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CHAPTER ONE

INTRODUCTION, ORIENTATION AND STATEMENT OF THE PROBLEM

The best way to make children good is to make them happy.
Oscar Wilde (Lankton 1989:379)

1.1 INTRODUCTION

The alarming number of referrals of children displaying difficult behaviour has fuelled an inevitable explosion of interest in a disorder which, according to Goldstein and Goldstein (1998:xi) has been referred to by at least thirty descriptive terms over the past eighty years. It is now referred to by the American Psychiatric Association (Gilliam 1995:2) as **Attention Deficit Hyperactivity Disorder**. Goldstein and Goldstein (1998:ix) further point out their observation that articles on the subject are being published at a rate of twenty to thirty each month, and that a journal, the Journal of Attention Disorders, has even been devoted to the topic. Gilbert (1998:1) also refers to the "*mass of literature currently available on the topic*" which he claims, put to good use, enables these children to attain their full developmental potential.

Yet, despite the upset, confusion and frustration involved in raising such a difficult child, and the levels of stress placed on the family, along with the abundance of material pointing out proven strategies and techniques that improve the overall functioning of the child, to bring harmony into the home, there still appears to be much resistance, by professionals and parents alike, firstly, to the diagnosis and secondly, to the treatment which is to be followed. Ingersoll (1998:x) justifies this attitude to a certain extent by pointing out that media publicity has not always been positive. She claims that Attention Deficit Hyperactivity Disorder has been portrayed in an unflattering light, with individuals suffering from the disorder being depicted as "*crazed and out of control*" by television programmes and newspaper articles. Furthermore, "*the risks associated with medication have been grossly exaggerated, and some critics have even implied that medication is just the easy way out for lazy parents and teachers*". Certainly, as suggested by Gilliam (1995:1), "*Lack of agreement about the definition of ADHD also contributed to the controversy*".

It is surely the responsibility of the significant adults in the child's life to do everything possible to help him achieve competence and feelings of self-worth as he is guided towards adulthood. Langeveld (Van Niekerk 1986:2) emphasises the fact that, although the child wishes to become someone in his own right, he can only achieve full human status with the assistance of adult educators. In this regard, one has to take into account the adult's competence to cope with this demand. In particular, the parent's involvement in the child's education is being stressed at present. Bloomquist (1996:31) believes that "*The importance of the parent as a direct influence on the child's behavior must not be understated*". He likens parenting to dancing, (1996:x), where the parent takes the lead and sets the stage for the way the dance unfolds, emphasising research findings that indicate that active parent involvement in a child's treatment plan leads to greater success in dealing with behavioural difficulties.

At the same time, Bloomquist (1996:x) acknowledges that parents who are suffering from stress are less competent than others to deal with the demands of parenting, and, when their child displays behavioural difficulties, they become "***burned out***", which leads to further disruption of parenting and more behaviour problems in the child. Furthermore, he claims (1996:x) that parents need to be "**ready**" to make the changes. Often, the emotional issues of parents, such as personal problems, negative attitudes, or other factors, serve as a potential roadblock to change.

The present study will address the task of improving the parent-child relationship, in this way, hoping to find a means of helping the child with ADHD move towards adulthood with self-confidence and intact relationships.

To avoid the awkward use of the 'he/she' pronouns, which could impact on the fluency of the reading material, the use of the male gender will be used throughout. However, the writer acknowledges that girls also suffer from Attention Deficit Hyperactivity Disorder, and is aware of the recent belief that the disorder has been under-diagnosed in girls (Ingersoll 1998:18), possibly because their problems seem to be less visible and less annoying than the problems of boys with ADHD.

1.2 AWARENESS OF THE PROBLEM

The writer's interest in ADHD first grew out of painful personal experience with her own son, which gave her firsthand knowledge of how difficult and troubling the problems associated with the disorder can be. At first vehemently denying the possibility of the diagnosis and a probable need for medication, and yet being aware of the learning difficulties that arose as a possible consequence, a search was made for as much knowledge as possible. In this quest, a career change was made, firstly into teaching, then into remedial teaching, and the ultimate step, into educational psychology.

Working in a remedial school environment led to the realization that the quality of life in so many families is affected by the immense stress placed on all members by a child with ADHD. It became easier, firstly as a teacher, and later as a psychologist, to deal with the issues in other families in a more objective way. The benefits of stimulant medication were very obvious in some instances. Yet, there was also an increasing awareness of the parents' concerns about the potentially harmful physical and emotional effects of psycho-pharmaceutical drugs. Then too, there were those parents, and also many teachers, who viewed a prescription as a panacea for all educational difficulties.

Within the school environment, parents who were severely traumatised by the educational difficulties their children experienced, seemed to benefit from the support of other parents who found themselves in a similar situation, when group meetings were arranged and facilitated by a professional expert. This finding was strongly supported in a previous study by the writer, where a support group of ten parents was formed, comprising both mothers and fathers of children with learning disabilities (Clark 1995:ii). A programme was planned to empower parents by providing them with information and giving them the opportunity to share and discuss their concerns. Afterwards, *"Parents were more accepting of their child's handicap. They felt less isolated and more competent to cope with their educational task*".

A move into private practice resulted in daily discussions with parents and teachers about behavioural difficulties experienced at home and in school. This led to the awareness of how many parents lack knowledge about the disorder and effective coping strategies,

regardless of the fact that "*books on ADHD have proliferated at a dizzying rate*" (Ingersoll 1998:x). Consequently, they torment themselves with the belief that they are incompetent and to blame for the difficulties. Despite the misery these parents suffer, the reactions to the mention of a possible diagnosis and a referral to a neurologist led to extreme and varied emotional outbursts. Another observation was that, when child-focussed therapeutic intervention was initiated, the treatment was often sabotaged, albeit quite unintentionally, by the parents. A further point of interest which emerged was the fact that when therapeutic stories were read to so-called 'hyperactive' children, they seemed to calm down, sit still and listen intently.

Whilst there appears to be an intensive network of support which empowers the parents of children with ADHD in the United States, Canada, Great Britain, Australia and New Zealand (Ingersoll 1998:ix-x; Train 1996:188-191), there appears to be limited support available for the parents of children with ADHD in South Africa, and a lack of awareness of the groups that do offer such comfort.

When it was initially decided to embark on this course of study, about twenty parents were approached to participate in a pilot study. All indicated their need for such help and their willingness to attend, but only four parents arrived for the first meeting and only two for the meeting the following week.

Whilst one wonders about the apathy of such parents, Van Niekerk (1998:2-4) points out the fact that many South African parents are burdened by divorce, financial restraints, strong social pressure towards materialism and few of the provisions for working mothers that are found in other first world countries. One can perhaps understand then, that with the limited time available, parents become exhausted as they carry out their daily routine, finding little time to fit in yet another programme. However, the socio-political changes in South Africa have created a number of difficulties and, despite the increased need for intervention for many of our children, financial resources are limited as the government attempts to meet the fundamental needs of the majority, and so the responsibility rests firmly with the parents.

The strong belief that parents need support with raising these difficult children persisted. In an effort to persuade parents, who subsequently called to express their desperation over

the stress their children were creating, to participate in a programme, it was decided to taper the programme down from an intensive multi-modal approach, to a weekly session of about an hour with the parents as a group, and an individual session of half an hour with each child, over a period of seven weeks. Class teachers would also be provided with guidelines on dealing with some of the behavioural issues. The intention of the programme was twofold: firstly, to reduce the parents' stress, and, secondly, to improve the behaviour of the children, thereby creating a more functional family, and hopefully, improved relations for the child.

1.3 EXPLORATION OF THE PROBLEM

1.3.1 Introduction

John Donne said: "*No man is an island unto himself*" (Serfontein 1990:133). A great deal of reflection is being done currently on "***goodness of fit***" (Abidin 1995:2). The reciprocal interactions between parent and child are largely influenced by individual qualities and temperamental dispositions, which, in turn, affect the parent-child relationship, further influenced by family context variables.

Whilst a few years ago, there were not many resources of accurate information available on ADHD, public awareness is finally catching up with scientific knowledge. In addition, school systems in many countries are taking steps to provide appropriate education as they themselves gain a greater understanding. Therein lies the hope. However, Abidin (1995:1) stresses that early intervention of stressful parent-child systems is necessary to reduce the frequency and intensity of behavioural and emotional disturbance among our children.

1.3.2 The Effect of ADHD on the Family

Parker (1994:2-3) confirms that parents of children with ADHD feel the problems are unique to them. In particular, mothers feel estranged from other parents and report feeling sad, isolated and incompetent with regard to their ability to raise their child. They may even come to resent the child whose behaviour has turned them into physical and nervous wrecks, destroyed their careers and/or marriage, and caused friends and neighbours to shun them (Train 1996:11).

Koplewicz (1996:42) mentions that the other children in the family often feel slighted when parents are forced to focus much of their time and attention on the problems of their child with ADHD. Given its genetic nature, the other children in the family are also at risk of having some of the features, including the behavioural problems of the affected child. Serfontein suggests that younger children often imitate the poor behaviour of the older sibling with ADHD, and become very confused by different standards of discipline (1990:143-144).

1.3.3 **The Effect of ADHD on the Affected Child**

In view of the fact that children with ADHD experience failure from an early age, it is not surprising that their self-esteem is damaged. Bain believes that medication, behaviour therapy and educational intervention, designed to address the core problems, may have little effect on the child's internal sense of mastery and competence (1991:173-174).

According to Serfontein (1990:122), children suffering from the disorder start off life having a diminished self concept, and view themselves as unworthy among their peer group. As a result of their increasing difficulties relating to other children of their age group, they tend to either withdraw from the group, or become very bossy, domineering and controlling.

Such children are often rejected by their peer group, and since, through play, they learn critical life skills, such as cooperation, negotiation, and how to settle disputes, they miss out on important learning experiences which prepare them for later life (Ingersoll 1998:44). Furthermore, they lose out on much of the fun and enjoyment available to most children.

Barkley (1995:90-91) points out the association of ADHD with other behavioural and emotional disorders. These children can be extremely demanding from early infancy, and display more symptoms of anxiety, depression and low self-esteem than other children. He refers to scientific awareness that these children are more oppositional, defiant, stubborn and argumentative than their peers. They tend to be aggressive, verbally and physically attacking others. Their conduct problems often lead to stealing, lying,

destruction, and other delinquent behaviour. In Barkley's opinion, "*as many as 45% may progress to the more severe level of conduct disorder*".

It would appear, that where the family is more functional, and the relationship between parents is stable, the child is more likely to overcome the difficulties (Serfontein 1990:133). Ingersoll (1998:17) believes that the prognosis is better for the child with ADHD who is intellectually well-endowed, and who is raised in a family where there are the necessary financial and emotional resources to provide for the child's needs.

1.3.4 **Therapeutic Intervention**

Bloomquist (1996:17-18) refers to research which has shown that "*children who receive Multi-modal intervention have the best outcome in later years*". He claims that interventions may include the child, parent/family, school, peers and occasionally the community. Furthermore, the child may receive many or all at some point of their lives.

Many therapists today use an eclectic approach, but Lazarus (Shapiro 1994:3) believes this is a very subjective approach. He promotes a "***systematic eclecticism***" which he calls **Multi-Modal Therapy**, and which takes into account behaviour, affect, sensation, imagery, cognition, interpersonal skills, drugs and health. Shapiro prefers to use six modalities, namely, affect, behaviour, cognition, developmental level, education and social system. He believes that "*The use of multiple techniques is particularly appropriate in short-term therapy where the object is to maximise the therapeutic effect in the least amount of time possible*".

1.3.4.1 **Parental Support Groups**

Clark (1995:10) refers to the findings of Simpson, who noted more successful adaptation of parents when they were provided with information on their child's specific difficulties, and Lerner, who found that when parents had the opportunity to meet with other parents whose children encounter similar difficulties, their sense of isolation was reduced.
Barkley (1995:126-127) suggests that the parents are motivated to join a support group when they have truly accepted the child's ADHD. From this perspective, they see clearly that the child has a problem and needs their support, and this leads to a thirst for

knowledge about how best to provide this support. He claims (1995:142) that not only are support groups a great source of information and advice, but they also provide opportunities to release commiseration, leading to the formation of true friendships.

Koplewicz (1996:42-43) encourages parents to join a support group where they can receive practical information and emotional solace. Shapiro (1994:201-202) echoes this sentiment. He believes that support groups provide an educational forum for members, often providing more specialized and up-to-date information than professionals provide. Furthermore, they serve an important lobbying function in terms of the perceptions of a disorder and the laws which affect the education of the children.

1.3.4.2 **Therapeutic Story Telling**

Gardner (1993:xiv-xv) reminds us that, over the generations, "*Legends, myths, fables, parables, and allegories have traditionally been useful ways for educating children, and imparting to them the behavioral patterns that are considered to be desirable in a particular society.*" He emphasises that children both enjoy telling and listening to stories, and suggests that, since story telling is the child's favourite mode of communication, it should be used as a therapeutic technique. He expresses his belief that the child is more receptive when the stories are told in his own language.

Davis (1990:v) refers to research conducted at the Trauma Center of Harvard University, where it was discovered during brain imaging of volunteers having flashbacks, that the right side of the brain, where images, vision and emotions are located, was extremely active. She points out that metaphors and symbols are the language of the right brain and explains why therapeutic stories are so effective in treating victims.

Mills and Crowley (1986:xix-xxi) say that the special effects of the techniques used to create the story lead to "*an effortless flight into an inner world*" which ultimately leaves the child with a very important message. A child naturally responds spontaneously to the stories with the full force of imagination, a critical substance to change and healing, once activated. However, they stress (1986:20-22) that change does not occur all at once but that an interactive loop is established between the story and the listener's inner world, once a personal connection is made. In this circular flow of change, new meanings which

are generated produce new behavioural responses which reinforce the metaphorical input, so that another series of meanings is formed, so providing a self-generating feedback system.

1.3.4.3 Medical Management

Relationships between children with ADHD and their families have been shown to improve with medication treatment (Green:1995; Goldstein & Goldstein:1998; Ingersoll:1998; Peters: 1997; Train:1996). Goldstein and Goldstein (1998:479) refer to research findings addressing family relationships in relation to the administration of methylphenidate, where in eighteen out of thirty-five boys who were found to be **'Ritalin responders'**, "*interaction between the ADHD child and his siblings and mother demonstrated increased maternal warmth, decreased maternal criticism, greater frequency of maternal contact and fewer negative encounters with siblings*".

Despite the strong belief by many that medication can dramatically improve the attention span and reduce hyperactivity and impulsivity, there are those who are strongly opposed to its use. In the foreword to the writings of Block (1996), Smith blames crowded classrooms, indifferent teachers, nutrient deficiencies and food sensitivities for what Block refers to as the "***Ritalin industry***". Block (1996:15) believes the goal is no longer to fix the problem, but rather, to treat the symptom in a way that is detrimental to the individual's health, whilst at the same time, generating money for the industry. Debroitner and Hart (1997:6) advocate a holistic, non-drug approach to treating the disorder.

1.3.4.4 Classroom Management

Green (1995:71) acknowledges the fact that it is not easy to teach a restless, inattentive child. Furthermore, he points out that there are no simple solutions to the problem, which is a chronic condition. Beukes (1994:8) expressed her concern about the "*lost children*" in the South African education system, who often fall prey to the ignorance of teachers and more senior educators who are unable to identify the disorder, and lack the necessary knowledge to remediate the problems which manifest. She pleads that they be helped, "*Before he fails, before he becomes a pathetic human being, before he becomes depressed, negative and a problem*".

Given the current movement towards inclusion of handicapped students in our mainstream classrooms, it seems imperative that classroom teachers be given the necessary training to work effectively with ADHD students. This is particularly important when one considers the fact that "*the classroom teacher is viewed as the major factor in the success or failure of any student and particularly those with ADHD*" (Reid et al. 1994:195).

Gardill et al. (1996:90) refer to a number of studies that show that combining medication and behavioural programmes is effective in increasing levels of on-task behaviour and improving the academic performance of students with ADHD. Kirby and Kirby (1994:144) are not surprised that children with ADHD become problems in school, considering the demands of a school situation for compliance and conformity. They believe that, with an understanding of the disorder and a willingness of school staff to adapt programmes to accommodate the individual needs of these children, they can become well-adjusted adults.

1.4 STATEMENT OF THE PROBLEM

The discussion thus far leads to the ultimate problem of the researcher:

Will the behaviour of children with attention-deficit/hyperactivity disorder be improved by psycho-educational intervention?

