A.G. (Ed.). (2000, Summer). *Teaching and counseling diverse exceptional education students: The ESST Project Journal, 1,* 1-55.

Astigarraga, J. & McEachern, A.G. (2000). Not broken, just different: Helping teachers work with students with attention deficit disorders (AD/HD). *California Journal of Counseling and Development, 20.* 28-33.

Publications Under Review

Kenny, M.C., & Gans, A. (2001). Comparing the self-concept of LD and non LD peers. *Journal of Learning Disabilities.* Accepted with Revisions.

Kanski, E., & Del Valle, P. (2002). Demele. *Journal of Multicultural Counseling and Development.* Accepted with revisions.

Publications In Process

McEachern, A.G. (2002). Training school counselors to work with urban, culturally, and linguistically, diverse, exceptional education students. (Manuscript in progress).

McEachern, A.G., & Astigarraga, J. (2002). Working with AD/HD students: Educators' perspectives. (Manuscript in progress).

Gallagher, A., & McEachern, A. G. (2002). An examination of teachers' attitudes toward inclusion. (Research and Manuscript in progress).

National and Regional Presentations

McEachern, A. G., (2002, March). *Serving diverse exceptional education students.* Poster presentation at the American Counseling Association World Conference, New Orleans, Louisiana.

Del Valle, P., & McEachern, A. G. (2002, March). *Using social stories with autistic children.* American Counseling Association World Conference, New Orleans, Louisiana.

McEachern, A. G. (2000, October). Serving diverse exceptional education students: A current look at school counseling pre-service education. Southern Association for Counseling Education and Supervision, Greensboro, North Carolina.

McEachern, A.G. (1999, September). *Training school counselors to work with urban, culturally and linguistically diverse exceptional education students, the ESST Project.* Poster session presented at the Office of Special Education national conference, Challenges for Personnel Preparation in Special Education, Washington D.C.

McEachern, A.G. (1999, April). *Training school counselors to work with urban, culturally and linguistically diverse exceptional education students, the ESST Project.* American Counseling Association World Conference, San Diego, California.

State Presentations

McEachern, A. G. (2001, October). *Serving diverse exceptional education students: A current look at pre-service counselor education.* Florida Federation Council for Exceptional Children, Miami, Florida.

Del Valle, P., & Kanski, E. (2000, November). *Jaspora: Understanding the Haitian students and their families.* Florida School Psychologists Association Annual Conference, Miami Beach, Florida.

Kenny, M.C., & Gans, A. (2000, November). *A comparison of self-concept between students with learning disabilities and their non-learning disabled peers.* Florida Counseling Association Annual Conference, Daytona Beach, Florida.

McEachern, A.G. & Astigarraga, J. (1999, November). *Working with AD/HD students: An educators' survey.* Florida Counseling Association Annual Conference, Tampa, Florida.

Del Valle, P. & McEachern, A. G. (1999, November). *Group work with ESE students.* Florida School Psychologists Association, West Palm Beach, Florida.

McEachern, A.G. (1998, November). *Training school counselors to work with culturally and linguistically diverse exceptional education students, the ESST Project.* Florida Counseling Association Professional Conference, Orlando, Florida.

Local Presentations

Kanski, E., & Del Valle, P. (2001). *Demele*. Nova University Clinical Psychology Multicultural Counseling Conference, Ft. Lauderdale, Florida.

Kenny, M.C., & Gans, A. (2001, May). *Comparing the self-concept of LD and non LD peers*. Linking Forces, Miami, FL.

Del Valle, P., & Kanski, E. (2001, November). *Jaspora: Understanding the Haitian students and their families*. Florida International University Counseling Center Clinical Internship Program, Miami, Florida.

Kanski, E., & Del Valle, P. (2000). *Demele*. Florida International Unviersity Multicultural Counseling Conference, Miami, Florida.

Kanski, E., & Del Valle, P. (1999, November). *Demele*. Miami Dade County Public Schools Student Services Mini Conference, Miami, Florida.

FIU, Counselor Education
ESST Research Symposium I, Fall 1999

Not Broken: Just Different Helping Teachers Work with Children with ADD/ADHD
Presenter: Joan Astigarraga

Using Social Stories with Autistic Students
Presenter: H. Dawn Chambers

Jaspora: Understanding the Haitian Students and Their Families
Presenters: Dr. Patricia Del Valle, Elda Kanzki

Group Counseling with ESE Students
Presenters: Drs. Patricia Del Valle, Adriana McEachern

ESST Research Symposium II
Spring 2000

A Self-esteem Group Intervention for High School Students with Learning Disabilities
Presenter: Maria Martinez

Meeting the Educational Needs of Gifted Students with Learning Disabilities
Presenter: Javier Bornot

An Urban School Story: A Preventative and Crisis Intervention Model With Cuban Rafter Children, Los Balseritos Presenters: Drs. Patricia del Valle and Adriana McEachern

Selected Research Papers

Basti, M., Barbetta, P., & McEachern, A. G. (2001). *Counseling and teaching strategies for working with children with emotional disabilities.*

Erbel, S., & Del Valle, P. (2002). *The relationship between depression and anxiety in students with learning disabilities.*

Escudero, L, & Kenny, M. (2002). *A neuropsychological screening of LD students.*

Estrada, C. S., & McEachern, A. G. (2002). *Implementing a self-determination model with secondary exceptional education students in transition.*

Falco, M., & Kenny, M. (2002). *Inclusion: Students' Perspectives.*

Gardner, J., & Del Valle, P. (2000). *Counseling needs of homeless children.*

Orlando, G., & Del Valle, P. (2000). *A survey of parental attitudes and perceptions of collaborative and consultative practices in exceptional student education.*

Torres, P., & Del Valle, P. (2000). *A survey of school counselor training in career assessment and counseling ESE high school students.*

Curricular Additions

As a result of the success of this Project, modifications to the 54 semester hour program were made by adding the EEX 6051, Education of Students With Exceptionalities, to the program curriculum.

Results of Follow-Up Graduate Survey

A survey to determine where the ESST trainee graduates were working following graduation and completion of the Project revealed the following:

- *14 graduates were mailed the survey; 11 (78%) returned the survey*
- *9 of them are working in area schools as counselors*
- *2 are elementary school counselors, 1 is a middle school counselor, 5 are high school counselors; 2 are college counselors; 1 is on maternity leave*

- *9 reported working directly with exceptional education students in the schools*
- *They are providing to exceptional students the following services: individual counseling, group counseling, classroom guidance instruction, conflict mediation, assistance with job placement, parent consultation, teacher consultation, career counseling, job shadowing experiences. peer facilitation, child study staffings,*
- *When asked on a scale of 1-3 how satisfied they were with the ESST Project in terms of the training they received, **100% of them reported being "very satisfied'** with the Project*

IMPLICATIONS FOR PRACTICE, POLICY, AND FUTURE RESEARCH

School counselors have vital roles in the schools in serving the comprehensive needs of students with disabilities. They are partners with teachers, administrators, and parents in meeting the needs of these students to assure their academic success. However, not all students with disabilities have opportunities to see their school counselors because they are overburdened with administrative duties, large numbers of students that must be served, and crisis in the schools. It would be ideal if there was at least one counselor at every school dedicated to serving students with disabilities. In addition, many school counselors lack training in serving exceptional students. Consequently, it is important that during their graduate training, school counseling students have opportunities to work with diverse exceptional students as part of their internship experience. Courses and/or competencies that enhance knowledge and skills in working with individuals with disabilities should be part of the graduate training program. However, the research shows that this may not true in most school counseling programs (Korinek & Prillaman, 1992; McEachern, 2002).

Funding projects such as this one can impact on these barriers by training school counselors with the knowledge base, skills, and sensitivity to serve diverse exceptional student

populations. It can also impact on policy by helping to increase the awareness of counselor educators, counselors, and school policy makers of the need to include courses, competencies, and experiences in counselor education training programs. It is also important that state certification requirements and guidelines address the need for competencies and courses in exceptional student education and counseling these students. Not all states have such requirements (Frantz & Prillaman, 1993; McEachern, 2002).

Future research should focus on (1) the types of services needed by students with disabilities in schools that need to be provided by school counselors; (2) graduate training program requirements (courses, competencies, field experiences) in relation to serving this population; and (3) state and national certification and accreditation standards in relation to serving this population.

RECOMMENDATIONS FOR OSEP

1. Continue to fund school counseling training projects that aim at better preparing school counselors to meet the needs of diverse exceptional education students.

2. Recognize that special education teachers also must counsel students and consult and collaborate with parents and other school personnel and fund training programs that include these components into special education training, particularly at the graduate level.