An analysis of the problem has led to the following observations, recorded in Table 1:

Table 1: Observations Regarding the Problem of the Study

1.	Parent become 'stressed out' and torment themselves with the thought that a child's difficult behaviour is the result of their own incompetence.
2.	The entire family of a child with ADHD often experiences stress, anger and guilt that can destroy the marriage and the ability of the family to function harmoniously.
3.	Parents have a limited understanding of ADHD and few strategies to combat the difficulties that arise.
4.	There appear to be few supportive outlets where parents can voice their concerns about their child with ADHD.
5.	If not diagnosed and treated effectively, the child with ADHD may develop significant emotional difficulties, which, with the recent finding that ADHD can follow into adulthood, may have serious implications.
6.	Therapeutic stories offer a learning experience for the child which could lead towards greater awareness of the difficulties which manifest.
7.	The reciprocal interactions between parent and child have a profound effect on their relationship.

With reference to the above observations, the following questions should be addressed:

1. Are parents more competent to cope with the demands of parenting when their stress levels are reduced as a consequence of having some of their needs met?
2. Does the entire family benefit when the parents' levels of stress are reduced and the parents feel empowered?
3. Are parents better equipped for their educational task when they are given cohesive strategies and concrete tools to cope with the difficulties within a supportive environment?
4. Are parents willing to sacrifice valuable time and energy to attend a support group programme, where they can get comfort in knowing they are not alone?
5. How can the child with a negative self concept, formed as a result of behavioural difficulties, be guided smoothly, by parents and teachers, through experiences, in such a way that will eventually enable him to become a confident and competent grown-up?

6. Will the child's behaviour improve as a direct result of listening to therapeutic stories?
7. Will the parent-child relationship become more positive when both parent and child are feeling more positive about themselves?

Based on these questions, hypotheses will be set. These hypotheses will be stated in Chapter Four and, in the final analysis, they will be accepted or rejected.

1.5 PURPOSE OF THE STUDY

1.5.1 Specific Aims

(a) An in-depth literature study will focus on:

* Attention Deficit Hyperactivity Disorder
* Therapeutic Intervention

(b) An empirical study will involve the following interventions:

(i) A support group comprising a small number of parents who meet once a week will be formed. An attempt will be made during these sessions:

* To empower the parents by providing them with information about attention deficit hyperactivity disorder, so that they gain some insight into the behaviours which manifest, and some effective strategies to deal with the problems.
* To provide the parents with an outlet for sharing their concerns and hardships with other parents who have similar problems.
* To give parents an opportunity to benefit from the support of other parents who truly understand their circumstances, and in turn, commiserate with these parents, within the safety of a therapeutic group setting.

(ii) Individual sessions will be planned with the children. During this time, an attempt will be made to focus the attention of the children on the therapeutic stories which will be read to them in an effort:

* To reduce levels of hyperactivity
* To reduce impulsive behaviour
* To increase focus of attention
* To improve oppositional behaviour
* To improve the child's relations

(iii) Contact will be made with the teachers of the children, and guidelines will be provided for dealing with some of the behavioural manifestations.

1.5.2 Indirect Aims

* To reduce levels of parental stress, making parents more competent to cope with their educational task.
* To improve the parent-child relationship initially, leading to more positive relations for the child with other family members, teachers, peers and self, so that the child can move towards adulthood with feelings of competence and self-worth.

1.6 DEFINITION OF CONCEPTS

1.6.1 Attention Deficit Disorder

The term for the disorder now known as attention deficit hyperactivity disorder was referred to in 1980 by the American Psychiatric Association in DSM-III-Revised as Attention Deficit Disorder (ADD) (Green 1995:16).

1.6.2 Attention Deficit Hyperactivity Disorder

According to the American Psychiatric Association (1994), "*The essential feature of Attention-Deficit /Hyperactivity Disorder is a persistent pattern of inattention, impulsivity, and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development*". Gilliam (1995:1) points out that "ADHD has only recently been recognised as a distinct disorder, but parents, educators, and clinicians are becoming more aware and knowledgeable about

it". Ingersoll (1998:11) refers to criticism of these guidelines by Dr Russel Barkley who argues that impulsivity, hyperactivity and attentional problems are not the only major symptoms in individuals with ADHD, but that *"deficits in rule-governed behavior should be considered the central problem in ADHD"*.

1.6.3 **Attention-Deficit/Hyperactivity Disorder Test**

According to Gilliam (1995:1-14), "*The Attention-Deficit/Hyperactivity Disorder Test (ADHDT) is a standardized, norm-referenced test that contributes to the diagnosis of students with Attention-Deficit/Hyperactivity Disorder (ADHD). Based on the DSM-IV (American Psychiatric Association, 1994) definition of ADHD, the ADHDT is comprised of three subtests: Hyperactivity, Impulsivity, and Inattention.*"

"*The best overall estimate of a subject's behaviour is the ADHD Quotient, which takes into account all the symptomatic behaviours of ADHD*". "*If the Quotient is 90 or above, the person probably has ADHD. Standard scores of 8 through 12 for the subtests or ADHD Quotients of 90 through 110 are within the average range for subjects with ADHD in the normative sample. Approximately 50% of the subjects with ADHD scored in this range. Standard scores above 12 or ADHD Quotients equal to or greater than 111 are highly indicative of ADHD.*" "*If the ADHD Quotient is below 70, the person very probably does not have ADHD.*"

1.6.4 **Learning Disabilities**

Clark (1995:13) refers to the controversy surrounding the issue of learning disabilities and the many definitions thereof. For the purpose of this study, the definition by Hamil et al. (1987:109) will be adopted:

"*Learning Disabilities is a generic term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and the use of listening, speaking, reading, writing, reasoning or mathematical disabilities. These disorders are intrinsic to the individual and presumed to be due to central nervous system dysfunction, and may occur across the life span. Problems in self-regulatory behaviours, social perception and social interaction may occur concomitantly with other disabilities but do not themselves*

constitute a learning disability. Although learning disabilities may occur concomitantly with other handicapping conditions, for example sensory impairment, mental retardation, social and emotional disturbance or intrinsic influences such as cultural differences, insufficient or inappropriate instruction, they are not the result of those conditions or influences".

1.6.5 **Multi-Modal Therapy**

In this study, multi-modal therapy will refer to the use of a number of different interventions applied concurrently, specifically, parental support, child-focussed intervention through the medium of story telling, and, where prescribed, medication. The teachers will also be given guidelines on improving behaviour in the classroom.

1.6.6 **Parental Stress**

Jackson (1992:3) states that "*stress arises when a person's perception of an environmental demand exceeds his or her perception of his or her resources to cope with that demand*". He explains that "*It is not the demand made on us that causes stress, but our reaction to that demand*", and emphasises the subjective nature of parental stress. Bloomquist (1996:32) reminds us that individuals cannot function well if under too much stress, as this affects their ability to parent.

1.6.7 **Parent Support Groups**

Parent Support Groups consist of a group of parents who share their frustrations and encouragement (Bain 1991:199). For this particular study, the leader is a professionally qualified educational psychologist. She will play the role of facilitator, also providing knowledge and useful strategies for coping, as well as suggestions for getting help and resources. At the same time, she will maintain her role as mother of a child with ADHD, sharing some of her own feelings and experiences.

1.6.8 **Therapeutic Story Telling**

Therapeutic stories are designed, through metaphor and symbols, to speak to the right

side of the brain, where images, vision and emotions are located. They can be used in a classroom setting, or in individual, group or family therapy (Davis 1990:v-vi). An important aspect of these stories is that the child is left with a very important message (Mills & Crowley 1986:xxi).

1.7 LIST OF ABBREVIATIONS

What follows is a list of abbreviations of some of the frequently used terms, as they suit the purpose of this work:

Table 2: List of Abbreviations

ADD	-	Attention Deficit Disorder
ADHD	-	Attention Deficit Hyperactivity Disorder
ADHDT	-	Attention Deficit Hyperactivity Disorder Test
CD	-	Conduct Disorder
LD	-	Learning Disability
OCD	-	Obsessive Compulsive Disorder
ODD	-	Oppositional Defiant Disorder
PSI	-	Parenting Stress Index

1.8 METHOD OF RESEARCH

A literature as well as an ideographic study characterises the investigation.

The literature study will involve a discussion of ADHD with regard to historical background, the nature of the disorder, aetiology, associated disorders, multidisciplinary assessment; and interventions aimed at improving, firstly, the parent-child relationship, and ultimately, the negative behaviour of the child with ADHD.

The ideographic research will involve the forming of a support group consisting of parents of children with ADHD, facilitated by the researcher. In addition, the children will attend a weekly session with the therapist, during which time they will have a therapeutic story

read to them. The teachers of the children will be contacted, and the purpose of the study will be explained to them. They will also be involved in the programme, to a limited extent.

Van Den Aardweg and Van Den Aardweg (1988:113) explain that the ideographic approach attempts to understand and describe the individual, usually accentuated in a case study. The intention is not to generalize such findings to groups, but rather to complement the nomothetic approach, which serves this function.

In a lecture at Unisa in 1994, Jacobs warned that one of the limitations of such a study is that the results cannot be generalised to a wider population. He pointed out the advantage as the personal nature of the findings. Jacobs (Smith 1989:116) explains that an ideographic study is a scientifically accountable manner in which an effort is made to give direction to an empirical study, to evaluate the progress made and to accurately demonstrate changes which may take place.

Fox (Griesel 1985:57) states: "*The basic rationale for the close study is that there are processes and interventions such as aspects of personality and social functioning which cannot be studied except as they interact and operate within the individual. The probability is that if we learn how these processes interact in some few individuals, we shall learn all there is to know about them.*" Vorsters (1986:71) cautions that "*variables over which the researcher has little or no control will inevitably influence the final results*".

Bearing the inherent weaknesses in mind, it can be argued that an empirical study is best conducted in a real-life setting, where a certain amount of intimacy can be maintained within the small group setting, and changes within individuals can be personally monitored.

1.9 PROGRAMME OF THE STUDY

Chapter One covers the introductory orientation and statement of the problem, and includes a description of terms, as well as an exploration of the problem, and the planning of the study.

The second chapter is devoted to a more intense study of ADHD, as detailed in the literature. The historical background, nature of the disorder, aetiology and assessment of ADHD will be discussed. Attention will be given to associated problems and disorders.

The focus of the third chapter will be the various options with regard to therapeutic intervention, also making mention of alternative treatment approaches.

The research design will be highlighted in Chapter Four. A practical programme which involves multi-modal intervention will be planned, for use by teachers in a school situation. Hypotheses will be set, which, in the final analysis, will be accepted or rejected.

Chapter Five will contain a discussion of the ideographic study which forms the empirical research.

A summary, findings and recommendations for further study will be presented in the final chapter.

CHAPTER TWO

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

"The Story of Fidgety Philip"

Hans Hoffman (Goldstein & Goldstein 1998:6)

Let me see if Philip can
Be a little gentleman;
Let me see, if he is able
To sit still for once at table;
Thus Papa bade Phil behave;
And Mamma look'd very grave.
But fidgety Phil,
He still won't sit still;
He wriggles,
And giggles,
And then, I declare,
Swings backwards and forwards
And tilts up his chair,
Just like my rocking horse;-
"Philip! I am getting cross!"

See the naughty, restless child
Growing still more rude and wild,
Till his chair falls over quite.
Philip screams with all his might,
Catches at the cloth, but then
That makes matters worse again.
Down upon the ground they fall,
Glasses, plates, knives, forks and all.
How Mamma did fret and frown,
When she saw them tumbling down!
And Papa made such a face!
Philip is in sad disgrace.

Where is Philip, where is he?
Fairly cover'd up, you see!
Cloth and all are lying on him;
He has pull'd down all upon him.
What a terrible to-do!
Dishes, glasses, snapt in two!
Here a knife, and there a fork!
Philip, this is cruel work.
Table all so bare, and ah!
Poor Papa, and poor Mamma
Look quite cross, and wonder how
They shall make their dinner now.

2.1 INTRODUCTION

In 1845, the German physician, Hoffman, described, in a children's storybook, a little boy who never learnt from his mistakes, was always abuzz with activity and always in trouble (Barabasz & Barabasz 1996:1). The Story of Fidgety Philip, one of these stories, highlights the fact that ADHD is not a new disorder. The debilitating symptoms of ADHD, and the consequences thereof, are accurately described in the poem. The misperception that the problems stem from naughtiness is clearly underscored. Today, more than one hundred and fifty years later, despite the vast amount of literature readily available for study, the symptoms of ADHD continue to be perceived in this negative light by many (Goldstein & Goldstein 1998:6).

A personal interest in ADHD was greatly enhanced by the extremely negative behavioural phenomena which manifested in certain children. The question arose: **Why do some children with ADHD function reasonably well, at home and at school, whereas others are completely disruptive and aggressive?** In a therapeutic setting, the latter group appeared to be sensitive, approachable children, and positive behavioural changes were noted. Yet, these positive changes did not transfer to the school and home environments, and their behaviour, in the classroom, playground and at home, continued to pose a challenge for teachers and parents alike.

An analysis of the above situation led to the conclusion that, in families where there is little emotional support, or there is instability or inconsistency, the behavioural problems are far greater. Goldstein and Goldstein (1998:xiii-xiv) reinforce this finding. They have come to recognise the symptoms of ADHD as a catalyst. They believe that, when these children are placed in a **protective, nurturing environment**, they may cause problems, but are not viewed as the *"twentieth century equivalent of the devil"*. Yet, in a **chaotic, high-risk setting**, the qualities of ADHD act catalytically, to further worsen the child's outcome. Thus they argue, *"that successful treatment of ADHD requires a balance between symptom relief and building in protective factors that enhance resilience, defined as the capacity to recover from stress and lead children to successful transition into adulthood"*.

The focus of this chapter is on the historical background, the nature, aetiology and the assessment of ADHD, as well as associated disorders. The aim is to supply a scientifically balanced view of the problems associated with ADHD.

2.2 HISTORICAL BACKGROUND

"What is already passed is not more fixed than the certainty that what is future will grow out of what has already passed, or is now passing" George B. Cheever (Barkley 1990:106). Earlier writings serve as antecedents to the current conceptualizations of the disorder and its treatments. They provide insight into this important developmental disorder and an appreciation of why our perspective on these children has arrived at its current status. Goldstein and Goldstein (1998:6) claim that the earliest referral to the symptoms of ADHD is possibly provided by John the Baptist in Luke 1:41, where John describes foetal hyperactivity as *"the babe leapt in her womb"*. They point out that similar childhood problems are alluded to in the early civilizations, and mention that the Greek physician, Galen, prescribed opium for ***"restless, colicky infants"***.

At the turn of the century, behavioural problems were associated with brain damage. In 1902, in the United Kingdom, Dr George Still claimed that children whose behaviour was impulsive, hyperactive and inattentive, and who tended to be troublemakers, were suffering from **organic disorders of the brain**. He described these children as having ***"a lack of moral control"***. Barkley (1990:5) states that today, these children would probably be diagnosed with Oppositional Defiant Disorder or Conduct Disorder, and would most likely also have some sort of learning disability.

The notion that hyperactive children had suffered ***"minimal brain damage"*** or ***"minimal brain dysfunction"*** was reinforced by other researchers over the next three decades. Firstly, the effects on behaviour of encephalitis, a viral infection of the nervous system, were noted. Then, observations of brain injured soldiers who presented with behavioural problems also lent support to the assumption. This concept was reinforced in the late 1950s, when a study of these children revealed that their mothers suffered more complications during pregnancy than the mothers of children without behavioural problems. Unlike many other medical mysteries, where a large number of possibilities are considered one by one, until, through a process of elimination, they are excluded as the

central problem becomes clearer, researchers have moved from this narrowly defined conception to a broader notion. No longer is it considered reasonable to explain the behavioural difficulties associated with ADHD as arising from brain damage, but rather, the idea of **multiple possible causes and modes of treatment** is entertained (Bain 1991:41-42).

In the 1960s, medical professionals started to take an interest in specific behaviours, and described the **hyperactive child syndrome**. Green (1995:14-17) points out that the concept of hyperactivity remained the focus in the United Kingdom for many years.

In 1973, Dr Ben Feingold suggested a **relationship between diet and hyperactivity**. Green (1995:14-16) believes that the obsessive interest in diet over the next few years distracted attention from the complexity of the problems associated with ADHD, and from the well-proven benefits of stimulant medication. Whilst the use of stimulants rapidly increased thereafter, it was frequently impeded by media misrepresentation. Another assault on the use of stimulant medication which set back appropriate treatment by years, in Green's opinion, was made by the Church of Scientology, who asserted that **Ritalin** was a dangerous and addictive drug. Rather than review the research literature, frightened parents, educationalists, psychologists, psychiatrists, paediatricians and policy-makers were swayed by what was printed in the press.

Goldstein and Goldstein (1998:7) acclaim Still's insight, in that he not only noted that the pattern of behaviour found in children with ADHD was the possible result of injury, but that it may also be from **heredity** or **environmental experience**. The idea that symptoms of impulsivity, hyperactivity and inattention were biologically based became popular in the 1980s. The 1980s closed with most professionals viewing ADHD as a developmentally handicapping condition, generally chronic in nature, and with a strong biological or hereditary predisposition. It was felt that a significant negative impact was made on academic and social outcomes for many children. Its severity, comorbidity, and outcome were viewed as significantly affected by environment, especially family. *"Critics blamed parents, schools and society at large for the increase in ADHD symptoms"* (Goldstein and Goldstein 1998:18). There were growing doubts about the central cause of attention deficits, and an increasing interest arose in possible motivational factors as the core difficulty in ADHD. It was recognised that effective treatment required multiple methods

and professional disciplines working in concert, over longer periods of time. The view that environmental causes were involved was weakened by increasing evidence of the **heritability** of the condition and its **neuroanatomical localization**. Still, the belief that **environmental/familial factors were associated with the type of outcome** was strengthened. Treatment was extended to include parents and family, as well as to control children's anger and improve their social skills. **Tricyclic antidepressant** medications were found to be effective in the treatment.

Bain (1991:42) suggests that, as solutions have become more complex, *"they have also become better designed to address the total needs of children with ADHD and their families"*. Through the eighties and nineties, the idea became popular that ADHD is a **lifetime disorder**, affecting all areas of an individual's functioning (Goldstein & Goldstein 1998:19). *"Today when the term ADHD is used, it refers to a child who has a small but definite difference in normal brain function which causes the child to underachieve academically, and to behave poorly, in spite of excellent parenting* (Benn et al. Undated:1). Whist ten years ago, most ADHD children were *"depicted as whirling dervishes who careened through life, leaving a swath of destruction in their wake"*, we know now that quite a large number are **daydreamer**s, who find it difficult to organise themselves or to focus on the task at hand, making it difficult for them to meet the demands of everyday life (Ingersoll 1998:1).

2.3 THE NATURE OF THE DISORDER

There continues to be disagreement about terminology and many researchers are of the opinion that the DSM-V may reconceptualise the disorder, perhaps as an **impulse disorder**. The consensus among practitioners is that the symptoms of ADHD affect a significant minority of the population, who *"represent a poor fit between society's expectations and these individuals' abilities to meet these expectations"* (Goldstein & Goldstein 1998:5 & 15). Furthermore, Goldstein and Goldstein (1998:3-4) point out that significant and pervasive impairment in a child's day-to-day interaction with the environment is caused by the symptoms of ADHD. This ineffective interaction and the inability to meet expectations within one's surroundings results in a long history of negative feedback, which impacts forcefully on the child's emerging personality. The lack of success and consequent positive feedback from teachers and parents, which motivates

other children, as well as rejection by their peers, who may, in fact, shun them, leads to them feeling frustrated, angry and bad (Bain 1991:9). Train (1996:27-28) points out that the inability to focus, which is common to both the children with hyperactivity and without, hinders their capacity to form relations, and leads to a deterioration of behaviour, exacerbated when they commence school, since they find the work difficult.

Some researchers have argued that the problems with inattention, hyperactivity, and impulsivity are the result of **cultural phenomena**, whilst others point out the changing view that ADHD is a cross-cultural disorder (Goldstein & Goldstein 1998:9). Goldstein and Goldstein emphasise the biopsychosocial nature of the problem, and stress that *"the severity of the child's problems results from the interaction of temperamental traits and the demands placed upon the child by the environment."* They suggest that, in earlier years, children with behavioural and scholastic difficulties would have been taken out of school and sent out to work, where their impulsive qualities may have driven them to success. **Winston Churchill, Albert Einstein**, **Woody Allen** (Green 1995:11), **Mozart, Edison** and **Dustin Hoffman** (Hallowell & Ratey 1995:268) are some of the influential people who channelled their activity, drive and single-mindedness to achieve greatness. Today, however, there is an increasing emphasis on the importance, from an early age, of controlling impulses, sitting still, paying attention and finishing tasks. Thus, children compromised in their ability to do so, are unable to integrate into and meet the expectations of our educational system. Nevertheless, there is no doubt that the problems vary across cultures.

Debroitner and Hart (1997:12) point out that the terms ADD and ADHD do not refer, scientifically speaking, to a specific disease, but rather to a **cluster of symptoms,** the definition of which depends on the subjective opinion of observers. Barkley (1995:40) refers to the chronic difficulties in the area of inattention, impulsivity and overactivity as the ***"holy trinity of ADHD".*** According to Parker (1994:4), ADHD is a **neurobiological disorder**. Some people with ADHD are exceptionally hyperactive and impulsive, others are most notably inattentive, and still others have a combination of all three traits. These different types of the disorder are described in the Fourth Edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) published by the American Psychiatric Association in 1994:

Table 3: Types of Attention-Deficit/Hyperactivity Disorder

* **Attention-deficit/Hyperactivity Disorder, Predominantly Inattentive Type**
* **Attention-deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type and**
* **Attention-deficit/Hyperactivity Disorder, Combined Type.**

The predominantly hyperactive-impulsive type, along with the combined type, make up the majority of children with attention-deficit/hyperactivity disorder. Probably a third of all children with the disorder are the predominantly inattentive type and do not show signs of impulsivity or hyperactivity. In order to qualify for a diagnosis, the individual must present with the symptoms of inattention, hyperactivity, or impulsivity, before the age of seven, and impairment must be present in two or more settings, (i.e. at school, playground, at home). There must be evidence of impairment in social, academic, or occupational functioning, and the symptoms must not be the result of another psychiatric disorder.

2.3.1 Characteristics

Parker (1994:5-6) describes the characteristics of ADHD, as published in the Fourth Edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV).

2.3.1.1 Inattention

Attention span is not as visible as hyperactivity or impulsivity, but is usually the symptom of ADHD which causes the most problems in school. The child is not incapable of attending to situations which appeal to interests, and may have an ample supply of attention when performing enjoyable activities, such as playing video games or watching television. In the one-on-one situation, attention span may be normal. A child with attention-deficit/hyperactivity disorder, predominantly inattentive type exhibits at least six of the characteristics of inattention described below for at least six months, to a maladaptive degree:

Table 4: Characteristics of Inattention

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

2.3.1.2 **Hyperactivity-Impulsivity**

Hyperactive children usually exhibit far greater amounts of restlessness and overactivity than is typically found in most young children, and in many more situations than their non-hyperactive peers. *"Their impulsivity is reflected in their inability to control their emotions and behaviour to a far greater degree than is typical of other children their age"* (Parker 1994:6). The child with attention-deficit/hyperactivity disorder, predominantly hyperactive-impulsive type exhibits at least six of the characteristics described below, for at least six months, to a maladaptive degree:

Table 5: Characteristics of Hyperactivity

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

Table 6: Characteristics of Impulsivity

*	often blurts out answers to questions before questions have been completed
*	often has difficulty waiting in lines or awaiting turn in games or group situations
*	often interrupts or intrudes on others (e.g. butts into conversations or games)

2.3.2 **Prevalence**

Figures on the incidence of ADHD vary greatly between different sources of information. Differences in diagnostic practices possibly account for the higher incidence in the USA compared with other countries (Ingersoll 1998:18). Whilst Wolraich and Baumgartel (1996:168) state: *"Attention deficit hyperactivity disorder (ADHD) is the most common mental disorder in children"*, they also point out (1996:182) that prevalence rates differ according to the applied diagnostic criteria in the different areas. They refer specifically to the difference in the criteria between the USA and Europe. In their opinion (1996:184), it is essential that the **degree of impairment** or the **pervasiveness** should be taken into account, rather than just the presence of symptoms.

Benn et al. (Undated:2) claim that 3 - 5% of children are affected, within all population and economic classes. Goldstein and Goldstein (1998:19) report a higher incidence in lower socioeconomic families where ADHD adults cluster in certain low socio-economic neighbourhoods, integrate poorly into society, and have families. This is quite likely when one takes into account the effect of environment on outcome (Goldstein & Goldstein 1998:7). DSM-IV also reports that 3 - 5% of all children of school-going age have ADD or ADHD. According to Parker (1994:6-7), some experts believe as many as 20 - 25% of children are affected. Barabasz and Barabasz (1996:3) state that *"Prevalence of the disorder ranges from 5 % to 15% in community samples and 50% or higher among clinical referrals"*.

Some speculate that advances by the medical profession have led to the saving of many babies who may have died, and this has increased the incidence. Others attribute the higher incidence to the trend toward earlier enrolment in pre-school where the difficulties of inattention, overactivity and impulsivity are noticed earlier (Barkley 1990:66). McNamara (Goldstein & Goldstein 1998:10) suggests that there is a greater incidence of ADHD as the tempo of our society increases. A number of other researchers dispute this hypothesis and claim that the capacity for sustained attention at younger ages has increased due to children's early exposure to the media. It is possible that the increase in the rate of diagnosis reflects rather a greater awareness of the symptoms by the community, professionals and parents, so that more children are referred, diagnosed and treated. Barabasz and Barabasz (1995:1) say that *"It's ADHD's time in the sun and they are getting it*".

Barkley (1990:3) points out that in epidemiological or community-based studies, the ratio of boys to girls is 3:1, whereas in clinic referred settings, it is 6:1. He explains that this may be *"a function of the greater prevalence of other disruptive problems such as oppositional defiance and conduct disorder in boys with ADHD"*. Goldstein and Goldstein (1998:19) refer to studies which suggest that females tend to present with mood, affect and emotional problems, rather than with aggression. Other studies they refer to suggest that females present with greater cognitive and language function impairment than males. Wolraich and Baumgartel (1996:183) are of the opinion that girls have been identified to a lesser degree than boys, because they may be quieter and exhibit

less hyperactive and impulsive behaviours, and so they go under diagnosed and under treated. Barabasz and Barabasz (1996:3), who report male:female ratios as 4:1 by some and 9:1 by others, believe that the prevalence for girls and adolescents appears to be increasing.

2.3.3 The Evolution of ADHD

One of the most vexing aspects of ADHD is its evolution through the developmental stages. What works well at a particular stage may not work in another stage, or even in another situation. Whilst it is often first noticed when the child is three to four years old, or maybe even only in the first grade, some children are difficult, active and temperamental even in infancy. Up to 80% of children with the diagnosis will display symptoms through adolescence and between 30 and 65% into adulthood, depending on the definition of the disorder. Barkley (1995:80-84) describes the changes through the developmental stages.

2.3.3.1 Pre-school Children

Up to 57% of pre-school children may be diagnosed but the symptoms of many may improve. The degree of early symptoms and how long they last determines which children are likely to show a chronic course of ADHD. Where the pattern lasts for at least a year, the disorder is likely to continue. Parents describe these children as restless, active, persistent in their wants, demanding of attention and insatiable in their curiosity about their environment. They pose a definite challenge to their caregivers, particularly their mothers, especially when they are moody, quick to anger and slow to adapt. They need frequent close monitoring. Day-care staff and babysitters often refuse to care for these difficult children, leading to added stress for the parents.

2.3.3.2 Elementary School Children

The major area of concern during the elementary school stage is the lack of social skills. The ability to sit still, listen, obey, inhibit impulsive behaviour, cooperate, organise, follow through on instructions, and interact pleasantly with others, which is essential for a successful academic career, is lacking in these children. In addition to the complaints from teachers, parents also have to help their children adjust to academic and social demands,

whilst still coping with their troublesome behaviour at home. The overwhelming difficulties which manifest commonly result in low self-esteem. Many are likely to develop symptoms of conduct disorder, and many will require special educational assistance.

2.3.3.3 **Adolescents**

Whilst previously it was believed that ADHD is typically outgrown by the adolescent years, follow-up studies have indicated that 70 - 80% of children with ADHD will continue to display symptoms into adolescence. Many will display antisocial behaviour or conduct disorder and may experiment with alcohol and/or drugs. Many will have failed a standard and may have been suspended or expelled from school. Levels of academic achievement are below the norm for reading, spelling and maths. They continue to have problems with peers and many lack confidence and become depressed.

2.3.3.4 **Adults**

Research suggests that many children with ADHD continue to have symptoms into adulthood. Whilst many are self-supporting, their educational level may be lower than most, their work record poorer, and their antisocial behaviour continues to be troublesome. Many attempt suicide or commit acts of physical aggression towards others.

2.4 **DIAGNOSIS OF ADHD**

The parents' great difficulty in accepting that their child may have a disorder frequently seems to result in an avoidance of dealing with the problem. So many researchers (Abidin 1995:1; Bloomquist 1996:x; Koplewicz 1996:78; Parker 1994:12) point out a better prognosis when early intervention is initiated. Yet, when it was attempted to involve many of the parents of young children in a programme, following comprehensive evaluation, hoping that this could prevent much anguish later, they could not be persuaded that they needed anything quite so drastic, at that stage. It almost seems that the parents have to face a whole lot of battering, in the form of criticism, or extreme social and academic pressures, before they relent, and are willing to address the issues. This is a rather unfortunate situation, since it is ultimately the child with ADHD who suffers the most through this lack of acceptance.

Despite exciting developments in this high-tech age, there is still no test which validly and reliably diagnoses ADHD. Ingersoll (1998:48) acclaims Dr Michael Gordon's advice: ***"SEEK THE BEST IN EVALUATIONS BEFORE YOU SEEK THE BEST IN TREATMENT".*** She emphasises, that an evaluation should include a review of the child's and the family's history, information about past and current performance at home and at school, and a clinical interview with the parents. Green (1995:46), on the other hand, states: *"It is the positive response to our intervention that is important, not the individual diagnostic method".*

Diagnosis of ADHD is made according to the criteria specified in the DSM-IV. Block (1996:49) expresses sadness that children are misdiagnosed as having ADHD and are drugged to alleviate the symptoms whilst their underlying health problems go undetected. By the same token, Wachtel and Boyette (1998:6) also point out that "*ADHD can masquerade for a lifetime as something else - forgetfulness, laziness, even senility*". Whilst it is not difficult to note the primary characteristics of inattention, impulsivity and hyperactivity, it must be borne in mind that the presence of these symptoms may be due to other factors, such as frustration with difficult school work, lack of motivation, emotional concerns, and/or other medical conditions (Parker 1994:12). Goldstein and Goldstein (1998:232) also mention that Sydenham's chorea, hyperthyroidism, infections with pinworms, sleep apnoea and certain medications may mimic the symptoms. Block (1996:74, 83, 96, 115) adds hypoglycaemia, allergies, food sensitivities and Candida to the list of possible causes of ADHD symptoms, although her claim is disputed by many of the experts (Barkley 1995; Goldstein & Goldstein 1998; Ingersoll 1998). Barkley also disputes the theories that link hormones, lighting and motion sickness with ADHD, and expresses the hope that, as conclusive findings regarding ADHD are made, that quackery will vanish. Benn et al. (Undated:5) point out the following possible ADHD lookalikes which should be ruled out:

- the behaviour of a normal, healthy, active preschooler
- the child with an intellectual disability
- the hearing-impaired child
- the child who suffers epilepsy
- the child with some form of brain injury
- the child from a severely dysfunctional family
- the child who suffers from depression
- the child who suffers from a behavioural abnormality

A comprehensive assessment carried out by various professionals is necessary if an accurate diagnosis is to be made. It is also essential that parents give their input, and that information be obtained from the child, if he is old enough. In the early stages of the investigation, parents may be told they are to blame for the difficulties, which leads to feelings of guilt. Some parents drag their child from one professional to another in an effort to find answers, and this leads to the child feeling inadequate and resentful. Picton stresses the importance of parents doing some research before taking the child for too many assessments (1998:25). In Barkley's opinion, (1995:105), it is not important who is consulted to begin with, provided this person is familiar with the substantial scientific and professional literature on ADHD, and *"has a solid reputation in the area for dealing with ADHD children"*.

Parker (1994:17-18) underlines the importance of the various members of the team communicating their findings so that a conclusion can be reached regarding diagnosis and recommendations. Whilst a certain amount of discussion does take place between a limited number of professionals in a school and clinic setting in South Africa, rather sadly, the writer's perception is that most professionals in private practice work in isolation, each producing their own report with recommendations which often contradict those of the other professionals. It would appear too, that many professionals have not kept up with the latest research and still base their recommendations on what they learnt about ADHD ten to twenty years ago. This undoubtedly contributes towards the parent's confusion and anger.

2.4.1 **The Multidisciplinary Team Assessment**

The multidisciplinary team includes medical and para-medical specialists, psychologists, teachers and remedial therapists. Should any one of the team members detect difficulties in domains outside of his/her own, he/she will make the necessary referrals to other professionals, such as neurologists, paediatricians, psychiatrists, optometrists, occupational therapists, speech and language therapists, remedial therapists and/or social workers, so that the specific difficulties in those areas can be fully investigated and effectively addressed. Whilst Benn et al. (Undated:7) claim that the child may not need to see all the professionals, most will need to see two or more at some stage. Picton

(1998:26) reminds us that the type of therapist consulted and the period of time that the child attends therapy will depend on the specific needs of the child.