ESST PROJECT PARTICIPANTS DEMOGRAPHICS

Total Number of Student Participants = 23

Graduates	**17**
Employed	**14**
Currently Enrolled	**6**

Ethnic/Racial/Gender Breakdown

Hispanics	**13**
White (non-Hispanic)	**5**
African-Caribbean	**2**
African-American	**3**
Females	**14**
Males	**3**

Grade Point Average

Range	**3.3 - 3.9**
Mean	**3.6**

SERVICES PROVIDED IN THE SCHOOLS BY ESST PROJECT STUDENTS

Cumulative Totals

SERVICE	NUMBER SERVED	TYPES OF DISABILITIES SERVED	TOTALS
Individual Counseling	378	EMH, LD, VE, Tourette Syndrome, Physical Disabilities	378 students
Group Counseling	245	EMH, LD/ADHD, VE, Autism	245 students
Classroom Guidance	1414	EMH, LD, VE, Autism	1414 students
Parent Consultations (individual & group)	177	EMH, VE, LD	177 parents
Teacher Consultations	104	EMH, VE, LD, Tourette Syndrome	104 teachers

Over 2000 students served by ESST Project Trainees

As of the end of Fall 02

Gifted Students With Learning Disabilities: Implications and Strategies for School Counselors

Adriana G. McEachern, Ph.D., *is an associate professor with Florida International University, University Park, Miami. E-mail: mceacher@fiu.edu.* **Javier Bornot** *is a school counselor with Corporate Ace Academy North, Miami, FL.*

In the past, many educators saw learning disabilities and giftedness as mutually exclusive, although today it is generally accepted that an individual can exhibit characteristics of both (Brody & Mills, 1997). However, students who are gifted and have learning disabilities still are often not identified and frequently are under served in school systems (Dix & Schafer, 1996; Hishinuma & Tadaki, 1996; Rosner & Seymour, 1983). For these reasons, such students have been referred to as being "invisible in many school settings" (Rosner & Seymour, 1983, p. 77). Appropriate identification of these students can be difficult for educators, because the learning disability often inhibits or masks the giftedness (Maker & Udall, 1985; Silverman, 1989). Conversely, the giftedness can also mask the learning disability, as many of these students, because they are gifted, are often able to compensate for the learning deficiencies imposed by the disability (Maker & Udall, 1985; Silverman, 1989).

Moreover, identifying gifted students with learning disabilities for placement in appropriate educational programs can be problematic because of the ambiguity of the definitions for giftedness and learning disabilities (Hannah & Shore, 1995). Educators currently attempting to identify those students must often rely on the separate definitions for giftedness and learning disability, but these definitions are almost always inadequate for accommodating students who exhibit the characteristics of both groups simultaneously" (Brody & Mills, 1997, p.

283). One definition that includes the characteristics of both exceptionalities is critically needed for appropriate diagnosis and placement (Brody & Mills, 1997).

Intelligence tests such as the Stanford-Binet and the Wechsler Intelligence Scale for Children (WISC) are often used to identify gifted individuals (Kirk, Gallagher, & Anastasiow, 2000). An intelligence quotient of 140 and above, first proposed by Terman in 1925, was the accepted definition for giftedness for many years (Milgram, 1991). However, the Marland (1972) definition, adopted by the U.S. Department of Education and most state education departments and school districts (Brody & Mills, 1997), recognized that giftedness included a broader conception of other abilities. The gifted and talented are those who demonstrate high achievement or potential in "general intellectual ability, specific academic aptitude, creative or productive thinking, leadership ability, visual and performing arts ... compared with others of their age, experience, or the environment" (Kirk et al., 2000, p. 118). Most recently, the U.S. Department of Education (1993) has acknowledged that these talents can be present in individuals who come from all cultural groups and economic conditions.

Appropriate identification of gifted students with disabilities can be difficult for educators because the learning disability often inhibits or masks the giftedness.

Students with learning disabilities can experience a variety of learning problems, most notably in the areas of language acquisition and usage (Kirk et al., 2000). Students exhibiting these cognitive-processing problems tend to achieve below their intellectual ability (Hannah & Shore, 1995). A learning disability has been defined as a discrepancy between a child's academic achievement and his or her capacity to learn (Brody & Mills, 1997; Marsh & Wolfe, 1999). A discrepancy greater than one standard deviation below the mean on an achievement test is typically indicative of a learning disability (Mendaglio, 1993). This discrepancy between achievement and intelligence is critical for the purpose of diagnosis (Brody & Mills, 1997). Prior to establishing a diagnosis, however, alternate reasons for low achievement should be examined and excluded (H. Rosenberg, personal communication, September 28, 1999).

For counseling purposes, researchers have contended that students with both these exceptionalities can be viewed as underachieving gifted students (Gallagher, 1997; Mendaglio, 1993; Silverman, 1989). These students appear to have significant intellectual potential, yet academically are functioning at the average level or below (Gallagher, 1997). School counselors can assume important roles in helping these students succeed in the schools. This review provides a discussion of the following: (a) the issues associated with appropriate identification and educational placement of gifted students with learning disabilities; (b) the characteristics of these students; and (c) academic strategies and counseling interventions for working with this special group in the schools.

Identification and Educational Placement

Being able to identify gifted students with learning disabilities is of importance to school counselors for several reasons. First, these students need to be identified so they can be referred for psychological testing and diagnosis. Approximately 80%–85% of all referrals are made by regular classroom teachers, many of whom do not have the necessary training and time needed to distinguish these students from others in their classrooms (Hishinuma & Tadaki, 1996). Teachers are also less likely to refer students with learning disabilities for giftedness testing, as most teachers consider them ineligible for gifted placement (Minner, 1990). Counselors, familiar with the characteristics of these dual exceptionalities, can assist teachers in accurate identification of these students and development of effective classroom learning strategies for them. Second, the services provided by school counselors can help gifted students with learning disabilities cope with the interpersonal, emotional, behavioral, and academic issues they face. Third, parents also have problems understanding their children's dual diagnoses and can benefit from consultation with school counselors on the unique qualities and educational needs of their children (Mendaglio, 1993). Finally, school counselors participating in child-study team meetings will be better prepared to understand the needs of these students and to recommend vital interventions (Van Tassel-Baska, 1990).

Gifted students with learning disabilities can be grouped into three categories: (a) identified gifted students with subtle learning disabilities; (b) unidentified students who struggle to maintain average achievement; and (c) identified students with learning disabilities who are later discovered to be gifted (Baum, 1990). Conservative estimates indicate that between 2% and 10% of all children enrolled in gifted programs have learning disabilities (Dix & Schafer, 1996). The students who maintain average achievement often go unnoticed and are the ones who discover later in life, usually in college, that they have learning disabilities (Baum, 1990). Approximately 41% of gifted students with learn-

ing disabilities are not diagnosed until college (Ferri, Gregg, & Heggoy, 1997).

Additionally, difficulties identifying gifted students with learning disabilities are compounded in the primary grades because students are often able to compensate for their disability (Norton, 1996). Elementary age students may demonstrate higher-order thinking skills and contribute to class discussions but fail to submit written assignments (Tallent-Runnels & Sigler, 1995). They may be performing at acceptable levels initially; however, they may begin to falter in the secondary grades as the task demands increase, and they are no longer able to compensate for their disability with their giftedness (Tallent-Runnels & Sigler, 1995).

For gifted students with learning disabilities, confusion about their mix of special abilities and sharp deficits can lead to frustration, unhappiness, and isolation.

The effects of misdiagnosis for these students can be quite severe. An unidentified or misdiagnosed student will not be able to benefit from much-needed special instruction. Furthermore, students who qualify for one program should not necessarily be excluded from the other (Brody & Mills, 1997). For example, a student could score a full scale IQ of 130 or higher on the WISC III, but have achievement test scores that differ by more than 1.5 standard deviations. This student may qualify for a gifted program but may also need special educational programming for the learning disability. Special instruction in both areas of giftedness and learning disability must be provided. Without appropriate diagnosis and placement, the discrepancy between achievement and intelligence may not be reduced and may result in low self-esteem, boredom, anxiety, disruptive behavior, and poor social acceptance for these students (Norton, 1996).

Even when properly identified and diagnosed, some state policies do not permit school districts to be reimbursed twice for one student, and many of these students fail to qualify for multiple services (Brody & Mills, 1997; Fox, Brody, & Tobin, 1983). Furthermore, few school districts have dedicated programs for this under-served population, and those that are successful provide intensive and consistent interventions over extended periods (Gallagher, 1997; Johnson, Karnes, & Carr, 1997). One effective, dedicated program is an adaptation of Renzulli's, "Enrichment Triad Model" (Baum, 1988). This program provided opportunities for students to learn new information and develop academic skills by participation in cooperative, small-group learning activities based on their interests and academic strengths. It required the use of a district resource room, a teacher, an intern, a university professor, a museum curator, several consultants, and a computer mentor. After studying seven students identified as gifted with learning disabilities who participated in this program, Baum (1988) concluded that the program was successful, with only one student failing to complete a project, and with most students, teachers, and parents reporting improved academic achievement in other areas. While it is clear that such integrated, holistic, and challenging programs are needed, the usefulness of these programs are often hindered by costs, which are likely to be prohibitive for nearly all school districts (Gallagher, 1997; Johnson et al., 1997).

Characteristics of Gifted Students With Learning Disabilities

Gifted students with learning disabilities may have extensive vocabularies, which are much more advanced than that of their peers (Deshler & Bulgren, 1997; Ferri et al., 1997). They tend to exhibit good listening comprehension and are able to express themselves well (Hishinuma & Tadaki, 1996). They can reason abstractly and solve problems; many demonstrate a sophisticated sense of humor (Rivera, Murdock, & Sexton, 1995). They often prefer creative activities and usually have keen interests or hobbies outside of the school setting (Baum, 1988).

Divergent thinking and novel approaches to problem solving are often present (Ferri et al., 1997). These students may become bored and frustrated with grade-level reading or simple rote memorization in mathematics (Dix & Schafer, 1996). Hyperactivity, inattentiveness, or impulsivity may be evident (Dix & Schafer, 1996). They often have poor handwriting and spelling skills (Rivera et al., 1995). On the WISC-III, these students usually obtain higher scores on the block design, object assembly, picture arrangement, mazes, similarities, and comprehension subtests, but lower scores on the vocabulary, information, arithmetic, picture completion, coding, and digit span subtests (Dixon cited in Ferri et al., 1997). Typically, there will be more discrepancies and variability on the WISC-III subtests than that of a student who is only gifted or only has a learning disability (Ferri et al., 1997).

Gifted students with learning disabilities were found to have lower self-concepts than were gifted students (Van Tassel-Baska, 1991). They were also found to have lower opinions of their high school education and fewer out-of-class achievements (i.e., in leadership, athletics, arts) than their higher-achieving classmates (Gallagher, 1997). Moreover, in one study, teachers perceived them to be more asocial, less popular, quieter, and less

accepted by others than were gifted students (Waldron, Saphire, & Rosenblum, 1987). This same study also supported Whitmore's (1980) contention that these students are at more risk of having lower self-concepts and of facing rejection by their peers than are gifted students.

For gifted students with learning disabilities, confusion about their mix of special abilities and sharp deficits can lead to feelings of frustration, unhappiness, and isolation (Baum & Owen, 1988; Norton, 1996; Silverman, 1989). These conflicted feelings may also result in anger and resentment toward others, which may affect relationships with peers and family members (Mendaglio, 1993). Erratic behavior in the form of aggression, withdrawal, and lack of impulse control may be manifested at home and in school (Van Tassel-Baska, 1991).

Guidance and Counseling Interventions

Gifted students with learning disabilities can benefit from guidance and counseling interventions provided by school counselors. Counselors can conduct individual and group counseling to help students improve classroom behavior, increase self-esteem, and develop positive interpersonal relationships (Gallagher, 1997; Myrick, 1997; Wittmer, 2000). Including these students in peer facilitation programs can encourage peer interaction and help to foster social acceptance and self-confidence (Myrick, 1997). In addition, counselors can promote awareness and an understanding of the unique needs of this population by advocating on their behalf to school and community representatives (Van Tassel-Baska, 1990). A multidimensional approach that includes students, teachers, parents, and other school professionals has been found to be most effective in counseling these students (Mendaglio, 1993; Van Tassel-Baska, 1990).

Consultation With Parents

Parents of gifted students with learning disabilities often present themselves to school counselors with concerns. The concerns may include, "Everyone says my child is bright, but she doesn't seem to be performing up to her level at school," or "My child is really smart, but the teachers do not seem to be able to challenge him. He is bored, lacks interest, and is not working up to his potential in the classroom." Parents of these children perceive discrepancies between their children's intellectual abilities and school performance, and seek answers to help their children learn. Professional school counselors can help by consulting with the parents to provide information on the diagnosis and to suggest strategies that help support the educational process of their children (Snyder & Offner, 1993). Counselors should work to reduce the tension that may exist between parents, teachers, and students, and to facilitate development of appropriate emotional responses (Mendaglio, 1993). Counselors can advise parents that it will be counterproductive to the results they seek to embarrass or belittle these children in front of their peers (Snyder, 2000). Instead, school counselors can gently encourage parents to speak to these students in private to discipline them and correct their behavior (Snyder, 2000).

It is important for parents to develop an accurate picture of the child's giftedness and learning disability (Whitmore, 1985). Therefore, they can benefit from special meetings planned for the purpose of providing opportunities to vent and discuss feelings of anger and frustration that often result from parenting these special children (Daniels, 1983). Support groups can be created so interested parents can meet on a regular basis outside the school setting. In these groups parents can (a) share similar concerns regarding the parent-child relationship (b) gain competence and confidence in parenting, and (c) discuss strategies for implementing change in the family system (Orton, 1996). Parents appreciate it when their opinions are valued; therefore, counselors need to invite them to participate in the planning process. When introducing the concept of forming a support group, it is important for counselors to emphasize to parents that the group will benefit their children as well as other parents (Orton, 1996).

Sharing Academic Strategies With Teachers

Despite economic constraints that preclude the development of specialized programs for gifted students with learning disabilities in every school, a challenging curriculum can be designed to stimulate their interests (Baum, 1988). This curriculum should focus on discovery, investigative and exploratory learning, and should have provisions for students' individual learning styles (Young & McIntyre, 1992). The use of photography, drama, art, and other unconventional and progressive learning methods should be encouraged (Baum, 1988). Rote memorization and drill activities should be kept to a minimum (Whitmore, 1985). The use of educational games in language and math enhances learning without frustration, boredom, or complaints. Students should participate in self-directed activities of special interest to them, and they should be allowed and encouraged to be creative (Silverman, 1989; Silverman, 1993; Whitmore, 1985).

The use of computers for word processing can improve language and writing skills (Baum, 1990; Waldron, 1991). Individualized instruction via computers allows students to make mistakes without fear of ridicule (Waldron, 1991). Also, these students will benefit from the visual nature of the computer that entertains as well as challenges their superior intellect (Waldron, 1991). Calculators and tape recorders can also be used as teaching aides (Maker & Udall, 1985). Written mater-

ial can be taped for students by parents, teachers' aides, volunteers, or other students.

The curriculum should assist in the development of these students' talents, as well as remedy those areas in which they are deficient (Silverman, 1989). Educational activities and assignments that focus on students' strengths and interests and highlight abstract thinking and creative outcomes help develop their giftedness (Baum, 1988; Silverman, 1989). Overemphasis on students' deficiencies will often lead to low self-confidence; consequently, reinforcing positive academic behavior and achievement is highly recommended (Baum, 1988).

Students with these dual exceptionalities rely on alternative ways of learning (i.e., visually, orally, and kinesthetically); therefore, it is important for them to be seated where they can clearly see and hear the teacher (Maker & Udall, 1985). Teachers should try to make eye contact before giving instructions, and to limit the number of directions presented at one time (Silverman, 1989). It may be helpful to also write the directions on the board or on a piece of paper for the student. Realistic deadlines for completing assignments should be given (Maker & Udall, 1985). These students may need additional time to complete assignments. For students who experience difficulty in completing tasks, counselors can help teachers develop behavioral contracts with specific outcomes, timelines, and reinforcers (Thompson & Rudolph, 1996).

In addition, counselors should advise teachers that it is very important to provide emotional encouragement and assurance that conveys to these students they can be successful. Exposing them to role models of successful gifted individuals with learning disabilities through films, videos, books, guest speakers, and class discussions will help them realize that others have been able to overcome their deficiencies by focusing on their strengths rather than their weaknesses (Silverman, 1989).

School counselors can develop collaborative relationships with the gifted teacher facilitator, or coordinator who usually spends more time with such students (Van Tassel-Baska & Baska, 1993). These teachers, because of their specialized training, can provide support to counselors in meeting the social and psychological needs of gifted students with learning disabilities. They are also able to conduct small-group counseling and behavior-modification interventions right in the classroom, reducing the need to take students out for these activities.