2.4.1.1 The Medical Specialist's Role

According to Benn et al. (Undated:6-7), the medical specialist should follow these steps:

- Take a detailed history, noting indicators of ADHD
- Conduct a physical and neurological examination, specifically taking note of gross and fine motor development and congenital abnormalities, such as webbed fingers or toes, double crowns or abnormal finger prints
- Obtain objective reports on the parent's and teacher's observations by using behaviour rating scales, such as the Connors Rating Scale or the Attention Deficit Hyperactivity Disorder Test (Abidin 1995)
- Occasionally conduct an EEG or brain scan in an effort to exclude other conditions, such as epilepsy
- Obtain additional information from other members of the multidisciplinary team.

Goldstein and Goldstein (1998:) believe the medical history should include the results of recent tests of vision and hearing. Garber et al. (1996:33-35) cite vision and hearing problems as being the cause of attentional problems which may result in learning difficulties. Barkley (1990:88) refers to inconsistent evidence that children with ADHD have a higher incidence of otitis media than other children, which can lead to reduced hearing and problems with speech development.

In view of the fact that so many other factors result in ADHD symptoms, it is of some concern that many medical specialists do not conduct more extensive testing to rule out other conditions.

2.4.1.2 The Psychologist's Role

The parents may be referred to an educational psychologist by the medical or para-medical professionals, or by the school, or, they may request an evaluation of their own accord. The psychologist administers and interprets psychological and educational tests which

provide useful information on intellectual functioning, reasoning skills, use of language, academic achievement, perceptual skills, emotional functioning, restlessness, attention span and impulsivity. The extent of testing will depend on the child's specific problems, but the information received may be invaluable in helping the team arrive at a diagnosis (Parker 1994:14).

A relatively new tool in the clinician's arsenal of psychometric instruments for evaluating and treating the disorder is computerized assessment devices called continuous performance tests, such as the **Gordon Diagnostic System**, **Tests of Variables of Attention** and the **Conner's Continuous Performance Tests**. The subject is required to respond to computer stimuli in a specific way, which reflects attention span, reaction control and impulse control. Whilst Ingersoll (1998:56-57) points out that experts disagree on the usefulness of these test devices, she finds that her own understanding of an individual is enhanced by their use. However, she emphasises that they should never be used in isolation, and should only be used and interpreted by well-trained and experienced professionals.

Behaviour rating scales are also used, by psychologists and others, to describe significant commonalities in the history of children with ADHD and their families (Parker 1994:14-15). The scales offer quantifiable, descriptive information about a child, making it possible to compare him with others of the same sex and age.

2.4.1.3 The Class Teacher's Role

The child's behaviour in a group situation can be directly observed by the class teacher, who is able to make a comparison with other children of the same age. Behaviour rating scales and teacher interviews are used to obtain this information. Schools have access to records which reflect past classroom performance and social, emotional and behavioural characteristics. Whilst this information is usually invaluable when planning a specialised programme of intervention, some concern is felt about the effect of '**labelling**' these children. Friends, teachers and family members may stigmatize the child, following a diagnosis of ADHD, and may treat him as a problem child. However, Bain (1991:14-15) believes the label serves a useful function. Firstly, it relieves the parents' feelings of guilt and bolsters their self-confidence when they realise that they are not to blame. Secondly,

the child is helped when there is an awareness that he lacks the tools to conform to expectations, and is not misbehaving intentionally. In addition, doors are opened to myriad management strategies. Lastly, the schools are alerted to the fact that the child has special needs, and are provided with a framework from which they can work toward a better understanding of the disorder and a refinement of treatments.

2.4.1.4 The Remedial Teacher/Therapist's Role

The remedial teacher/therapist focuses on academic skills with which the child is experiencing some difficulty (Benn et al.Undated:7).

2.4.1.5 The Occupational Therapist's Role

The occupational therapist assesses in order to identify and treat specific weaknesses of visual perception and gross and fine motor coordination. They generally work with children up to the age of about eight years (Benn et al.Undated:7).

2.4.1.6 The Speech and Language Therapist's Role

The speech and language therapist assesses in order to identify and correct specific weaknesses of language processing and linguistic abilities. Benn et al. (Undated:7) believe that the speech and language therapist is a most important member of the team, in view of the fact that learning difficulties are often language based. Ingersoll (1998:39-40) confirms that reading disorders, previously assumed to stem from problems with visual perception, are now considered to be commonly associated with problems with language processing. She points out the overlap between ADHD and central auditory processing disabilities, which complicates the diagnosis.

2.4.1.7 The Optometrist's Role

If children are to learn effectively, it is essential that the visual systems function well. The optometrist examines a child to investigate the following visual systems (Picton 1998:131):

* Accomodatative System - the ability to sustain focus clearly at near point, and rapidly shift focus from near to far
* Visual Perceptual System - the way the child processes what is seen
* Binocularity - the integrated use of both eyes
* Ocular Motor System - tracking, for example, a line across the page

2.4.1.8 The Social Worker's Role

Social workers are the experts in family counselling and therapy. They will be consulted when significant disruption has occurred within the family (Benn et al.Undated:7).

2.4.1.9 The Parent's Role

The parents have a unique perspective on their child's development and current adjustment, having witnessed their growing up and their behaviour in a variety of situations. Information is obtained from them through interviews, which focus on family history and functioning, past and present, as well as relevant events from the child's medical, developmental, social and academic history. An important aspect to bear in mind is the subjective involvement of the parents, who bring, along with the objective information, a mixture of emotions about themselves and their child (Parker 1994:16-17).

2.4.1.10 The Child's Role

In-depth interviews with the child and psychological tests which evaluate social and emotional adjustment provide valuable information on the child. The observations of the clinician during interviews and testing yield information on the child's behaviour, feelings and attitudes. Normal behaviour during a one-on-one session may, however, not be reflective of the child's behaviour, level of activity, attentiveness or compliance in other settings (Parker 1994:17).

2.5 AETIOLOGY

Whilst a common pattern has been for parents to either blame others or to hold themselves responsible for the child's behaviour, and for teachers and others to blame the parents,

maybe even suspecting the parents of abusing the child physically or psychologically, fortunately we are becoming more enlightened. Needless to say, when one considers the complicated history and controversial process of diagnosing ADHD, there are also many opinions on the aetiology. Train (1996:46) stresses the significance of making the child central when looking for a reason for the poor behaviour, and emphasises the importance of acknowledging that **Nature** has as big a part to play as **Nurture**. Bain (1991:11-12) points to research which overwhelmingly supports the notion of an inborn, physiological component to the disorder, but also stresses that biology only explains one piece of the ADHD puzzle. Environmental factors are also at work, and demands placed on the child at school, as well as family interactions, play a part in determining to what extent attentional difficulties create problems.

Whilst a number of popular notions regarding possible causes of ADHD have been put forward, none of which should be discounted, since each one may contain an element of truth, Benn et al. (5) point out that two certainties exist, firstly that ADHD is a **hereditary** condition, and secondly, that the problems of ADHD result from an **imbalance of neurotransmitters** in the brain. They also claim that ADHD is not caused by poor parenting, a poor home life, poor schools, excess sugar, food allergies or too much TV. Nevertheless, they stress that poor parenting can exacerbate the behaviour. *"If parents are critical and hostile, this can lay the foundation for irreparable problems in the relationship with the child."* The following paragraphs involve a discussion on the possible causes put forward by researchers in recent publications.

2.5.1 **Brain Dysfunction**

Train (1991:47) refers to evidence that supports the theory that ADHD indicates a dysfunction in the chemistry of the brain. *"Research into chemical activities is proving to be the most promising of many attempts to understand the complexities of the brain"*. It would appear that children with ADHD have a malfunction with their neurotransmitters, such chemicals as dopamine, norepinephrine and serotonin, by which messages are sent between nerve cells. The chemicals excite the receiving cell and help it to propel the message further, regulating the way we think, feel and pay attention, among other things. The brains of children with ADHD simply do not work as well as they should, so that behaviour is badly affected.

In addition to the unusual balance in the message-transmitting chemicals of the brain, most researchers believe there is an under functioning of those areas of the brain that put the brakes on unwise behaviour, the frontal lobes. Children who tend to be hypoactive also process information slowly, according to the results of neuropsychology tests. Photon Emission Tomography (PET) scans of children with ADHD show underactivity of the frontal lobes, which are the part of the brain involved in the regulation of behaviour and intellectual activities. "*As a result, there is a lack of control of the higher centres of the brain associated with impulse control, memory, the ability to pay attention and reasoning with respect to the consequences of actions*" (Picton 1998:10). In this regard, according to Barkley (1995:58), the idea that brain development in children with ADHD is immature is quite appealing, since they are often socially immature and delayed in motor coordination and development. Recent studies have also shown that the electrical activity in the brains of children with ADHD is similar to that seen in younger non-ADHD children. However, studies at Yale University have not been able to detect differences in brain structure or anatomy.

2.5.2 **Genetics**

Benn et al. (Undated:5) claim that 80% of children with ADHD have a parent or close relative who also has the condition. According to Train (1996:48), "*ADHD is an inherited condition*", with many sufferers frequently having fathers, and sometimes, although less frequently, mothers, who had the same condition. As such, it is unlikely that the disorder can be cured, but rather that one should learn to cope with it. "*There is good research evidence to back up a genetic influence*" (Green 1995:20-22). If one identical twin suffers the disorder, there is a 90% chance that the other twin will also be affected. The risk between ordinary siblings is 30 to 40%. Whilst the strong familial component could be ascribed to the child's growing up in a chaotic environment, studies of adopted children indicate "*higher-than-average incidence of ADHD and related disorders among biological parents and other blood relatives, but a lower-than-average incidence of these problems in adoptive parents (who are carefully screened during the adoptive process)*". This reinforces the belief that heredity has a stronger influence on ADHD than does environment. Ingersoll (1998:66) refers to recent research which has identified specific locations on certain genes which may play important roles in ADHD.

2.5.3 Brain Damage

Whilst brain damage may result in hyperactivity and/or a poor ability to sustain attention, not all children who have ADHD are brain damaged (Train 1996:49). There is a small group of children with ADHD whose problems possibly stem from damage before or during birth, and these children are more likely to have comorbid problems. Ingersoll (1998:72-73) refers to a number of investigations which link ADHD with complications during pregnancy, premature babies, long length of labour, low birth-weight babies, and/or maternal alcohol/drug use or smoking during pregnancy. However, Barkley (1995:57) believes no more than 5 to 10% of children with ADHD have developed it as a result of brain damage.

2.5.4 Smoking and Alcohol Abuse During Pregnancy

Although it cannot be categorically stated that ADHD is caused by smoking and drinking during pregnancy, there is a strong enough link between these factors and the presence of ADHD (Gilbert 1998: 23).

2.5.5 Diet

Many parents believe that changing the child's diet alters his behaviour. In particular, it is assumed by some that artificial colourings, preservatives and salicylates should be eliminated from the diet. Research conducted at the Great Ormond Street Hospital for Children in London showed that many children are adversely affected by food additives and many are also sensitive to certain foods (Picton 1998:39). Debroitner and Hart (1997:214) support the view that food intolerance or allergies significantly contribute towards hyperactivity. Train (1996:50-51) refers to studies which indicate that certain substances, such as caffeine, can affect the level of activity in some children, but points out that *"while the behaviour of a small number of children might be affected by what they eat, there is no conclusive scientific evidence that ADHD is an allergic reaction to food"*. Other dietary approaches entail the inclusion of large doses of vitamins. The notion entertained in such cases is that the unwelcome behaviour is rooted in a chemical deficiency. Barkley (1995:68) warns that large doses of vitamins and minerals can actually

be harmful to children. Debroitner and Hart (1997:214) refer to studies which showed a connection with a low concentration of key fatty acids found in flaxseed, sunflower, soya and in primrose oils, as well as some cold-water fish.

Dietary modification appeals to many paediatricians, who in particular, recommend low-sugar diets for the children with behavioural problems. Ingersoll (1998:74) believes that there is a lack of evidence backing claims that such modifications are effective, and reinforces her belief by stating that '*experts such as Dr Keith Conners flatly state that research findings do not justify eliminating sugar in the diets of ADHD children*". Boyette and Wachtel (1998:64) say that the link between sugar and hyperactivity is one of the most enduring myths of ADHD. They also believe that restricting the child's sugar intake is not likely to have any effect on ADHD symptoms. Barkley (1995:67) believes that the changes reported by parents are the result of powerful psychological suggestion. He backs this claim by referring to a particular study where mothers reported poorer behaviour in their children after they had been falsely informed that the drinks they were given contained large doses of sugar. However, Block (1996:117) states that the Feingold diet is an overlooked remedy which changes behaviour for the better, but which is unpopular because the remedy is dietary and not a drug, and as such, it does not fit in with the medical model.

2.5.6 **Lead Poisoning**

Train (1996:51-52) claims it is reasonable to assume that noxious fumes of any sort will be harmful if inhaled, and accepts that a hyperactive child who rushes about more than others may optimise the possibility of a degree of lead poisoning from car emissions. He acknowledges that lead poisoning which results in brain damage can occur but stresses that it cannot be said it causes ADHD, since the majority of children with the condition do not have elevated blood levels. Barkley (1995:64-65) reports that, since lead is a toxin, extremely high levels of lead in the blood may be viewed as a potential cause of inattention, hyperactivity and, in some cases, even ADHD.

2.6 ASSOCIATED PROBLEMS/DISORDERS

Barkley (1990:74) points out that *"Children with ADHD have a higher likelihood of having other medical, developmental, behavioral, emotional and academic difficulties"*. Whilst these children do not all display all these problems, he reports (1995:86) that less than 20% of children who attend his ADHD clinic have only one disorder. This phenomenon is referred to as **comorbidity.** Wachtel and Boyette (1998:78-80) emphasise that these combinations occur more commonly than most people think. Diagnosis is particularly difficult because many of the symptoms of the various conditions overlap, possibly because these conditions all involve some of the same chemical processes and neurological pathways in the brain. For example, depression can cause inattention, whilst the difficulties that ADHD cause can result in depression. In Ingersoll's opinion (1998:26-27), this is the reason for so much diagnostic confusion and subsequent treatment failure among children with ADHD. She refers to changing opinions, making specific reference to her own belief just a decade ago that oppositional, defiant patterns of behaviour were a component of ADHD. Today we recognise that this is an entirely separate condition, although the two may coexist.

These new findings concerning comorbidity have important implications for diagnosis. *"Professionals who evaluate ADHD children should always be on the alert for other conditions that commonly coexist with ADHD."* Furthermore, in Barkley's opinion (1995:169), *"It is not enough simply to know the criteria for the diagnosis of Attention-deficit Hyperactivity Disorder (ADHD); the clinician must also be able to distinguish its symptoms from other psychiatric conditions that may bear a superficial resemblance to them"*.

Comorbidity issues primarily facing practitioners are focused in three areas:

- the additional presence of other disruptive, oppositional and conduct disorders
- the additional presence of a specific developmental disorder resulting in a learning disability
- the presence of internalizing problems related to emotional distress, particularly depression or anxiety (Goldstein & Goldstein 1998:115).

The following paragraphs describe the frequently associated problems seen in children with ADHD, or which, at times, may have a superficial resemblance to its symptoms.

2.6.1 Disruptive Behaviour Disorders

According to Barkley (1995:181), the conditions of **ADHD, ODD** and **CD** are not synonymous with one another, but they are more likely to exist in combination with each other. Particularly in families who are disorganized, chaotic, and psychiatrically disturbed, the ADHD child is at risk for subsequent ODD and CD.

2.6.1.1 Oppositional Defiant Disorder

Children with ODD deliberately do things to annoy others, adults in particular. Benn et al. (Undated:9) stress that, combined with the impulsivity of ADHD, *"it becomes very volatile, and even dangerous"*. When parents confront this behaviour in a hostile manner, the condition is worsened. Ingersoll (1998:28) has noted that the disorder often emerges quite early in life. She describes these children as often quarrelsome, spiteful and aggravating. They frequently resent siblings, blaming them for their unhappiness. They argue viciously and may be physically assaultive, brooding and sulking for hours after a temper tantrum. ODD is more common in males. Barkley (1995:176-177) reminds us that oppositional or noncompliant behaviour is a fairly common characteristic of preschool children, and that, in order to make a diagnosis, the symptoms must be present to a degree that is excessive or deviant for the child's mental age. ODD is usually seen in the home environment in preschool years, more often noted by mothers than by fathers. The condition occurs more in families where another member also has a pattern of negative and coercive behaviour, where there are marital and personal emotional or psychiatric problems, or where the family is socially disadvantaged. *"Over time, ODD is likely to be associated with low self-esteem, low frustration tolerance, temper outbursts, poor peer relations, and eventually poor school performance"*. Ingersoll (1998:29) underlines the importance of treating ODD during early childhood, to prevent the difficult behaviour spilling over in the school setting where a pattern synonymous with conduct disorder often develops.