Finally, regular classroom teachers need to know how to identify gifted students with learning disabilities so they can be referred for psycho-educational testing and placement. This population has its own set of defining characteristics, many of which parallel those exhibited by students with learning disabilities and attention-deficit/hyperactivity disorders. Teachers should be able to distinguish differences between these types of students (Dix & Shafer, 1996). It is critical that they view gifted students with learning disabilities as gifted (Whitmore, 1985). School counselors can help increase teachers' understanding and knowledge by facilitating and coordinating workshops that include guest speakers who can provide expert information and resources (Snyder, 2000). Counselors can prepare informational materials for teachers that focus on the special needs of these students and on learning strategies that have proven helpful. Opportunities for dialogue and discussion of teaching strategies should be a major consideration during development of educational seminars for teachers.

Individual and Group Counseling With Students

The paradox for gifted students with learning disabilities is that they must accept their intelligence while recognizing they may be less capable in certain academic areas than are their less intelligent peers (Daniels, 1983). Adults often tell these gifted students that the students are bright, but lazy, and are not living up to their potential (Daniels, 1983). These students face multiple expectations and pressure to excel, which they may feel inadequate to fulfill (Kaplan & Geoffroy, 1993; Whitmore & Maker, 1985). These paradoxical feelings can place these students at more risk of stress, burnout, self-blame, and suicide than their peers are (Delisle, 1986; Hayes & Sloat, 1989; Kaplan & Geoffroy, 1993). Since they grow up dealing with adjustment issues, gifted students with learning disabilities often are not aware that they can behave and think in different ways. Cognitive-behavioral interventions are designed to help them change their thinking, feelings, and behaviors (Vernon, 1990). While there seems to be no specific research on the use of cognitive-behavioral interventions with gifted students, this approach has been successful in reducing anxiety and in increasing leadership, initiative, and internal locus of control in adolescents with learning disabilities (Omizo, Lo, & Williams, 1986).

When applying a cognitive-behavioral approach, counselors can begin the counseling process with a discussion about the concept of having a learning disability while also being bright. Students need to understand and accept that both can exist simultaneously, and that inadequacy in one area or skill (e.g., spelling, organization) does not mean inadequacy in all areas. Negative self-talk must be discouraged, and counselors can teach these students to rephrase negative thinking and self-talk into positive verbalizations. Counselors can use and teach students Ellis' (1995) A, B, C, D, and E approach to dispute negative thinking. A, B, C describe how the problem develops and D, and E are the steps that will be taken to correct it (Thompson & Rudolph, 1996). It is important for counselors to reinforce rational, positive verbal expressions, belief systems, and behaviors as

they are exhibited. Other cognitive-behavioral strategies such as stress-reduction techniques (e.g., relaxation training, imagery) can be included in individual counseling (Kaplan & Geoffroy, 1993).

Art therapy is another technique that can be incorporated in both individual and group counseling with this population. Art will appeal to many of these students' creative nature and can provide an outlet for self-expression, especially for those children who are withdrawn and feel isolated from their peers (Orton, 1996). Art therapy is goal oriented, and symbolism is used to release painful feelings that may have been passively withstood by the student for years (Kellogg & Volker, 1993). The artwork provides a medium by which to discuss problems and begin to set goals. While appealing to all grade groups, art can also be used to assess student needs, solicit diagnostic information, and to build the counseling relationship (Orton, 1996). Art techniques are ideally conducted in a room with a sink (for clean-up), plenty of art materials and supplies, easels, and other mediums of artistic expression (i.e., clay, play dough, finger paints). However, counselors who are on a budget and have limited office space need only to have construction paper, crayons, markers, and clay available for students to use in art interventions.

Counselors can allow students to draw freely with limited structure, or they can ask them to draw specific objects, things, or events. For example, students can be asked to draw themselves, their families, homes, schools, and special events in their lives. It is important to listen and observe students carefully as they draw. Counselors will be able to gauge students' progress by observing the hostility and anger demonstrated while drawing or pounding on clay, or by the intensity and change in the colors of the paintings (Orton, 1996). The role of the counselor is to accept students' artwork and to encourage expression of feelings, problems, and conflicts based on the drawings. As the student tells the counselor what has been drawn, the counselor begins to draw out feelings, thoughts, and values by using a facilitative, person-centered approach such as that used in nondirective play therapy (Ryan & Wilson, 2000).

A problem-solving approach can be another effective technique to use in individual counseling. In this intervention, attention should be given to helping the student identify personal and academic strengths and weaknesses. Counselors can present weaknesses or areas for improvement as conquerable challenges that can be mastered (Silverman, 1989; Whitmore & Maker, 1985).

Approximately 41% of gifted students with learning disabilities are not diagnosed until college.

In counseling, students can generate strategies and solutions to alleviate weaknesses. It is also for school counselors to help students focus on their strengths, talents, and gifts and ways to further develop them (Silverman, 1989). Therefore, counselors should seek out information regarding students' hobbies, interests, and extracurricular activities (e.g., sports, music, art) and should inquire about the relative progress made in these activities. Students who are not engaged in these activities should be encouraged to do so and should be provided with information on how they can participate. Gifted students with learning disabilities need to know that participation in sports and hobbies has been found to improve the abilities and academic performance of students with similar difficulties (Whitmore & Maker, 1985). If agreeable to the student, the counselor can, at some point during the counseling process, facilitate a conference between the child and his or her parent(s) to provide opportunities for sharing and discussing the options and solutions generated in individual counseling.

Counselors can teach study skills individually or in groups to promote self-discipline and positive study habits. Information on effective methods for note taking, summarizing reading content, memorizing, and reviewing and studying for examinations should be provided (Van Tassel-Baska & Baska, 1993; Walker, 1982). Students with learning disabilities experience problems with organization, especially organizing for learning activities (de Bettencourt, 1987). Essential to the counseling intervention is a discussion of strategies to help students organize and later be able to retrieve information (Whitmore & Maker, 1985). Counselors should encourage the use of compensation strategies such as writing down all class assignments in a specific notebook that is color-coordinated by class, using worksheets and study guides, and checking for spelling errors before turning in assignments, (Baum, 1990; Skinner & Schenck, 1992).

Group counseling with this population should include a focus on self-esteem building, positive peer interactions, and identity formation (Mendaglio, 1993). Groups focused on stress reduction and healthy coping behaviors are also recommended (Kaplan & Geoffroy, 1993). Small groups can be formed with both gifted students and gifted students with learning disabilities so that both groups can share similar experiences and develop new friendships (Mendaglio, 1993; Whitmore, 1985). Similarly, groups with a focus on social skills development should include students who demonstrate

these skills and behaviors appropriately, as they can act as role models for others (Mendaglio, 1993). Many gifted students with disabilities will be relieved to know that, similar to many students with special needs, they may need assistance adapting to their new learning environments (Snyder & Offner, 1993).

Groups that emphasize teaching goal-setting and problem-solving skills will also be of benefit to gifted students with learning disabilities. However, goals must be kept specific and short-range so that the students can recognize immediate achievement and success (Daniels, 1983). College and career guidance information should be made available, especially at the high school level, although career exploration and guidance activities should really begin as early as elementary school (Van Tassel-Baska, 1990). College-bound students need instruction on the purposes and uses of the Scholastic Assessment Test-I (SAT-I) and the ACT assessment (Van Tassel-Baska, 1990). They also will need information on the best time to sit for these exams and on how to access information about test items and practice tests they can complete. Students need to know that if documentation of a learning disability is provided to the testing service, special testing accommodations (e.g., more time, computer testing) may be allowed (Skinner & Schenck, 1992). They also need assurance that once in college they can be successful. Consequently, counselors advising college-bound gifted students with learning disabilities should inform them of the varied types of college programs available to assist them (Skinner & Schenck, 1992).

Advocacy

Advocacy for gifted students with learning disabilities can consist of several types of activities. One significant way counselors can advocate for these students is to communicate with other school personnel on problems and general issues regarding the needs of this population (Van Tassel-Baska, 1990). Counselors can also assist students by monitoring their progress through appropriate and successful school experiences (Parke, 1990). This oversight can involve ensuring that academic classes are consistent with students' career goals and encouraging students' participation in extracurricular school activities that enhance academic learning and development of social skills. Counselors can also set up tutorials in academic subjects for which students need assistance. Peer facilitators can act as tutors and buddies to these students (Myrick, 1997).