2.6.1.2 Conduct Disorder

A vast majority of children with ODD develop a comorbid CD or pattern of antisocial behaviour toward others (Barkley 1995:178-179), which Ingersoll (1998:30-31) points out is a difficult condition to treat in its more serious forms, particularly when the poor behaviour is long-standing. The behaviour is noted in the community, at school and with peers as much as in the home environment. Age of onset is usually between six and eight years of age. Poor school performance, school suspensions and expulsions, greater tobacco, alcohol and illicit drug use are cited as frequent associated problems, as well as a higher incidence of precocious sexual activity, venereal disease and teenage pregnancy than is normal for age. The risk of suicidal gestures in adolescence increases. They may lie, steal, fight, set fires, and run away. Benn et al. (Undated:9) explain that CD children lack remorse for their misdeeds, becoming angry when caught, even blaming others. Some are bullies, who intimidate and attack others, and some are deliberately cruel to animals and other people.

2.6.2 Specific Developmental Disorders

A large number of children with ADHD also suffer specific weaknesses in learning. These children often have average to above-average intelligence, but have trouble processing information (Benn et al.Undated:8). Priscilla Vail (Ingersoll 1998:37) states that ***"the learning and performance profiles of these children are so jagged and irregular that they resemble a cross-section of the Alps".*** Whilst they may have incredible strengths in some areas, they display great weaknesses in others. Since many teachers fail to recognise the symptoms of these often lively, quick and intelligent children, they are presented with inappropriate work and when they are unable to meet the demands, they are branded as lazy or uncooperative (Train 1996:87). In particular, children with concentration problems who are not hyperactive, are often only identified when their learning difficulties become apparent in school (Garber et al. 1996:104). As a result of the tremendous difficulties children with ADHD have in the academic area, many of them have learning disabilities in **reading, spelling** or **mathematics** and many are likely to have to repeat a standard. Many are placed in specialised educational programmes for learning.

Whilst teachers often assume that the difficulties which manifest are due to the ADHD, Wachtel and Boyette (1998:84-85) stress that where a comorbid LD exists, it must be addressed. They believe that academic problems should not persist once the ADHD is treated, since the gaps in learning are deficiencies as a result of their attentional difficulties, rather than LD.

Like ADHD, learning disabilities also tend to run in families, and are also considered to be the result of differences in brain anatomy and chemistry (Ingersoll 1998:38-39). The most common LD involves reading, sometimes referred to as ***'dyslexia'***, and appears to stem from problems in the language areas of the left hemisphere of the brain. Whereas these problems are assumed to be linked to problems with visual perception by some, Ingersoll points out that *"dyslexic individuals most commonly have problems with language processing"*, which lead to difficulties with **phonological processing**. As a result of the **language-based learning difficulties**, they often have *"particular problems memorizing math facts and remembering the sequence of steps involved in math computation"*. According to Barkley (1995:86-87), although not seriously delayed in the development of language, they are more likely to have problems with **expressive language** than their non-ADHD peers (Barkley 1995:86-87). Picton (1998:134) underlines the fact that language is the medium through which learning takes place, and so deficits interfere with our ability to learn.

"Children with nonverbal learning disabilities have difficulty organizing visual information and coordinating visual information with motor activity" (Ingersoll 1998:39-40). They have a problem with **spatial relations**, and find it difficult to develop a sight word vocabulary, with the result that they have to sound out words, often losing the meaning in their attempts to decode. They have problems with **spelling** and with **handwriting**. They also have problems **reading maps** and cannot detect important **nonverbal cues** in social interaction, which creates problems with **social skills** and **interpersonal relationships**. Barkley's claim (1995:87) that these children also appear to be **disorganised**, is reinforced by Garber et al. (1996:157): *"ADHD folks are notorious for leaving, losing, or misplacing things"*. They frequently have problems with gross motor coordination and are clumsy and accident prone. According to Benn et al.

(Undated:9), difficulties with colouring in, drawing and writing lead to a reluctance to take part in these activities. This reluctance is frequently seen as the cause of the problems and the children are labelled untidy and careless, even when they try their best.

2.6.3 Emotional, Social and Behavioural Difficulties

Children with ADHD socialise poorly and have problems with peer relationships. *"Research shows that the inattentive, disruptive, off-task, immature and provocative behaviors of ADHD children quickly bring out a pattern of controlling and directive behavior from their peers when they must work together"* (Barkley 1995:91). Furthermore, despite their talkativeness, they fail to respond to the questions or verbal interactions of their peers, resulting in them having few friends with whom to play. Children with ADHD are often unaware of the negative responses many of their actions draw, and that their actions alienate them from their peers (Garber et al. 1996:122-125). In general, these children have an **external locus of control**, viewing the events that happen to them as being outside of their personal control (Barkley 1990:84).

Parents often fail to recognise that the demands on attention are equally important at home or during play, particularly when a child is not hyperactive or difficult to manage. They may overlook the effects of inattention in social interactions and simply label the child as shy. *"It is an interesting and sometimes heartwrenching experience to watch an ADHD child on the playground. You are likely to see quick displays of temper, rapid mood swings, lack of attention to what's going on around him, and the tendency to blame others for problems. Or you may see your child standing on the sidelines, wanting to enter the mainstream but not knowing how"* (Garber et al. 1996:125).

Barkley (1995:90-01) points out that children with ADHD are more demanding and difficult to care for from early infancy, and display more symptoms of anxiety, depression and low self-esteem than do other children. Picton (1998:133) believes that the low self-esteem and poor self-image *"aggravate existing problems, leaving them angry and aggressive towards society"*, or resulting in their withdrawal to protect themselves from further hurt and rejection. As a result of their interpersonal difficulties, they lose out on the opportunity to learn critical life-skills and experience the fun and enjoyment of

childhood (Ingersoll 1998:44). Serfontein (1990:57) cautions that, because they have a poor self-esteem, these children employ various techniques to gain the acceptance of their peers, and are often easily influenced. Children with ADHD find schoolwork difficult because they are distractible and impulsive, and when they are left behind, their behaviour deteriorates (Barkley 1995:87). The end result of the struggle with the environment may be a psychiatric disorder, such as an **Anxiety Disorder** or **Depression** (Benn et al.Undated:10).

2.6.3.1 Anxiety Disorders

To the untrained eye the restless, fidgety behaviour of an anxious child who has a poor span of attention and struggles with short-term memory could be mistaken for the symptoms of ADHD (Benn et al.Undated:10). According to Ingersoll (1998:33-34), no other psychiatric disorder, with the exception of ADHD, has as early an age of onset as anxiety disorders. Many depressed adults report onset of symptoms before fifteen years of age. Symptoms of some anxiety disorders, such as separation anxiety disorders, exist from the earliest months of life. Barkley (1990:188) emphasises that where symptoms of anxiety are seen in conjunction with ADHD, both are viewed as primary and comorbid conditions.

Separation Anxiety Disorder

Children with separation anxiety disorders protest with tears, tantrums and wails of anguish when separated from familiar people and surroundings. Some children with this disorder even follow parents into the bathroom, and insist on sharing the parental bed. **School phobia** is a common problem amongst these children (Ingersoll 1998:45).

Phobic Disorders

Children with phobic disorders suffer from **irrational fears** which cause great distress and which interfere with their lives (Ingersoll 1998:34-35). *"In some cases, phobias are so severe that exposure to the feared object or situation results in a* ***panic attack****, an episode of overwhelming anxiety accompanied* by physical symptoms such as shortness of breath, rapid heartbeat, and feelings of being choked or smothered."

Generalised Anxiety Disorder

Although the symptoms of generalised anxiety disorder are not as extreme as those of separation disorder or phobic disorder, they are still troublesome to children who are tense, anxious perfectionists who worry about everything. In particular, they worry about whether or not their own performance will measure up to standard (Ingersoll 1998:35).

Obsessive-Compulsive Disorder

OCD is less common than other anxiety disorders and is often associated with a mood disorder. Children with OCD are troubled by obsessions - persistent, unwanted thoughts or impulses that seem beyond their ability to control - and compulsions, which are repetitive acts (Ingersoll 1998:35). They suffer considerable distress which affects their everyday functioning .

Tourette Syndrome

According to Ingersoll (1998:36), a small percentage of children with ADHD have mild episodic motor or vocal tics, and an even smaller number suffer from full-blown Tourette syndrome. *"In Tourette syndrome there are multiple and persistent motor and vocal tics which, when the condition is severe, interfere with the individual's ability to function in society"*. At least half of these sufferers have ADHD and many also have OCD, depression and problems with aggression. Many have problems with associated learning disorders. More boys are affected than girls. Picton (1998:130) points out the belief that the same gene is responsible for ADHD and Tourette syndrome. Whilst some children experience tics for a short while, the person with Tourette syndrome experiences them over a period of at least a year, varying in frequency and intensity. Benn et al. (Undated:11) warn that the possible existence of this disorder should be identified, since the drugs used to treat ADHD can cause tics, or trigger the condition in a person who is predisposed to Tourette syndrome.

2.6.3.2 Mood Disorders

According to Bain (1991:29), mood disorders include depression, dysthemia, and occasionally bipolar disorder. Whilst **Dysthymic Disorder** is considered to be less severe than depression, Ingersoll (1998:32-33) warns that, it is often the forerunner of a full-blown depressive episode. Many children with ADHD suffer from a full-blown clinical **depression**, which is not merely a state of mind, but an illness that affects every aspect of an individual's life (Ingersoll 1998:32-33). Depressed children are likely to be irritable, whiny, and prone to bad moods. They complain of aches and pains for which no medical cause can be found, and are vulnerable to every bug that comes along. They often have trouble falling asleep or may suffer frequent awakenings throughout the night, so they often complain of fatigue and low energy. They have a pessimistic outlook on life, and may withdraw from friends and social activities. In severe cases, they may even attempt suicide. Depression tends to coexist with other comorbid disorders, making symptoms more severe and treatment more difficult. *"People with **bipolar disorder** experience alternating periods of depression and mania"*, (Bain 1991:29). During the manic periods, they may appear hyperactive and distractible, and they may behave impulsively, taking risks without thought of consequences. Bipolar disorder was considered to be rare in children. However, Ingersoll (1998:33-34) points out the recent finding that at least one in four children who suffer from depression will develop a bipolar disorder. *"Those at greatest risk are youngsters with a history of severe hyperactivity, serious temper outbursts, an unstable mood, along with a family history of bipolar disorder and alcoholism"*.

2.7 CONCLUSION

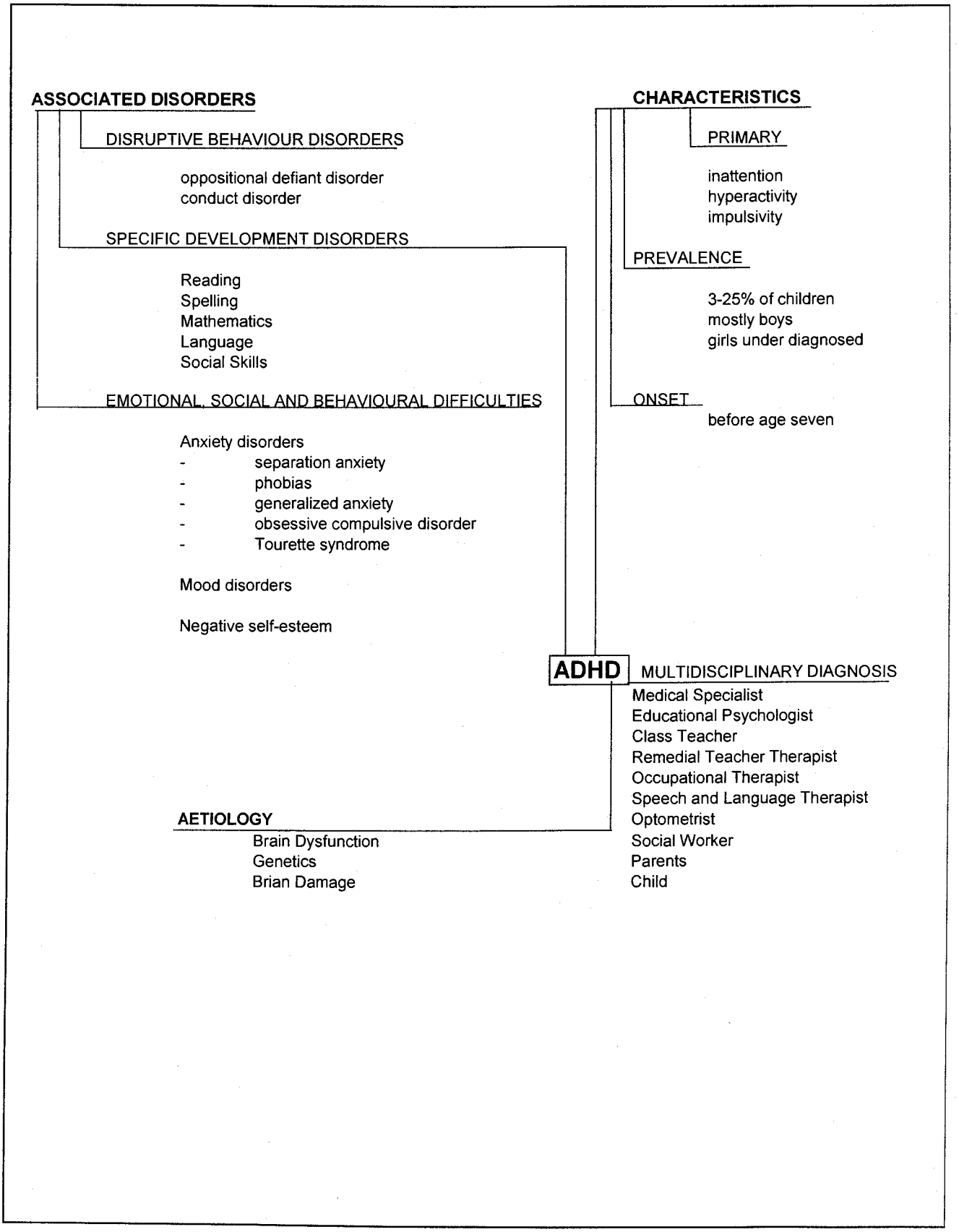
This chapter has laid an important educational foundation to enable the educational psychologist to facilitate the understanding of ADHD for parents and teachers in respect of historical background, the nature and aetiology of the disorder, as well as the diagnosis and the impact of comorbid conditions.

Descriptions of inattentive, impulsive and hyperactive behaviour in children appear in texts as old as the Bible. Despite the blizzard of well-controlled research which has dramatically increased our knowledge, controversies rage. In the eighties, many children with ADHD went unreferred, undiagnosed and untreated, whilst today, it is suggested by some, that the pendulum has swung in the other direction, resulting in inappropriate diagnosis and treatment for those whose behaviours result from other problems. The complex interaction of a variety of factors with the symptoms complicates the diagnosis, underscoring the need for caution, patience and tenacity. It has been demonstrated how the environment of the child and comorbid conditions represent powerful factors which impact on treatment success.

Whilst it has been shown that children with ADHD are not alike and will exhibit different patterns of behaviour, development and later risks, all share the problem of reduced ability to inhibit behaviour and sustain effort to activities. Regardless of the way they present, and despite the challenges they pose to the significant people in their lives, all children are in need of adult care, support, guidance, nurturance and love. It is the responsibility of the educational psychologist to facilitate this process, so that all these children are able to recover from the symptoms and are guided effectively towards adulthood.

The following chapter will address the issue of intervention, from a multimodal perspective, in an effort to enhance the child's transition towards adulthood. Alternative therapies will also be discussed.

Figure 1: Diagrammatic Summary of Chapter Two



CHAPTER THREE

INTERVENTION

'Tis skill, not strength, that governs a ship.
Thomas Fuller (Nelson-Jones 1993:1)

3.1 INTRODUCTION

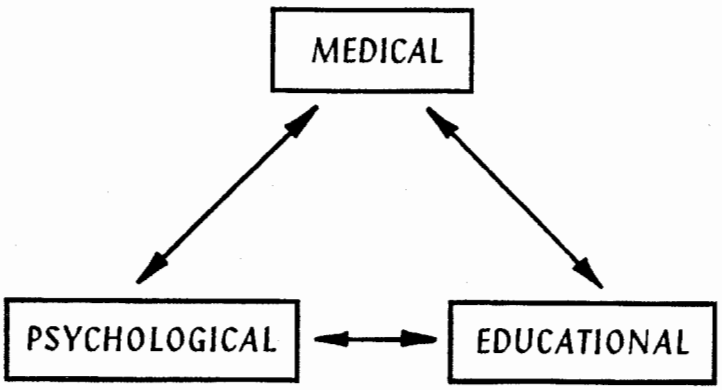
Goldstein and Goldstein (1998:458) point out that ***"pills will not substitute for skills"***. Based on their experience, they are of the opinion that when parents understand the cause of their child's problems, and are able to incorporate behavioural techniques and strategies into their management of their child, they are better able to attribute problems benignly. No training is given to parents of a newborn baby. No qualification is deemed necessary for the very crucial task of parenting any child, let alone one who poses the challenges that a child who has ADHD poses. Yet, the parents remain responsible for guiding the child towards adulthood, since, as Langeveld (Van Niekerk 1986:2) postulates, the child wishes to be someone in his own right, but full human status can only be achieved with the assistance of adult educators. This point of view is reinforced by Debroitner and Hart (1997:20) who state that *"Children, being immature, unformed and dependent by nature, cannot initiate their own recovery from attention deficit disorder"*.

Although ADHD cannot be cured, many professionals over the centuries have altered the lives of thousands of distressed children and their families, despite opposition from many quarters. By gaining control, the child is better able to function in various aspects of his life, at home, school and socially. Self-control is essential to prevent potential major emotional, social, career and other problems in the child's life. According to Nash (1994:98), the main goal of management is to enable the child with ADHD to make use of the best available means to normalise his attention and behaviour so that he is more able to achieve his full potential in the full range of activities, despite his disability. Nash stresses the need for a continuous process of awareness and for regular assessment of the condition and of progress, in view of the variable nature of ADHD, so that specific treatments can be modified where necessary. Since each child with ADHD and the situation in which he finds himself is unique, the various treatments used must suit his individual needs and those of his family.

Bloomquist (1996:x) informs us of greater treatment success when parents are actively involved in child focused interventions. He points to research which shows that children who receive multi-modal interventions have the best outcome in later years. Whilst Goldstein and Goldstein (1998:456) claim that available research data argues strongly in favour of medication as a first-line treatment for children with ADHD, education about the disorder and modification of tasks to make them more interesting, as well as payoffs to the child, should be considered as integral parts of the multi-modal treatment plan.

"The main members of the management team are the child himself, the parents and his teachers" (Nash 1994:99-100). Nash underscores the importance of these members working closely together, carrying out activities in a consistent way so that everyone is clear about what is being done and what still needs to be done. Other members may be a paediatrician, neurologist or psychologist, as well as other professionals who may need to become involved because of the presence of related conditions. In the view of Nash (1994:101-102), *"There are three main broad groups of effective treatments available"*, utilising various medical, psychological and educational methods. Frequently, particularly in the case of the more severe forms of ADHD, a combination of interventions is required. These methods often enhance each other as illustrated by their relationship in the figure which follows:

Figure 2: The Three Main Broad Groups of Treatment



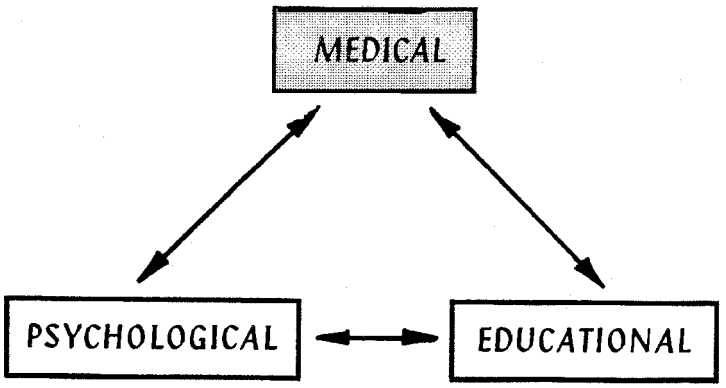
3.2 MEDICAL MANAGEMENT

I don't care what causes it. I just want to help my child.

Mother at an ADD conference (Diller 1998:214)

In late twentieth-century America, when it is difficult or inconvenient to change the environment, we don't think twice about changing the brain of the person who has to live in it.

Ken Livingstone (Diller 1998:312)



Gilbert (1998:34) points to evidence that has shown that ADHD is ***"a definite clinical condition caused by specific chemical imbalances"***. Whilst there is no actual brain abnormality, there appears to be a deficiency in the way in which messages in the brain are transmitted.

Some people consider that medication should be used as a last resort, but Nash (1994:109) argues that it should be the first line of treatment, since it has been proven scientifically to be effective, it works quickly, is simple to use and is less time-consuming than other strategies. Furthermore, many medications are inexpensive. Most important

of all, medication enhances other forms of treatment. When the child's internal environment is corrected, appropriate external strategies are more likely to be effective (Nash 1994:105). Train (1996:32) emphasises that when difficult behaviour is persistent and pervasive and seriously impairs development and the lives of those in the child's environment, medical treatment should be provided. Medication can improve behaviour, thinking and learning ability, as well as the child's relationships with others (Munden & Arcelus 1999:85).

Our knowledge about medication and who is most likely to benefit from it has increased considerably over the past decade. There is also a great array of medications currently available. Whilst many myths and misconceptions still abound, with media coverage periodically fuelling parents' fears, particularly regarding stimulant medications, the general population seems better informed and the use of medication in the treatment regimen of ADHD has gained greater acceptance. Ingersoll (1998:84) underlines the belief that medication is the most effective form of treatment for ADHD. She maintains that improvement can be so dramatic that no further intervention may be necessary. Nash (1994:105) believes that, when children have mild ADHD without complications, medication may be all that is needed. However, Gilbert (1998:68) cautions that no medication magically alters the behaviour of a child affected by ADHD. She maintains that *"Drugs are just one part of the range of treatment available, the most significant part of which is behaviour modification techniques which are used in each and every situation in the child's life"*. Nevertheless, she acknowledges that when drugs are used alongside behaviour modification, some children have excellent results. Benn et al. (Undated:12) are of the opinion that behaviour modification should be tried before medical intervention is considered. The importance of heeding this advice becomes particularly meaningful when one considers the rather scary proliferation of prescriptions for Ritalin in recent years. Livingstone (1997:5) reports a fourfold increase in the rate of methylphenidate consumption in America between 1989 and 1994.

3.2.1 **Groups of Drugs**

There are two main groups of drugs used in the treatment of ADHD. The most commonly used is the **stimulant** group of drugs, which offers an effective means of controlling symptoms. **Antidepressants** are also used (Hallowell & Ratey 1994:237).

3.2.1.1 Stimulant Drugs

Stimulants have been used in the treatment of hyperactivity since 1937. It is suspected that they *"have an effect on the body's neurotransmitter chemicals thus enabling the child to better focus attention, control impulsiveness, regulate motor activity, improve visual-motor coordination, and in general exhibit more purposeful, goal-oriented behavior"* (Parker 1994:20). Approximately seventy percent of children with ADHD show improvement on stimulant medication. Livingstone (1997:9) reminds us that, since there is no way to know which drugs will be useful for any individual, **trial and error** methods are used to see which drug treatment improves the troublesome pattern of behaviour. He cautions that administration should not be used as a diagnostic tool, since research has shown that stimulant drugs improve the performance of even those people who do not have ADHD.

Livingstone (1997:8-9) believes it is worth spending time trying to understand the theory of James McCracken (1996) and his colleagues at the University of Texas Health Science Center in San Antonia. They proposed the ***"catecholamine hypothesis"*** to explain the working of the brains of people with ADHD.

The catecholamines are among the dozens of special chemicals in the brain, known as neurotransmitters, that make it possible for the millions of nerve cells in the brain to communicate with each other, allowing activities of the mind, such as reading, to take place. *"When a nerve cell 'fires', it releases tiny amounts of these chemicals into the small gaps, called synapses, that separate it from the cells to which it sends connections. These chemicals diffuse across the gap and attach themselves to special receptors on the receiving cell. Upon attaching, they change the chemical balance inside the receiving cell, making it more or less likely to fire in its own turn."*

These electrochemical processes must occur at the right levels of intensity and in the right patterns for the mind to function effectively. Too much or too little of a neurotransmitter released in various parts of the brain may lead to a disorder, such as when there is an imbalance in the circuits that control attention and some form of ADHD results. *"The right balance must be appropriate to the kinds of tasks and situations one encounters"*,

and so it is likely to be different for different people. Stimulant drugs affect the balance *"by increasing the amount of time that catecholamine molecules remain active in certain synapses"*.

Benn et al. (Undated:14) state that stimulants:

- *are extremely safe, having been studied for over forty years*
- *are not addictive in children*
- *do not sedate the child*
- *improve attention span*
- *reduce symptoms and improve behaviour management*
- *decrease restlessness, fidgetiness, overactivity, inappropriate behaviour*
- *can improve aggressiveness*
- *improve ability to sit still and concentrate on one task for longer*
- *improve ability to relate socially to other children, so confidence and self-esteem improve, and child has more friends*

Examples of stimulant drugs used in South Africa are **Ritalin** and **Dynalert** (Benn et al. Undated:14).

Ritalin

Gilbert (1998:70-72) claims that Ritalin is the most commonly used drug for the treatment of ADHD. It has an excellent safety record. Benn et al. (Undated 15) state that Ritalin is short-acting - about four hours, and that the benefits are almost immediate - between fifteen and forty-five minutes after administration. They believe that the child should be given the lowest possible dose to begin with, which can then be adjusted according to response, to a maximum dosage of 60 mg per day. Ritalin is not usually recommended for children under the age of six years.

According to Gilbert (1998:71-72), side effects can occur, including mild sleep disturbance, loss of appetite, mild irritability and occasional twitching (tics). She suggests that, if side-effects occur, parents should speak to the prescribing doctor who may change

the dose or move the child to another drug. However, she advises that minor side-effects can be avoided as follows:

* The last dose of the day can be taken well before bedtime to reduce sleep disturbance. Many children cope adequately with a morning dose followed by a smaller dose at midday.
* Ritalin can be given before or with a meal to prevent the loss of appetite.
* Irritability can be controlled by avoiding 'triggering' situations, along with other behaviour modification techniques.
* Tics can be controlled by reducing the dose.

Benn et al. (Undated:15) reassure that ***"Many of the side effects disappear after a week or two"***. They add increased hyperactivity as a side-effect and warn that Ritalin should not be given if there is no improvement in this condition after a three to four week period, or in the case of Tourette Syndrome. Epilepsy can also be aggravated and the dosage needs to be carefully adjusted with anti-epileptic medication. Hallowell and Ratey (1994:237-239) caution that it may take months to find the right dosage and suggest that patience is exercised during the process.

Dynalert

Dynalert is a long-acting drug which is recommended to be taken with meals, in doses of 0,5 to 1 mg per day and adjusted according to the response. According to Benn et al. (Undated:15), side-effects include an increased heart rate, nervousness and disturbance of liver functions.

3.2.1.2 Non-stimulant Drugs

Children with severe anxiety or depression in addition to the ADHD may not respond to stimulants and their symptoms may actually worsen with its use (Munden & Arcelus 1999:93). Stimulants are discontinued when they do not control the ADHD or when they produce troublesome side-effects (Nash 1994:105-106). Non-stimulant drugs are usually only considered when stimulants have been tried unsuccessfully (Benn et al. Undated:14).

They offer similar benefits to the stimulants. Examples of non-stimulant drugs used in South Africa are **Tofranil, Tryptanol, Aurorix** and **Dixarit.**

Tofranil and **Tryptanol**

Tofranil and Tryptanol are long acting drugs, which can be given once daily, and which can be combined with stimulant medication, provided doses are appropriately adjusted. Their use is indicated for depression and bed-wetting and they can be given to children under six years of age (Benn et al. Undated:15). Possible side-effects include sedation, a dry mouth, constipation, increased heart rate, blurred vision, retention of urine and emotional upset.

Aurorix

Aurorix has not been extensively tested for ADHD, but is sometimes prescribed as it avoids many of the possible side effects of Tofranil and Tryptanol (Benn et al. Undated:16).

Dixirit

Dixirit controls impulsive, overactive behaviour and improves the ability to sleep. It is generally used in combination with stimulant medication. It can take up to two weeks before the effects are noticed (Benn et al. Undated:16).

3.2.1.3 New Possibilities

Adderal

Ingersoll (1998:85) refers to the recent introduction of **Adderal**, a combination of four amphetamine salts used for weight control, for the treatment of ADHD. In a study comparing its effects with those of Ritalin, it was rated superior in terms of symptom control and side-effects.

BuSpar

BuSpar, an anti-anxiety medicine, is currently being studied for use in children who have ADHD and symptoms of anxiety (Koplewicz 1996:83).

3.2.1.4 Combinations of Medications

Often a combination of medications is required, depending on the specific target symptoms and behaviours which need to be managed. In addition to the ADHD, the child may be aggressive or depressed. He may bedwet or he may also have Tourette Syndrome. All these conditions need to be treated (Nash 1994:107). *"Sometimes the addition of another medication will allow the first medication to work better"* (Hallowell & Ratey 1994:239).

3.2.1.5 Monitoring the Medication

Nash (1994:108) points out that ADHD is a chronic disability and the symptoms are variable. He stresses that regular review is necessary to determine progress and modify treatment if indicated. Hallowell and Ratey (1994:74) believe that *"The parents are in the best position to monitor the effects of the drug"*.

Some children experience **"rebound"**, or a deterioration in behaviour, when the effects of stimulant medication wear off and it may be necessary to alter the dose to manage this. Sometimes, after months or even years of successful treatment, children develop a tolerance to the medication. Although this is usually temporary, it necessitates a change in medication for a while. When the medication is reintroduced, it is usually effective again (Nash 1994:106-107).

According to Benn et al. (Undated:16):

> ***Children on medication should have regular checkups. Parents should talk to the child's teacher regularly.***

Side-effects may occur and these need to be reported by the parents and closely monitored by the prescribing doctor. The child may need the dose of medication adjusted as he grows. Doctors monitor the height and weight of children on medication. However, Munden and Arcelus (1999:91) reassure that *"Despite previous concerns, there is good evidence that Ritalin does not stop children growing"* but rather that '**growth delays** ' observed in children on stimulants are related to the developmental delay that is a part of the ADHD itself. Gilbert (1998:68-69) stresses the importance of liaison with nursery school or school staff who should inform the parents if the child is regressing to more difficult behaviour. Furthermore, his behaviour may be different at school. Since the child taking the medication may not always be aware of its effect, the assessment of efficacy should include reports from other people in his environment. **Behavioural checklists** filled out by the teacher can be particularly helpful (Hallowell & Ratey 1994:240), despite the problem of them depending on subjective judgements (Armstrong 1995:14).

Medication can be discontinued during school holidays and during weekends. However, Nash (1994:110) cautions that the disability of ADHD does not *'switch off'* and, in severe cases, it is usually necessary to medicate every day to improve the child's self-control. Parker (1994:23) reminds us that the main purpose of administering medication is to improve the child's behaviour, in the classroom, in social settings and at home. Munden and Arcelus (1999:93) maintain that children have more to learn than just schoolwork. *"There is so much to be enjoyed and learnt in life, including getting on with your family and friends and being able to safely participate fully in all the opportunities life offers".*

Hallowell and Ratey (1994:240) recommend a discontinuation of the medication for a week or so every four to six months. This provides an opportunity to decide whether or not the medication is still necessary. However, Koplewicz (1996:83) maintains that the parents usually dread this, since they may find the child extremely difficult to manage during this time. In particular, Munden and Arcelus (1999:92) warn that this must be a planned exercise, carried out at a time of the year when the child's chances of success in examinations or other important events are not jeopardised.

3.2.1.6 Informing the Parents

Many parents have great difficulty in accepting the long-term use of medication by their child. It is an issue which needs to be handled sensitively. Nash (1994:110) believes it the responsibility of the prescribing doctor to provide parents with sufficient information regarding medication so that they can make an **informed decision**. Gilbert (1998:68) says that doctors must address the parents' secret fears. They need to be reassured that there is no evidence that the drugs are addictive. She argues that ADHD can be as life-threatening to the child as an illness such as diabetes or epilepsy, since the sufferer is in constant trouble and possibly friendless as a result of impulsivity and lack of concentration. *"So if there is a drug available which can help him to control these characteristics, it is surely sensible that it should be used to enable the child to grow up happily, and develop his full potential"*.

Bain (1991:92) rationalises that medication does not make the child smarter or perfect, but it can relieve some of the child's difficulties and enable him to tackle problems more successfully. Medication ameliorates the problems, just as a pair of glasses helps the nearsighted person to see better, but it does not cure the syndrome (Hallowell & Ratey 1994:239-242). It is important that parents learn that the administration of medication is not done as an act of faith, but rather an act of science. Hallowell and Ratey (1994:244) tell their clients that medication has proven to be extremely useful for some people, ineffective for others and, for a very few, it has even been harmful. However, if the diagnosis of ADHD has been carefully made, they state that, based on the best research data, a trial of medication is indicated.