School counselors can inform parents about the process of evaluation and educational placement and encourage them to be active participants in the process. Through their team participation in child study teams, counselors can help influence others to ensure that gifted students with learning disabilities receive appropriate services (Van Tassel-Baska, 1990). Referrals to outside agencies or school specialists may be necessary; therefore, counselors should have a list and network of resources available to share as needed (Lombana, 1992).

Conclusions

Gifted students with learning disabilities are misdiagnosed, under served, and invisible in our schools. These students have special needs that require appropriate educational programs and curricula. They must be identified early and placed in specialized programs to enhance their giftedness, while remedying or compensating for their learning deficiencies. School counselors can be facilitators and collaborators to ensure that these students then have positive, successful academic, personal, and social experiences. Counselors are advocates and mediators among students, parents, teachers, and other school professionals. A multidimensional guidance and counseling approach that focuses on the strengths and interests of gifted students with learning disabilities is recommended to serve this special population. ■

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Using Social Stories with Autistic Children

Patricia R. Del Valle,[1] Adriana G. McEachern,[2] and Hermell D. Chambers[3]

Children with autism have difficulty communicating and interacting with others. Lacking in social skills, they may exhibit symptoms of withdrawal, abnormal language patterns, and a preoccupation with unusual routines, behaviors, and objects. Therapists working with these children can create social stories to improve social functioning and behavior. Social stories are brief narratives that describe situations in terms of social cues and appropriate responses. They are individualized to the needs and abilities of the child and can be used to help children behave appropriately in social situations and to develop problem-solving skills.

KEY WORDS: autism; children; storytelling; social stories; narrative therapy.

Children of all racial, ethnic, and social classes are affected by autism. Approximately 400,000 individuals in the United States have some form of autistic disturbance; 15 of every 10,000 individuals are affected with the disability (Autism Society of America, 1997). It is the third most common brain-based, developmental disability. Autism has multiple causes with its characteristic feature being a series of striking deviations from normal developmental patterns that become noticeable by age three (Batshaw & Perret, 1992). One of the most mysterious and disabling of all childhood disorders (Gray, 1998), autism affects cognition, interpersonal communication, social interaction, and behaviors. Interestingly, and for unknown reasons, autism is four times more prevalent in boys than in girls (Autism Society of America, 1997).

Autism was first clinically described in 1943 by Dr. Leo Kanner, when he presented his work on 11 children who displayed distinctive behavioral traits. In

[1]Address correspondence to Patricia R. Del Valle, Florida International University, University Park, ZEB 240, Miami, FL 33199; delvalle@fiu.edu.
[2]Associate Professor, Program Leader for Guidance and Counseling, Florida International University, Miami, Florida.
[3]A graduate student in the Counseling Education Program at Florida International University when the article was written.

particular, these children exhibited symptoms such as withdrawal, obsession of sameness, and a preoccupation with unusual routines and behaviors (Gray, 1998). Others have identified symptoms of autism as (a) a preoccupation and unusual attachment to objects, (b) mutism or abnormal language, (c) minimal eye contact, (d) parrot-like repetition of phrases (echolalia), and (e) repetitive and unimaginative play (Batshaw & Perret, 1992; Klin & Volkmar, 1995; Mash & Barkley, 1998; Vollmer, 1995).

CHARACTERISTICS OF AUTISM

Wing (1997) stated that there are no physical tests for autistic disorders. However, for a child to be diagnosed with autism, eight of the 16 criteria listed in the *Diagnostic and Statistical Manual For Mental Disorders-IV* (DSM-1V) (American Psychiatric Association [APA], 1994) must be met. These criteria are grouped into three areas: (a) impairment in reciprocal social interaction, (b) impairment in communication and imaginative activity, and (c) marked restricted repertoire of activities and interests (APA, 1994).

In children with autism, the development of language is severely delayed or deviant. For the first six months of life, cooing and babbling may develop normally but later regress. Speech may or may not develop. About half the children with autism remain mute throughout their lives and may not even be able to use gestures to communicate (Batshaw & Perret, 1992). Those who develop language do not use it creatively or spontaneously. They usually have high-pitched voices with unusual speech rhythm and intonations that make their speech sound sing-song or monotonous. Their language tends to be repetitive and rote. These children may demonstrate excellent memorization skills, yet are able to communicate very little meaning in their verbalizations (Batshaw & Perret, 1992). For example, autistic children will repeat long phrases and commercial jingles without really understanding what they are saying.

Distressed responses to environmental changes and restricted and rigid behavioral patterns are also striking features of autism (Powers, 1989). Rigid insistence on eating at the same time of day, sitting in the same position at the table, and eating a restricted menu of foods are examples of obsessive rituals and strict routines common in individuals with autism (Bruey, 1989). Children with autism may show intense attachment to unusual objects (Powers, 1989). For example, lining objects in a row is a common form of play, and young children with autism may be fascinated by shining surfaces, rotating objects, and people's hair. Other children may become intensely preoccupied with schedules. Typically, those children with low IQs display stereotypical movements and self-stimulating behaviors, such as rocking, hand waving, arm flapping, toe walking, head banging, and other forms of self injurious behaviors (Howlin & Rutter, 1987; Russell, 1997).

Approximately half of the individuals with autism score below 50 on IQ tests, 20% score between 50 and 70, and 30% score higher than 70 (Newson & Rincover, 1989). Sattler (1992) noted that there is no diagnostic pattern of performance on intelligence tests in autistic children. Some youngsters perform like normal children on IQ tests, while others show significant unevenness in functioning. Some children with autism have restricted areas of higher functioning called splinter skills (Batshaw & Perret, 1992). These include musical skills, exceptional rote memory, an unusual capacity for jigsaw puzzles, and the capacity to do specific calculations such as finding the day of the week for distant or past dates. Although splinter skills involve some useful functions, the child very often is not able to apply these skills to real life situations (Batshaw & Perret, 1992).

Social interactions represent the fundamental problem for children with autism (Wing, 1997). An absence of pleasure in affection, that may be obvious as early as the first 2 to 3 months of life, may be seen in these children (Wing, 1997). Lack of eye contact with an apparent lack of interest in the thoughts and feelings of others will be exhibited, along with an inability to imitate others or engage in imaginative play (Powers, 1989; Wing, 1997). Other social deficits associated with autism include not seeking comfort when hurt and lacking interest when forming friendships (Batshaw & Perret, 1992).

TREATMENT

Although currently no cure exists for autism, there are some treatments, which can help the autistic child cope with this disorder. They typically include pharmacological, educational, and behavioral interventions (Gray, 1998). It is important to keep in mind that no single treatment, technique, or program is likely to be useful for all autistic children or for all the symptoms for any given child. Since biological abnormalities are found among autistic individuals, a pharmacological solution to some of the problems associated with the disorder may be possible. Antidepressant medications, antipsychotics (neuroleptics), and stimulants have been used to treat symptoms of autism (Gray, 1998).

LANGUAGE AND STORYTELLING AS THERAPEUTIC INTERVENTIONS

Language and storytelling are therapeutic strategies that have been used to treat autistic children and adolescents. Writings, narratives, stories, and poetry can help children relieve pressure, deal with stress, and express inner feelings that may be difficult to verbalize (Orton, 1996; Woytowich, 1994). The therapist can tell a story that reflects the child's unexpressed feelings while encouraging the child to elaborate and provide an ending to the story. The mutual storytelling technique, first developed by Gardner (1971), uses children's stories to help them explore

solutions and solve problems. The child tells the story. After the story is finished, the therapist creates a similar story that introduces positive alternatives for solving the child's conflict (Gardner, 1993).

Narrative therapy is a variation of the mutual storytelling approach currently being used by family therapists (Freeman, Epston, & Lobovits, 1997). Narrative therapy involves listening, telling, or retelling stories concerning people and their life problems. The stories help create new realities and serve as a bridge of meaning in the healing process. These narratives help clients structure, predict, and understand the world around them. The linguistic practice of "externalization" is used to separate the individual from the problems thus helping to alleviate feelings of blame and defensiveness that can result from verbalizing specific life events (Freeman et al., 1997, p. 15).

With children, especially those with autism, it is helpful to personify and individualize the narratives because it is less threatening and models appropriate social behavior (Gray, 1994). A therapeutic, narrative intervention that can be used to improve social functioning in autistic children is social stories. Social stories can be used to model appropriate play, social interactions, and language; as well as prompt behavior and reinforce appropriate client responses (Thompson & Rudolph, 1996). This strategy can also be taught to parents and teachers, so that generalization of learning can occur from the therapist's office to the home and school environment.