3.2.1.7 Informing the Child

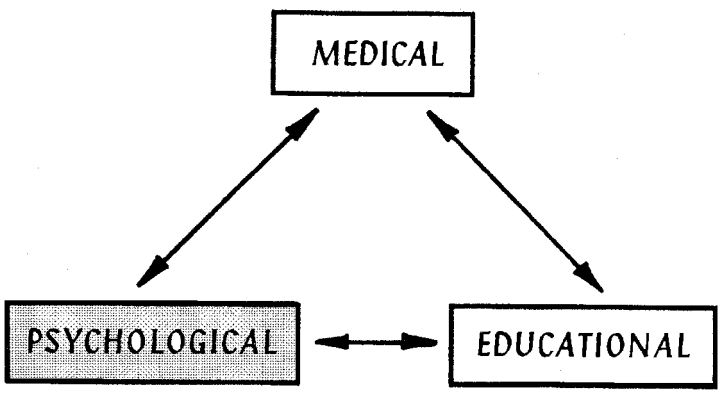
Gilbert (1998:69) believes that children like to conform and, since taking medication is not the norm for most children, explanations must be given. She suggests that a knowledgeable friend or close relative should give the explanation, since the child may pick up on the parents' worries regarding administration. However, the explanations have to be consistent, so parents need to be aware of the exact information the child has been given. It is also essential that subsequent questions asked by the child are answered with complete honesty.

Some children believe that medication is being administered as a punishment because they are **naughty** (Munden & Arcelus 1999:85). Since children often feel that taking medicine is like admitting that something is wrong with them, or a crutch that they should not need to use, Hallowell and Ratey (1994:236) emphasise that *"It is essential that these feelings be explored and dealt with gently and respectfully"*. Parker and Parker (1993) have written a story, called ***Slam Dunk,*** about a young boy's struggle to succeed in school because of his ADHD. With the help of his parents, teachers and concerned health-care professionals, the boy in the story learns about the condition and ways to help himself. At the end of the story, commonly asked questions about symptoms, causes, treatments and outcomes are discussed frankly and positively. Helpful ideas are presented for developing good study and homework habits, as well as for improving social skills and reducing impulsive thinking.

3.3 PSYCHOLOGICAL MANAGEMENT

Wisdom comes when hindsight turns into foresight.

Deborah Rozman (Debroitner & Hart 1997:183)



By the time a diagnosis of ADHD is made, the family will in all probability have been through considerable stress in trying to deal with the behavioural and/or learning difficulties that the disorder presents. Whilst greater compliance is usually shown to father's instructions, mothers, who spend much more time with the child in general, are frustrated in their efforts to get him to listen. Sibling relationships are more strained than usual, exaggerated by the temperamental emotional make-up of the child with ADHD. For this reason, Parker (1994:27-28) stresses that **psychological intervention** is a very necessary component of the treatment plan.

Munden and Arcelus (1999:100) point out *"that there are more feelings and damaged relationships to sort out than initially meets the eye"*. They believe that both parents live with feelings of despair, fear, humiliation and defeat when their children suffer difficulties which cause problems in their relationships. Furthermore, teachers, social workers and others who work with children with ADHD feel humiliated and frustrated when accused of incompetence or not caring. The thoughts, feelings and actions of all concerned need to be recognised and addressed.

According to Debroitner and Hart (1997:197), psychotherapy can be useful for gaining access to **deeper levels of mind**, **gaining awareness of unproductive patterns** and **motivating positive change**. *"Forming a relationship with a knowledgeable professional guides you through the process"*. They refer to studies which indicated positive results in achieving goals set when clients entered into therapy and an alleviation of mental distress. In fact, research has even shown that psychotherapy can change brain chemistry.

According to Munden and Arcelus (1999:101), mental health workers will utilise a number of different therapies in their efforts to make up a tailor-made package of care which meets the child's individual needs within his own personal life situation. They believe that most parents are sensible, but would welcome any practical help and suggestions that may work. In particular, they advocate **parent training** and **behavioural therapy** as treatment options.

3.3.1 **Individual Therapy**

Parker (1994:29) believes that the child with ADHD may benefit from supportive counselling to help repair injured self-esteem, overcome feelings of demoralization or depression, learn more effective problem-solving behaviour patterns and better understand his behaviour. *"Some of the signs and symptoms of ADHD are at least in part the result of earlier life experiences"* (Munden & Arcelus 1999:109). Individual therapy allows the child the opportunity to explore his feelings, thoughts, relationships and experiences within a safe, rewarding and beneficial relationship.

Geldard and Geldard (1997:2-7) maintain that, since children are unlikely to benefit from conversational therapy, we need to use verbal counselling skills in conjunction with other strategies, such as play, drama, story-telling or in the use of media, such as miniature animals, clay or various forms of art. They stress the need to have clear ideas about how goals can be achieved and identify four different levels at which goals can be set:

Table 7: Therapeutic Goals

Level 1	Fundamental Goals
Level 2	The Parents' Goals
Level 3	Goals formulated by the Counsellor
Level 4	The Child's Goals

All these goals need to be kept in focus by the counsellor during the therapeutic process. It is the counsellor's responsibility to see that the goals are achieved by ensuring that the counselling relationship positively influences the final outcome of therapy. It is assumed that the therapists who counsel children with ADHD are trained in basic counselling skills and so this process will not be covered in depth in this work. Munden and Arcelus (1998:109-110) stress that this counselling should only be undertaken by appropriately skilled, trained and supervised therapists, since *"bad therapy is worse than no therapy'*. They believe that a bad therapist may inadvertently do a great deal of harm.

The most important contemporary idea is to select from a wide range of practice methods in an effort to achieve the best possible outcome for the child in the most cost-effective way. Sometimes, as has been highlighted throughout this work, it may be appropriate to work with a child in the context of the family, or with parents or by using a combination of therapies (Geldard & Geldard 1997:35). A number of the popular therapies used with children will be briefly described in the section which follows.

3.3.1.1 **Psychodynamic therapy**

Following in the footsteps of Sigmund Freud, *"**psychodynamic therapists** seek to help patients recognize and come to grips with the unconscious conflicts, fears, and fantasies that interfere with their ability to cope with the demands of everyday life"* (Ingersoll 1998:106). Kaduson and Schaefer (1997:19) point out that children communicate best through play which is a natural medium for self-expression. In play, their defences are reduced and they are allowed to enact thoughts and feelings of which they are aware but cannot express in words.

According to Ingersoll (1998:107-108), *"Insight-oriented therapists who work with children use puppets, dolls, art materials, games and toys to help them understand the child's fears, needs and inner turmoil"*. As the child comes to grips with painful memories and frightening thoughts, *"his inner stress subsides and he is able to behave and interact with others in a more appropriate and more satisfying manner (Ingersoll 1998:108)*. Wallace (1996:233) cautions that therapy should be undertaken by someone who likes children and, in particular, likes children who have ADHD, since these children are perceptive and will soon dismiss a therapist if they sense anxiety, rejection or disapproval. They will not respond to a boring, dull or confined setting. Therapy should be transferred from the clinic setting to real life through contracts and reminder sheets.

In Ingersoll's view, the problems of impulsivity, hyperactivity and inattention do not respond to psychodynamic psychotherapy (1998:108). However, it can be of considerable benefit for the emotional problems such as anxiety, depression and poor self-esteem that often co-exist with ADHD.

3.3.1.2 Behaviour therapy

Behaviour therapists believe that specific behaviours are learned because they produce specific consequences which the individual experiences as either positive or negative (Ingersoll 1998:106). Sometimes referred to as **"behaviour modification"**, this form of intervention seems tailor made for many of the problems faced by children with ADHD (Ingersoll 1998:114-115). Ingersoll points out that *"the overriding principle of behavior therapy is that behavior is affected most strongly by consequences that immediately follow the behavior"*. She claims that consequences need not be dramatic to affect behaviour, but may even be a smile or a frown, known as **social consequences**. **Positive consequences** tell us that we are on the right track, whereas **negative consequences** signal an error. However, negative consequences do not provide us with information on what we should do, but only what we should not do. Munden and Arcelus (1999:103) claim that behaviour therapy is based on the idea that, since all behaviours are learned, they can also be unlearned. The two main behavioural approaches Munden and Arcelus (1999:109) recommend are the **ABC Analysis** and **Positive Reinforcement**.

ABC Analysis

This behavioural approach, recommended by Munden and Arcelus (1999:103-105) *"is based on the notion that the expression of most behaviour is influenced by **Antecedent** events (what happened before the **Behaviour**) and **Consequent** response (what happened following the behaviour")*. Since altering the antecedents or consequences of any unwanted behaviour may change the frequency or occurrence, parents are asked to record the events happening prior to the child's unwanted behaviour. Together, the parents and the therapist try to establish a pattern that may illustrate how the child exhibits the unwanted behaviour in certain circumstances. The parents are also asked to record events happening following the child's behaviour in case the child acquires gains as a result of the behaviour. For example, if the child does not enjoy sitting quietly in the lounge with visitors, he may misbehave if the punishment is that he goes to his bedroom, where he has his computer, so inadvertently, the parents are rewarding his negative behaviour. A brief summary of the technique follows:

Table 8: ABC Analysis

Antecedent events, such as: 1. *What was happening before the unwanted behaviour?* 2. *Who was present when the unwanted behaviour occurred?* 3. *Where did the behaviour occur?* 4. *What time of day did the behaviour occur?*
Description of the Behaviour: 1. *How is the onset of the behaviour?* 2. *What did the child do or say?* 3. *How frequently does this behaviour happen?* 4. *How severe is this behaviour?* 5. *How long does this unwanted behaviour last for?*
Consequences, such as: 1. *Changes in the demands and expectation of the child by others following the unwanted behaviour.* 2. *Changes in the amount of attention that the child receives following the unwanted behaviour.* 3. *Attainment of child's immediate goals and wants.*

Positive Reinforcement

According to Ingersoll (1998:116), *"Positive consequences, or reinforces, are the most potent tool in a good behaviour management program, and how you select and use them will determine the success of your program"*. Reinforcers that are meaningful to the child must be used if they are to be effective. *"There is not much point in using a chocolate icecream as a reward for a child who doesn't like chocolate or icecream"* (Munden & Arcelus 1999:106).

Type of Reinforcers

Everyday activities that the child enjoys can be used, for example, watching television, talking on the telephone, playing computer games, going for a walk with Mom or playing a game with a grandparent. Young children respond well to star charts. Munden and Arcelus (1998:106-107) suggest that rewards should be given as soon as possible after the behaviour has occurred and should be altered frequently since specific rewards may lose their appeal after a while. Ingersoll (1998:116) suggests the following tips should be kept in mind when selecting reinforcers:

- **Avoid the 'goodies trap'**. Let the child earn expensive items through a rental programme rather than buy special treats. For example, the child may earn the privilege of using a stereo if he completes homework in a satisfactory manner for a week.

- **Use lots of praise.** Smiles, winks and hugs yield huge dividends in good behaviour. Wallace (1996:148-149) recommends that a **Success Book** be gradually built up, in which any small achievements can be recorded, for example, when the child behaves at a birthday party, the invitation can be pasted into the book with a positive comment next to it. Wallace stresses that *"A Success Book is effective only if it is constantly updated"*.

Ingersoll (1998:117-118) recommends the following ideas when using positive consequences:

- **Be generous; reinforce often.** Scientists have observed that the behaviour of children with ADHD improves markedly when reinforcers are delivered frequently but that it deteriorates more rapidly than that of other children when reinforcers are few and far between.

- **Reinforce small steps toward improvement.** Children with ADHD live very much in the present and find it difficult to wait for long-term payoffs. Small reinforcers for goals which are within the child's reach should be offered.

- **Do not reinforce what has not yet happened.** Children with ADHD are quick to make promises but are very slow to keep them. To avoid the dilemma, keep in mind the old-fashioned rule: ***"Work before you play"***.

Munden and Arcelus (1999:105-106) add the following ideas:

- **Specify with the child the behaviour that is expected.** The child needs to understand the meaning of good and bad behaviour.

- **Explain to the child the consequences of good behaviour.** The child will then be aware of when and what he will get for appropriate behaviour.

- **Ignore undesired behaviour** (within reason). A child who is always in trouble will become discouraged and may give up trying to be good.

- **Help the child attain the desired behaviour by planning ahead.** Parents should avoid putting the child in situations where he is likely to fail, for example taking him to the supermarket if he finds it impossible to wait patiently in a long queue.

For more complicated behaviours, it is important to reinforce in small steps, a process referred to by Parker (1994:45-46) as **shaping**. An example would be to shape the child to pay better attention to homework by providing positive reinforcement at several points in the process of homework completion, such as for writing down the complete homework assignment at school, bringing home the correct books, getting down to work at the correct time and several times while he is doing the homework.

Negative Consequences

Whilst Ingersoll (1998:118-119) does not advocate only positive consequences, based on research findings that show that positive consequences alone are not enough, she does warn that punishment can lead to an increase in undesirable behaviour and also has an adverse effect on the one who doles it out, who may feel guilty about negative interaction with the child.

Types of Negative Consequences

According to Ingersoll (1998:121), negative consequences should not be harsh, humiliating or painful. The point is rather to steer the child away from the poor behaviour. She recommends time-out and penalties as negative consequences (Appendix I4.2).

Whilst she points out that behaviour therapy is an effective means of controlling the child's behaviour, she warns that it is not a panacea or a cure, and like stimulant medication, the effects do not last if the treatment is stopped. Furthermore, point programmes require a considerable amount of organisation and follow through, which the single parent or a parent with ADHD may not be able to manage successfully.

3.3.1.3 Cognitive therapy

Cognitive therapy takes a direct approach to treating disturbed behaviour. People are taught to identify, challenge and change patterns of self-defeating thought, beliefs and attitudes in an effort to bring about changes in emotions and behaviour. The techniques have been applied to a variety of problems, including those characteristic of ADHD, depression and anxiety (Ingersoll 1998:106). The methods used are usually combined with the methods devised by Albert Ellis, who developed the "ABC Model", which explains how what we believe (B) about an adverse event (A) results in how we feel as a consequence (C). With regard to the child with ADHD, programs were designed which encouraged these children to 'stop, look and listen" or to ask, "What is the problem?" and "What do I have to do?" Finally, the child was taught to check his progress along the way and to review his work for careless errors.

Once again, disappointing results were reflected in this type of approach with children with ADHD. Parents were offered the false hope that their children would learn strategies to control their behaviour, eliminating the need for medication. However, cognitive therapy has been shown to benefit children with coexisting mood and anxiety disorders (Ingersoll 1998:110).

3.3.1.4 Problem Solving Skills

Children need to be given the opportunity to make their own decisions so that they learn to come up with their own solutions to problems in their everyday life and are allowed to take responsibility for their choices (Parker 1994:61). Children with ADHD find it difficult to problem solve. These skills can be taught to the child. He is encouraged to study the problems he experiences, to look at possible courses of action and the impact of these courses of action and then to choose which one to take. Finally, he should review success or otherwise (Munden & Arcelus 1999:110).

Bloomquist (1996:16) believes that only children who have a mental age of over eight years can benefit from problem-solving training. He refers to research which has established that this therapy is successful in reducing aggressive behaviour in children but not for improving the behaviour of children with ADHD. As a result, it should not be the sole intervention for the child but should be used in combination with other interventions.

3.3.1.5 Therapeutic Story Telling

Kaduson and Schaefer (1997:32-33) refer to the well-known fact that children are interested in stories, both in listening to them and in telling them. Story-telling may aid the child in generating **alternative thoughts**, **feelings** and **actions** regarding a particular struggle he is having. Gardner (1993:xiii-xv) states that story-telling is not a therapy per se, but rather one technique in the therapist's armamentarium. He believes that the therapist has a better chance of being heard when he speaks in the child's own language and points out that stories have traditionally been used to educate children and impart behavioural patterns that are appropriate in a particular society.

Shapiro (1994:33-34) observes that children have been profoundly influenced by therapeutic books and underlines his belief that it is one of the most effective techniques in a child therapist's arsenal. Therapeutic books include **metaphoric books**, such as fables and fairy tales, **realistic books** about the common problems children face and with which they have to cope, **informational books** which explain problems and offer solutions and **workbooks** which provide interactive experiences for children to learn

'psychological skills'. They can be read by children or to children. Oaklander (1978:91-92) observes that children respond better to stories that have been written to entertain the child than to books which are written specifically for getting at feelings. In particular, she believes that **fairy tales** and **folk tales** offer a wealth of material for working with children. She expresses that, although these stories are not always pleasant, *"they spring from the depths of humanity and involve all the struggles, conflicts, sorrows and joys that people have faced through the ages"*.

Many books which address the psychological issues of children are available which are almost always effective on some level. Shapiro (1994:34-35) points out that books written by a therapist for a child are particularly special. They are a tangible representation of the therapeutic process which can be read and re-read, and which convey an unspoken message from the therapist to the child that *"I care about you a great deal. I am willing to take the time and energy to create something just for you, which you can have with you for as long as you like"*.