ABOUT SOCIAL STORIES

A social story is a short story (i.e., two-to-five sentences) that describes a situation in terms of social cues and appropriate responses (Gray, 1998; Swaggart, Graham, Bock, Earles, Quinn, Myles, & Simpson, 1995). They serve a wide variety of purposes and can be modified to meet the child's abilities and specific needs. Social stories can be used to (a) introduce changes and new routines at home and school, (b) describe social situations and appropriate responses in a nonthreatening way, (c) personalize or emphasize social skills, (d) explain and identify, in a realistic way, appropriate and inappropriate interactions depicted, and (e) teach academic lessons by relating learned skills to real situations (Gray, 1998; Heflin & Simpson, 1998).

Children with autism have difficulty with questioning skills, therefore, answers to who, why, what, where, and when questions should be included when teaching social stories. These children should have access to social information presented in class that can be easily understood so as to minimize confusion in instructional interactions (Garand & Gray, 1993). Swaggart et al. (1995) report on three informal, classroom-based studies using social stories to teach appropriate social behavior to three children diagnosed with autism. The behaviors measured included aggression, parallel play, and sharing behavior (Swaggart et al., 1995). By using social

stories, the researchers were able to increase these children's appropriate behaviors while reducing undesirable ones.

Social stories are best used with students who are functioning intellectually at the trainable mentally impaired range or above and have basic language skills (Yirmiya, Sigman, Kasair, & Munday, 1993). When writing social stories, therapists should take into consideration the perspective of the child for whom the story is written. The story should focus on what the child may see, hear, or feel in various situations, and it should be written in the child's vocabulary and within his/her comprehension level (Garand & Gray, 1993). The story is first read by the adult then read by the child. Once the child is acquainted with the story, it can be read or recited individually by the child. For children who cannot read, the therapist can audio or videotape the story. A bell can be used to signal page turning. The child's comprehension and generalized learning can be checked either by using a checklist or by having the child role-play the social skill being taught in the story (Garand & Gray, 1993).

Three types of sentences are used in social stories: descriptive, directive, and perspective. In descriptive sentences, the occurrence of a situation is objectively defined, describing who is involved, what they are doing and why (Gray, 1993). An example of a descriptive sentence would be: "Mike loves to sit alone by the window and play with his blue car." Directive sentences are statements of desired responses which often follow descriptive sentences, and tell the child an expected response to a given cue or situation. Directive sentences often begin with "I can" and "I will." A directive sentence might be: "I will raise my hand before I speak." Feelings and reactions are described in perspective sentences. An example of a perspective sentence would be: "Joe gets to be first so he feels happy and smiles" (Gray, 1993).

Some autistic children display self-injurious behavior such as head banging. Since parents may not be able to stop this behavior at home, providing the child with a helmet or a soft back chair is one way to prevent injury to the child. Additionally, therapists can teach parents to use social stories with their children. One such story may be:

> Sometimes I bang my head on the wall.
> When I bang my head it hurts.
> If I keep banging my head I will get sick.
> I don't want to get sick so I will stop banging my head.

The child should read this story or have it read to him or her several times. Reinforcement should be provided when appropriate behavior is demonstrated. Reinforcing appropriate behavior and withdrawal of reinforcement when behavior is not appropriate can help to extinguish self-stimulating behavior (Gray, 1993).

Autistic children may demonstrate unusual attachment to certain objects (Powers, 1996). For example, the child may carry around a piece of string or a blanket as a form of security. Any attempt to rid the child of the object may be

distressful. A social story that could be used in this situation might be as follows:

I love to have my string with me at all times.
Sometimes I can put it where I can look at it while
I do other things I like to do.

To distract the child, therapists and parents can subsequently engage the child in an activity so the child can see the object while performing the task. Each day the activity could be longer so the child is separated from the object for a longer period of time.

Autistic children do not like changes and like to follow strict routines (Powers, 1996). For example, the child who may want his/her lunch at exactly noon. Parents can allow the child to have lunch a minute before or a minute after noon at first, then each time making the period a little longer. After a while, the child might get accustomed to eating at any given time. Here is a social story suitable for this situation.

I love to eat lunch at noon, but I don't have to do this all the time.
I can eat before noon or after noon and still be okay.

Introducing new foods might not be easy. One way to do this is to mix small portions of the new food with the usual meal, each time increasing the amount. Sometimes it might be necessary to insist that the child take a tiny portion of the new food before getting his/her favorite food (Bruey, 1989). Prior to introducing the new food, parents could use a social story to prepare the child for the change. For example:

I enjoy the food my Mom gives me to eat.
There are some foods I do not know but I will try anyway.
I might enjoy them too.

A child who is autistic typically does not readily accept or seek affection (Mash & Barkley, 1989). Therefore, in order to find comfort, the child may crawl under a table or into some space. When this happens, the child should be left alone as long as he or she is not causing danger to self or others. For example, Temple Grandin, an adult with autism, said that whenever she feels overwhelmed, she retreats to her bedroom and crawls into a device she invented to calm her nerves (Bane & Gorgan, 1995; Hart, 1993). This device which she called a "hug machine" has been used with autistic children since 1986 (Hart, 1993). Here is a social story that could help the child who does not accept or seek affection from others.

Some people like to hug others and let other people hug them.
That is okay.
I do not like when people hug me, I just like to be by myself.
That is also okay.
One day I might allow someone to hug me.

An example of a social story that can be used with a child who is not socializing with others during play activity would be:

Mike loves to play alone with his blue car.
Although he plays near Roy he doesn't play with him.
He hears and sees Roy playing with his red car.
It is okay for Mike to play alone and see Roy having fun playing with his red car.

Will Mike play with Roy and have fun?

Treating the child as normally as possible and engaging in normal family activities is another way parents can help their autistic child. Therapists can help family members develop techniques to distract the child whenever there are signs of misbehavior. For example, when a family member becomes aware that the child is getting angry or begins to throws things whenever a particular commercial is seen on television, the child can be distracted by quickly switching to another channel as soon as the commercial begins and presenting a reinforcer or engaging the child in conversation. Instead of waiting to react to inappropriate behavior, therapists can help parents develop their own preventive measures. Children usually give some cues such as whining, tightening of the muscles, or hand flapping when they are about to misbehave (Bruey, 1989). Instead of assuming an inevitable escalation of the behavior, the misbehavior may be avoided by slowly giving the child instructions. For example, "Please close the door," or "Put the books on the shelf" (Bruey, 1989).

A social story that could be used in this situation is:

When I start to flap my hands and tighten my muscles,
I am about to scream and throw things.
But I don't have to scream and throw things.
I can find something else to do.

Confusion also escalates the behavior of these children. The child who knows what to expect in the near future will feel less anxious "and will be less likely to start problem behaviors" (Bruey, 1989, p. 84). The following social story could be used:

We are now going to the store.
Many people might be in the store.
We will pick up a few things we need.
We will not stay long in the store.

Some parents are fearful that their child may "act out" in public. As a preventive measure parents can be advised to describe to their children the consequences of misbehaving before they are in a situation where the misbehavior is likely to

occur (Bruey, 1989). Here is a social story that can help:

> If I scream for what I want when I am in the store, when
> I get home I will not be able to watch television that day.
> If I ask for what I want quietly and do not scream,
> I will get to watch television that day. I will also get ice cream.

It takes many children with autism longer to learn toilet training, so they may occasionally wet or soil their clothes. Putting diapers on them may help, but it can be both frustrating and expensive as they get older. In helping to toilet train these children, parents could record every time the child wets or soils the diaper. When they have a clear idea of the child's toileting pattern, they can set up a rigorous schedule of bathroom visits during the times the child is most likely to use the toilet and ensure that the child goes during those times. The child should be encouraged to use the toilet even if he or she wants to go during unscheduled times. If an "accident" occurs, the child, if old enough, should clean up, so he or she can begin to recognize that there are consequences for this behavior (Bruey, 1989). One social story that could be used in this situation is as follows:

> Whenever I feel like using the toilet I will go right away.
> If I do not, I might wet or soil my clothes.
> If I wet or soil my clothes I will have to clean up myself.
> I will not wet or soil my clothes.

Almost all children with autism have difficulty with language. Interactive and meaningful conversations should be modeled and practiced. Echolalia should be discouraged (Gray, 1998). With children who are mute, attempts should be made to train the child to control verbal utterances such as babbling and jargoning (Batshaw & Perret, 1992). Children with autism should be spoken to in short, direct sentences. For example, instead of saying "Go directly to your seat and sit down." A simple "sit" would be better. Parents can also use the following social story to encourage their child to speak:

> I use the words I know to say the things I want to say.
> Sometimes it is hard to find the right words, but I will try anyway.

Gray (1993) cited the study of one parent of a four-year-old autistic son who had such a terrible fear of the Energizer Bunny commercial that he refused to enter stores that had it on display. He would become upset, and it would take time to calm him down. The family could not watch TV for several days for fear that the Energizer Bunny would appear. Therefore, the child's mother developed a social story. The social story was written in a book format and given to the child to read. The child read the story until he saw the page where the Energizer Bunny was mentioned and immediately began to cry and threw the book down. The book was

put on a shelf in sight, and the child was told to ask for it if he wanted it. However, whenever he asked for the book, his mother was only able to read one page further before the child became upset and started crying. This continued five more times until the child was finally able to get through the entire book without crying. After that, he would not put the book away and would carry it around reading it to himself and others. There were several positive outcomes from this intervention. Not only was the family now able to watch TV, but the child was no longer afraid of the Energizer Bunny (Gray, 1993).

Evidence of success in using social stories with autistic children has been documented in the research findings of Kuttler, Myles, and Carlson (1998) who conducted a case study on a twelve-year-old boy diagnosed with autism (Fragile X syndrome and intermittent explosive disorder). Using two social stories the researchers aimed at changing two behaviors: inappropriate vocalizations and dropping to the floor, which served as precursors to tantrum behavior. The ABAB design was used to assess the effectiveness of the social stories. In an ABAB design, a baseline is established for the target behavior(s) then the intervention is presented. Another baseline measure is recorded, and the intervention is resumed. The results of this study showed a significant decrease in the targeted behaviors when the social stories were used, and an increase when they were withdrawn. Kuttler et al. (1998) concluded that social story interventions were an effective method of reducing behavioral precursors to tantrum behavior.

Living with a child with autism is not always easy. The more disabling the condition, the more difficult it will be for family members to cope. Collaboration must occur among therapists, parents, and teachers to ensure the success of these children in-and-out of school. Therapists can conduct therapy with family members to teach them social stories techniques and help them cope with the unique behavioral patterns of the autistic family member. They can help also families develop support systems for one another. Parents can be encouraged to meet regularly to share common concerns, strategies, and solutions that have worked for them. Educational workshops can be provided for families on topics dealing with the disorder itself, applying behavior modification principles, teaching language and speech skills, and coping with stress.

CONCLUSION

The use of social stories with autistic children is a creative method that enhances the therapeutic interventions for the treatment of clients and families. This language approach provides a structured, organized, and reality-based strategy needed by these special children to develop pro-social behaviors in real life situations. Social stories also help children to solve problems as they occur in daily life activities. The stories bridge and connect the therapist with the autistic youngster

while also externalizing the problem, thus making it less threatening and fearful for the child. The stories build on children's strengths and special abilities and help them to shape and change problematic behavior. Although presently lacking a substantial empirical basis, therapists who use this approach find it beneficial as it links language to behavior, promotes behavioral rehearsal, and personalizes social skills training (Gray, 1994).

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Recommendations for future research, in addition to those indicated above, would be, first of all, to replicate this exploratory study using a greater number of randomly selected participants. Further, analyzing junior high and high school counselor data separately to gain more specificity about assessment practices in each setting would be valuable. Follow-up qualitative studies for the purpose of validating the outcomes of the larger study should also be considered. Finally, studies about the content of assessment courses in counselor preparation programs would increase knowledge about the way counselors are being trained to utilize both standardized and nonstandardized assessment techniques.

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Not Broken, Just Different: Helping Teachers Work with Children with Attention-Deficit/Hyperactivity Disorders (AD/HD)

Joan Astigarraga and Adriana G. McEachern

Teachers often experience frustration and concerns when dealing with children with attention-deficit and attention-deficit with hyperactivity disorders (AD/HD). School counselors can assist teachers by educating them about these disorders and by providing strategies they can use to help these children. Collaborative consultation between school counselors and teachers is recommended for improving children's academic, social, and personal performance.

Three-to-five percent of school-age children are diagnosed with attention-deficit and attention-deficit with hyperactivity disorders (AD/HD) (American Psychiatric Association [APA], 1994; Backover, 1992; Woodrich, 1994). More males than females are diagnosed, with male-to-female ratios ranging from 4:1 to 9:1 (APA, 1994; Saunders & Chambers, 1996; Woodrich, 1994). Woodrich (1994) asserted that 23-30% of children with AD/HD have trouble achieving the level predicted by their intelligence scores, with 30-70% failing at least one year of school. Many of them take longer in learning new material and show disparities between intellect and actual performance level (Warren & Capehart, 1995). Most get through preschool and kindergarten with minimal problems; however, by the third grade, gaps in achievement and academic performance become evident (Reid, Vasa, Maag, & Wright, 1994). This paper describes the symptoms and causes of AD/HD, and provides strategies school counselors can use with teachers to help these children achieve academic and personal success.

Definition, Causes, and Treatment of AD/HD

Misdiagnosis of AD/HD is frequent since the symptoms of other disorders (e.g., thyroid malfunction, inner ear problems, mood disorders, Tourette's Syndrome, and learning disabilities) can resemble those of AD/HD (Warren & Capehart, 1995). AD/HD is not a learning disability in itself, but is accompanied by one about 35-50% of the time (Livingstone, 1997; Warren & Capehart, 1995). Once termed ADD by the APA (Cartwright, Cartwright, & Ward, 1995), it is now identified in the *DSM-IV* (APA, 1994) as AD/HD and defined as a "persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development," (APA, 1994, p. 78) (Barkley, 1997; Guerra, 1998). AD/HD is divided into three subtypes: predominantly inattentive, predominantly hyperactive/impulsive, and combined (APA, 1994). To be diagnosed with the disorder, six or more of the symptoms in either categories must be present for at least 6 months (APA, 1994). Federal law does not recognize AD/HD as

Joan Astigarraga, School Counselor, Redlands Middle School, Homestead, Florida; Adriana G. McEachern, Associate Professor, Counselor Education, Florida International University, University Park, Miami, Florida.

a disability (Cartwright et al., 1995; Reid et al., 1994); consequently, to qualify for special education placement, these children must be classified as having learning disabilities by an interdisciplinary professional team (Cartwright et al., 1995).

Symptoms of AD/HD

Inattention, impulsivity, and hyperactivity are the defining characteristics of children with AD/HD combined type (APA, 1994; Barkley, 1997; Kirby & Kirby, 1994). They are expected to mature at a slower pace, have trouble with attention spans, and be easily distracted and impulsive in normal reaction situations (Schiller, Jensen, & Swanson, 1996). Hyperactivity in these children occurs when both large and fine motor muscles work overtime (Parker, 1996). Children who exhibit lack of impulse control have difficulty delaying gratification, are hyperactive and emotionally overaroused, and exhibit constant motion, uncontrollable emotions, and inappropriate reactions (APA, 1994; Kirby & Kirby, 1994). Conversely, children with AD without hyperactivity may have either normal or passive temperaments (Kirby & Kirby, 1994; Phelan, 1993). "They often appear as if their mind is elsewhere" (APA, 1994, p. 78), fail to pay close attention and complete tasks, and have difficulty with organization (APA, 1994).

The intensity and frequency of behaviors and level of thought interference distinguish children with AD/HD from other children. Children with AD/HD pay particular attention to random thoughts (Warren & Capehart, 1995). One outcome of attending to every thought is increased hyperactivity. Further, the intensity and frequency of inappropriate behaviors exhibited may also precipitate social malfunctions. These create a greater risk for self-destructive and damaging behavior (Warren & Capehart, 1995), depression, anxiety (Shapiro, DuPaul, Bradley, & Bailey, 1996), and for prime childhood behavior problems (Backover, 1992; Shapiro et al., 1996). AD/HD has been associated with adult disorders such as antisocial personality, substance abuse, and depression (Saunders & Chambers, 1996).

Causes of AD/HD

There are two main empirically based theories on the causes of AD/HD. The first is a belief that it is caused by an imbalance of neurotransmitters in the brain (Livingstone, 1997). The brain is understimulated and has difficulty regulating its own activities. Phelan (1993) has described this as a brain center with a "lazy governor" (p. 40) which translates into random, unfocused, disorganized, aggressive, and chaotic activity. The second is a belief that low glucose is present. Low glucose results in lower metabolic activity that permanently affects two areas of the brain, the ability to pay attention and the ability to regulate motor activity (Parker, 1996). Decreased blood flow and less electrical activity to brain centers that govern planning and control have also been detected in these children (Woodrich, 1994).

Most studies suggest heredity as a factor in AD/HD. For example, more than one-third of parents of children with AD/HD had the disorder themselves (Phelan, 1993; Woodrich, 1994). Livingstone (1997) cited mounting evidence that the problem does run in families. Other potential causes include diet, sleep, rest, and home and school environment (Lavin, 1991), and food dyes, chemical preservatives, and artificial flavorings (Feingold as cited in Hunter, 1995). Exposure to chemical stimulants or overdemanding or unstable environments, emotional disturbance due to parents' divorce, and other developmental disorders or learning disabilities contribute to the symptoms (Lavin, 1991). Other research has contradicted the idea that food additives,

sugar, lead ingestion, or improper parenting causes AD/HD (Schiller et al., 1996). Despite disagreement regarding causes, most experts seem to agree that the disorder requires interventions aimed at helping the child develop socially, physically, and intellectually (Backover, 1992).

The Use of Medication

Medication is often prescribed for children with AD/HD to control hyperactivity, help regulate children's behavior, and measure behavior change. Used appropriately, medicines like Ritalin act as stimulants to help neurotransmitters "fire" more dependably and efficiently with no residual effect (Schiller et al., 1996). Physicians, in general, do not allow enough time to assess children with AD/HD (Power & Ikeda, 1996), and medication sometimes becomes an alternative without a full analysis of the problem. It is one tool to help guide the child, but should never be the sole approach utilized to treat them. Generally, dealing with AD/HD is best accomplished with a three-fold approach: (a) alter the environment, (b) alter perceptions of the disorder, (c) provide medicine as a support (Warren & Capehart, 1995).

The Counselor's Role

Many children with AD/HD do not receive comprehensive treatment that covers needed educational, psychological, and social aspects; consequently, they continue to perform poorly academically and behaviorally, and may become conditioned to believe that external events are responsible for their successes or failures (Lavin, 1991). These children can be a cause of frustration for teachers who are skeptical of the children's lack of behavior control. Some teachers may blame parents for children's nonconforming behaviors; this can create a rift in the parent-teacher relationship and distract from the need to help the child perform successfully. Others believe the disorder does not actually exist, or they lack self-confidence, skills, and adequate training to work with these children (Kirby & Kirby, 1994; Snyder & Offner, 1993).

Teachers who teach children with AD/HD often need assistance and support. School counselors have the knowledge and skills to provide this assistance (Council for Accreditation for Counseling and Related Educational Programs, 1994). Children can be offered a variety of guidance and counseling interventions. One critical intervention is collaborative consultation, in which school counselors act as resources to teachers. Several guidelines are important in the consultation process.

1. Allow teachers to express their concerns and frustrations. Many teachers are not familiar with the special needs of these children and may feel inadequate, helpless, and confused when encountering them in their classrooms (Snyder & Offner, 1993).

2. Listen attentively and respond empathically to feelings, thoughts, and beliefs about their experiences with these children (Myrick, 1997).

3. Educate teachers about the disorder and the behavioral and cognitive implications for students.

4. Encourage teachers to use more hands-on-strategies, allowing children to practice what is being heard as they experience the concepts being taught. Activities can be used to reinforce and motivate behavioral changes (Stormont-Spurgin, 1997).

5. Brainstorm about strategies that can be used with a particular child or set of children. Invite a group of teachers together to discuss and share strategies that have worked and have been implemented in classes (Riegel, Mayle, & McCarthy-Henkel, 1988).

6. Have teachers test instructional strategies and return to consult with the counselor about their results. Counselors can monitor teachers' progress by periodic contacts and classroom observations (Myrick, 1997; Riegel et al., 1988). Provide teachers with positive reinforcement and feedback on their efforts and outcomes (Myrick, 1997).

Collaborative consultation can ensure that teachers and counselors establish team relationships with regular and frequent communication to validate that strategies are being implemented appropriately (Riegel et al., 1988).

Teaching Strategies to Help Children with AD/HD Learn

Teachers can benefit from consultation that focuses on alternative instructional methods and learning strategies. Teachers are generally left-brain learners and must exercise a paradigm shift to teach all types of children (Warren & Capehart, 1995). Teachers who insist upon set structures and auditory and visual learning activity may not understand the need for classroom accommodations for these children. Counselors can suggest alternatives.

One of the most important strategies for children with AD/HD is to focus on positive strengths. Counselors can help teachers recognize the uniqueness of each child with less reliance on labeling of children to determine expectations. Labels are often not productive (Hunter, 1995).

Creative learning activities and a restructured environment are especially important for children with AD/HD. These children, especially those with hyperactivity, can be sensitive to strong lighting, lack of background noise, and natural weather changes such as barometric pressure drops, full moons, and brewing storms (Warren & Capehart, 1995). It is advisable to vary learning methods to reduce written work, request more one-word answers, and use multiple choice and matching exercises. Avoidance of needless copying and long-sentence writing is better for these children. The concept of "less is more" is recommended; children can learn with 15 repetitions instead of 100. Children with AD/HD benefit from a more tactile learning style which includes learning to write using alternative methods like writing in sand or shaving cream or pudding placed on wax paper (Reid et al., 1994).

Counselors can recommend a behavior management approach (Woodrich, 1994) for use in the classroom. Subtle gestures can be used to prompt required behavior both in the classroom and at home (Stormont-Spurgin, 1997). A signed behavior contract or agreement can be developed between the child and the teacher to modify undesirable behaviors (Lavin, 1991; Myrick, 1997; Stormont-Spurgin, 1997). The contract can contain one or two behaviors targeted for change, reinforcers and consequences, and timelines for completion. Children can be taught to record, graph, and track the progress of their behavior changes. For example, children with AD/HD can learn to measure their own attention span and employ alternatives when off task. The use of self-monitoring behavior frees the teacher and encourages more on-task behavior from children (Garber, Garber, & Spizman, 1990).

Hands-on-learning and flexible teaching styles benefit all children, but especially those with AD/HD (Hunter, 1995). Children with AD/HD need monitoring related to their organization skills. They benefit from routines that maximize object placement and make use of assignment folders and planners (Stormont-Spurgin, 1997). They may need help focusing, preparing for homework or projects, and organizing their desks. Teachers can use "label graffiti" (Hunter, 1995, p. 95) to help children organize their desks and folders. The labels, folders, and picture clues can be bright and handmade and will draw attention (Stormont-Spurgin, 1997).

The self-esteem of the child cannot be overlooked in the learning process. Children with AD/HD are more accustomed to negative feedback and are often socially ostracized by their peers. Hunter (1995) reported that 90% of these children have negative perceptions of themselves because of the disability. Most have problems with self-esteem and often struggle with social problems, making it difficult to develop and maintain friendships (Saunders & Chambers, 1996). These children can be taught to identify negative thoughts and to change them into more helpful, positive thinking (Banez & Overstreet, 1998). Counselors can help teachers understand these difficulties and suggest methods to help these children improve interpersonal relationships. One strategy is the "buddy" system where children act as "peer helpers" (Myrick, 1997). Peer helpers can act as friends, positive role-models, and tutors to children with AD/HD (Myrick & Erney, 1984, 1985). Counselors can also work individually or in groups with children who have low self-esteem.

Relaxation techniques can be taught to children with AD/HD to counteract hyperactivity. Counselors can teach children relaxation methods which the teacher can further reinforce in the classroom (Garber et al., 1990). Teachers can enlist children's support by calling the techniques a unique name and practicing the breathing skills with them. They can suggest sports activities; some researchers believe that martial arts, Judo, and Tai Chi can help these children (Woodrich, 1994).

Finally, teachers must recognize that children with AD/HD will have periods of peak performance based on the medication taken, the nature of assignments, and the time for completion (Kirby & Kirby, 1994). Teachers can restructure the most difficult work in the morning or break the academic tasks into manageable parts. Reviewing the exercises to assess the time commitment involved can aid in tailoring assignments. Counselors also need to encourage teachers to help children generalize their learning to situations outside the classroom, as this will aid in understanding and assimilating concepts (Garber et al., 1990).

Conclusion

Maintaining a positive perspective will help teachers working with children with AD/HD provide the attention, care, concern, and respect they need. School programs and teaching methods cannot be rigid, and educators must be flexible in their interventions. Adaptations must be structured in ways that help all children learn; medication alone cannot be expected to make them adapt, behave, or stay on task (Livingstone, 1997). In an ideal world, the optimal learning environment would include flexibility with behavior management, social skills instruction, remedial help, smaller class sizes, increases in one-on-one learning, reduction of distractions, and focused applications of behavior management (Reid et al., 1994). Counselors can help teachers create more positive learning environments that can make significant differences for these children with special needs.

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