Brett (1988:26) believes that stories offer a learning experience to the child who can absorb the message at his own rate, on his journey towards **hope** and **understanding**. Lankton (1983:397) states that *"The unconscious mind of the child, as with the adult, is set to the purpose of learning to cope with and master the ecosystemic demands which face them"*. Mills and Crowley (1986:xviii-xix) underline the fact that children are generally receptive to story-telling, preferring this to being *'talked-at'* by some parent. They found that, because of the child's natural receptivity to metaphor, a conscious and directed application of a therapeutic metaphor via story-telling produced effective and gratifying results.

Since any child's concerns depend on the actual situation at hand, as well as the child's temperamental style, stories should be modified to fit into the child's situation. Issues which apply to the particular child should be woven into the tale so that the child can identify with them (Brett 1988:6-7). Brett (1988:12-14) believes that we cannot solve our children's problems for them, but we can help them by *"giving them strength, a belief in themselves, and the confidence and hope to seek a successful resolution of their own"*. She feels that we can talk to our children through stories of the ways *"of the world, of the fact that there are seasons of hope as well as despair, of the knowledge that there are*

times when even the strongest feel weak and times when even the weakest can learn to feel strong". The awareness that other people have experienced similar feelings and problems makes the child feel less isolated and inferior. Whilst stories do not provide a magic wand which whisks away the troubles and pain of the real world, they allow children to learn more about themselves and their problems.

Stories can be used to suggest new possibilities, to get a client's total attention, to evoke abilities, to intersperse suggestions and to establish hope and optimism by exposing the client to a happy ending. Since the tales are free from confrontation, the client may be less resistant. Children may unconsciously integrate the components of stories, develop a new attitude towards conflicts and borrow the skills and solutions that the protagonist uses to overcome problems (Kaduson & Schaefer 1997:36).

3.3.2 **Family Therapy**

Family therapy may refer generally to any type of therapy in which other family members are directly involved. It may also refer to a specific way of thinking about how the child's disturbed behaviour reflects disturbances in the overall functioning in the family (Ingersoll 1998:106). *"The term appeals to parents of ADHD children because many are acutely aware of the difficulties their ADHD child's behavior causes in the family"* (Ingersoll 1998:111). Bloomquist (1996:16) maintains that, even if the parents are not the cause of the disruptive behaviour manifested by the child, they are likely to be a big part of the solution.

Armstrong (1995:203-205) points out that, *"In family systems theory, each member of a family is seen as an interconnected part of the whole, and each member influences and is influenced by every other member."* Problems that arise, such as hyperactivity, may represent a response to some kind of tension existing in the family matrix. Research clearly indicates that families with children with ADHD are not trouble-free, with evidence of higher levels of marital stress, parental psychopathology, (including depression and anxiety), and other life stresses. There is also well-documented research which suggests that *"different family structures significantly affect the outcome of a child's experience with the 'disorder'"*. Too often, the family projects the deeper systemic problems onto

the child who has been diagnosed as having ADHD and fails to deal effectively with the family issues.

Family therapists work on improving **communication** and **understanding** between family members, seeing the ADHD as a family problem (Munden & Arcelus 1999:108). Calhoun et al. (1994:658) claim that the relationship between children with ADHD and their parents is often strained, so attention should include treating depression experienced by the parents. Whether the problems the parents experience are the result of the difficult child, or the child becomes difficult because of deeper family issues is not entirely clear, but either way, family therapy is likely to be of benefit. Ingersoll (1998:113) observes that, whilst family therapy does not alter the core symptoms of ADHD, it may be useful in identifying misunderstanding among family members and helping parents to work together to manage the child more effectively. Since there are often relationship problems in families where there is a child with ADHD, Garber et al. (1996:212-213) stress that parents should not feel guilty if the family needs professional help to overcome them.

3.3.3 Group Therapy

Group therapy can take several forms. The child could be helped to see what effect his behaviour has on others or he may be taught specific skills, such as social-skills. The group serves as a safe place in which the child can work on these problems and try out new, more satisfying ways of behaving (Ingersoll 1998:106). Ingersoll (1998:113) reports success working with children with ADHD on social skills when the groups are small. She maintains that the school setting is the most logical place in which to run such groups.

3.3.4 Support Groups / Parental Guidance

Parent training techniques involve working with parents, exploring the extent and nature of the difficulties and what coping mechanisms have been put in place. Follow up on this will include working with the parents to develop strategies that are appropriate to their families. The child's reaction to the implementation of a new behavioural programme may be an increase in the number and severity of undesired behaviours but Munden and

Arcelus (1999:102) stress that the parents must persist. The therapist must be available to offer support. However, the shortage of trained professionals to offer this support is acknowledged.

Parker (1994:28) stresses that parent education about ADHD and related problems is an important part of the counselling process, since *"Understanding usually reduces the frustrations and worries that often dishearten parents"*. Educating parents provides them with skills which empower them to better help their child. Parker suggests that issues of **discipline**, **parent-child communication**, **school programming**, **advocacy**, **use of medication** and so on can be addressed at parent support group meetings, where the parents can share their experiences of raising a child with ADHD with other parents who are going through similar problems. Often speakers are invited to share new information and may provide lending libraries for their members (Garber et al. 1996:215). Munden and Arcelus (1999:102) say that support groups *"aim to increase awareness of ADHD and related conditions and to improve the quality of interventions offered to young people with ADHD and their families"*.

3.3.5 **Hypnotherapy**

Hypnosis is a state of **deep relaxation**, the kind we experience in the twilight moments between sleeping and waking (Debroitner and Hart 1997:200). The difference between hypnosis and meditation is that, in hypnosis, the relaxed state is used to fill the mind with helpful ideas, images and attitudes, rather than to provide an opportunity to empty the mind. The person in hypnosis is always in control, but in the safe, comfortable atmosphere provided, the hypnotherapist can focus the mind on future goals, seeding the unconscious on a deep level with positive messages which are tailored to the individual.

According to Hartman (1995:1), it is quite likely that hypnosis has been used with children since the earliest times. However, the topic is still largely neglected. Children, given their closeness to internal imagery and their readiness to pretend or make believe, have been found to be good responders to hypnosis. The interest in hypnosis with children was revived in the fifties when a number of children were successfully treated with hypnosis because of the ease with which they can be hypnotized (Hartman 1995:3). Hartman claims that **ego state therapy** using the medium of hypnosis can be effective in the therapy

of **sexually traumatised children** and expressed the hope that therapists would experiment with its application in a wide variety of child disorders. Loffredo et al. (Calhoun et al. 1994:658) found that hypnotherapy was unsuccessful with a **group of children** with ADHD, but that it was successful with some **individuals**. Burte and Burte (1994:8), viewing the ADHD problems as a family problem, applied hypnosis in their family therapy, finding it useful in the following situations:

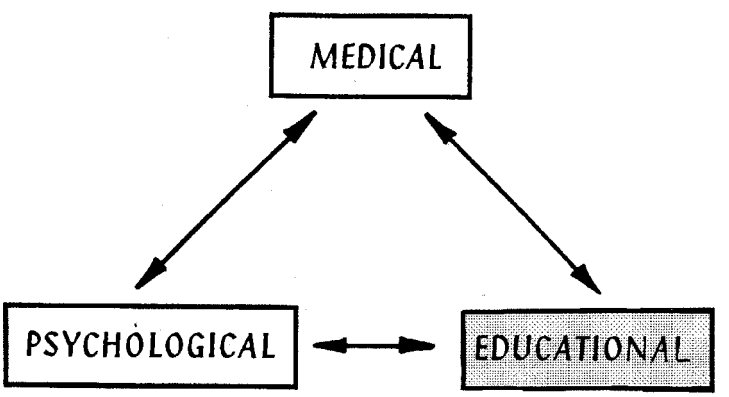
- when family communication needs improvement
- when the family is fearful of change
- when the family is emotionally stuck
- when there is a need to increase the family's expectations for success
- when the family needs a holistic emphasis and
- when the family needs to examine new possibilities or choices.

Burte and Burte also employed hypnosis to reinforce **prosocial skills** taught during group sessions with the children. Suggestions for change in direct and indirect ways are interwoven throughout the session.

3.4 EDUCATIONAL MANAGEMENT

Education is not the filling of a pail but the lighting of a fire.

W.B. Yeats (Hartmann 1997:119)



According to Parker (1994:25), the most frequently expressed concern of the parents of a child with ADHD is with respect to performance at school. Many children with ADHD have serious **learning problems** which cause frustration and discouragement for the children and the parents. Teachers have received little training about ADHD and, until recently, few books were available on how to manage such children. Picton (1998:111) found, when her child was in his early school years, that few teachers realised the extent to which hyperactivity affected every aspect of his life. She believes that the situation has changed considerably since more information has become available, making teachers more aware of the difficulties these children face. However, Munden and Arcelus (1999:114) feel that many children do not receive the help they need to prevent crises because of the lack of awareness and appropriate training for teachers, who note problems but do not always know that they represent a treatable condition.

"One untreated hyperactive child in a class can cause ripples of chaos throughout the day" (Gilbert 1998:56). Whilst the **hyperactive** child soon attracts the attention of the teacher, frequently in trouble because of his constant motor activity, the quieter attention deficit child with **concentration problems** is often only identified at the Grade 3 level, when they are no longer able to mask difficulties by compensating in other ways. For example, a child may memorise the reading book and recite words according to pictures, seeming to be reading. The news that their child is struggling often shocks the parents, who may not take the teacher's advice immediately. At other times, parents have a gut instinct that their child has problems and the teacher discards the idea (Picton 1998:112).

Munden and Arcelus (1999:110-111) stress that one of the crucial aspects of managing ADHD is the maintenance of a spirit of optimism. *"Educating the child and family in a sensitive and constructive way will enable them to participate fully and empower them to be able eventually to solve successfully many ADHD-related difficulties independently with success".*

Hartmann (1997:43) believes that our schools are set up along **'Farmer'** lines. *"Sit quietly at the desk, children are told, while the teacher talks and points to pages in the book. Ignore that child next to you who's sniffling; don't rattle your papers; don't look ahead in the book".* The child with ADHD who has a **low boredom threshold** experiences this as pure torture. This situation is becoming worse with schools facing a

lack of funding. Teachers are overloaded as classrooms continue to increase in size, resulting in an increased number of distractions for the child and a decrease in the amount of energy and time that can be devoted to the difficult child. If our schools were structured to allow for the expression of **'Hunter'** characteristics, such as **voracious curiosity**, **continual scanning** of the environment and **broad-based interest**, ADHD may become an irrelevant medical classification.

Parker (1994:26) believes that most children with ADHD can be accommodated in the regular classroom by teachers who adapt their teaching style to suite the unique learning needs of individual students. Ideally, both parents and teacher need to be involved in the management of the child, so that academic and behavioural difficulties can be minimised (Picton 1998:112). All aspects of the child's functioning should be given consideration, including **academic performance, behaviour, self-esteem** and **social interactions**. Nash (1994:125) maintains that interventions which focus on the prevention of problem situations as well as the management of various behaviours when they do occur should be carefully planned.

3.4.1 Management in the Classroom

The following ideas, adapted from the suggestions of Diller (1998:216); Garber et al. (1996: 58-64); Gilbert (1998:62-64); Ingersoll (1998:180-186); Nash (1994:126-134); Munden and Arcelus (1999:115-116); Picton (1998:112-115) and Wallace (1996:188-206) should be of help to teachers in the classroom situation:

- **Develop a special relationship with the child**

  Hyperactive children are criticised and ridiculed and frequently develop a poor self esteem and aggressive tactics. They find it difficult to obey rules. However, with a supportive and consistent teacher with whom they can relate, they will make every effort to please her. The child is likely to respond best to a very positive but firm teacher. The overly permissive teacher is not the best choice, neither is one who is too rigid and strict. Wallace (1996:191) stresses that, since not every teacher is suited to the child with ADHD, parents should politely approach the

school principal to point out the child's special needs so that the teacher best suited to the child can be chosen. The teacher should determine the behavioural and learning style of the child and should find out about and implement techniques that help the child to concentrate and learn. Students need to be taught through their most capable learning style which may be auditory, visual or kinaesthetic.

- **Teach the child organisational skills**

  - Children with ADHD are usually mentally and physically more disorganised than other children. The teacher should first organise the child and then attempt to teach self-organization skills, starting with organisation of the desk top, satchel and books before progressing to the organisation of written words on a page.
  - Lists of articles required for future activities can be given to the child to assist him with organisation.
  - Keeping a spare set of articles and equipment for use at school when the child has forgotten these at home can prevent a disruptive situation.
  - Children with ADHD require adequate space on their desks, and sufficient space between desks, to avoid disturbing others. However, the extra space allotted should not be too obvious to other children who may see this as favouritism so that the child becomes further isolated from his peers.
  - They benefit greatly from regularity, routine and consistency as part of an overall strategy.
  - Clear and realistic expectations must be set. These children need firm guidelines and structured supervision. They need to have their school books checked more frequently than the average child. They may need the teacher to write down their homework so that valuable teaching time is not lost whilst they are scolded yet again for not completing homework successfully. The homework diary serves as a wonderful means of communication between parent and teacher.

- The student can be helped to gauge how long a task will take by getting him to make an estimation and comparing it with the actual time taken. He will need to write down starting and completion times as well as the estimated time.

- **Minimise difficulties related to inattention**

- Short bursts of instruction, interwoven with other activities are ideal for the child with ADHD. Ideally, quiet and active sessions should be alternated, and difficult work should be done early in the morning, when the child is still alert.
- Physical activities between more formal school tasks and during the latter part of the school morning are likely to be of benefit.
- Learning should be fun and the teacher should try novel approaches. The curriculum should be flexible regarding content and workload. A change in tone of voice and alternating between visual and auditory stimuli should improve interest.
- A child with ADHD cannot remember too much information at a time and will be unable to follow the instructions of a teacher if too much is said at once. A basic strategy should be to speak less and more concisely. The teacher will need to make eye contact, or perhaps even physical contact, and repeat instructions several times to cement them in the child's mind. Instructions are more likely to be followed if they are given in combined verbal and written form. For printed instructions, encourage the pupil to underline, circle or highlight key words in the written instructions before he begins the task.
- Encourage him to review his work for errors and to sign the page after he has done so.
- Allowing the child to use a computer to complete work may result in a huge change in attitude and productivity.
- Ideally the child should be in a small class where it is possible to give him the individual attention he needs.

- He is likely to be distractible and his position in the classroom is an important consideration. By seating the child near her, the teacher is likely to manage the child proactively, noting when he has not grasped the nature of the tasks, or when he is falling behind. However, if the child needs to know what his friends are doing, it may be better for him to sit at the back of the room, away from the action but where he can peruse the situation and then get back to work. Isolating the child by partitioning the classroom in some manner blocks external visual distractors but cannot prevent the daydreaming, doodling and whatever else takes him off-task. Furthermore, it could have the unfortunate side-effect of making a child whose self-esteem is already low feel ostracized.
- Putting him next to a quieter child who is able to monitor his performance can be useful, provided it does not interfere with the performance of the other child and the child with ADHD does not suffer poor self esteem as a result. Peer tutoring can be a valuable learning tool for pupils of all ages.
- Whilst sitting near the teacher is useful, if the child is tactile defensive, he may experience discomfort with the other children behind him when the teacher's desk is at the front of the class. In such a situation, it would be better for him to sit with his back against the wall to avoid the threat of unexpected touch.
- He should be away from distracting visual and auditory stimuli, such as colourful posters, mobiles, air conditioners, doors or windows.
- Non-verbal cues, such as a raised eyebrow, can be used to bring the child back to the task at hand. The three card warning system can be used. Each time the student behaves inappropriately, a red card is placed on his desk. Three red cards automatically mean *'time-out'*.
- Limit the amount of time spent on a specific task. Calhoun et al. (1994:658) believe that even children who do not have ADHD are sometimes expected to attend to an activity which is appropriate for their age but for too long. As a result, they become restless. Often these children are then considered to be suffering from ADHD. They warn teachers to note the time devoted to specific activities and suggest that twice the child's age in minutes should be used as a guideline for a given activity for children who do not have ADHD.

- When the child can no longer sit still and continue working on a task, he could be sent on an errand to give him a break.
- Sustained attention should be acknowledged and appropriately rewarded. However, praise should not be too lavish since children with ADHD are over-sensitive and over-reactive and they may become silly after too much stimulating recognition.
- Positive feedback for acceptable behaviour, effort and performance should be given immediately.
- Rewards should be changed frequently since the child with ADHD will soon lose interest if he becomes accustomed to a particular reward.

• **Help them control impulsivity**

Hartmann (1997:53) claims that **impulsivity** and **craving** are two characteristics which, although in moderation can lead to incredible success, can seriously challenge the person with ADHD in life and society if not under control. *"When out of control, impulsivity and craving can drive a Hunter to self-destruction or prison"*.

- In order to avoid an impulsive response from the child, they should be given enough time to sort out a sensible response to questions.
- The child with ADHD should be given rewards for good behaviour. Behaviour that is irritating can be ignored but he should be punished for unacceptable behaviour. Punishment can take the form of time-out, deprivation, being sent to the office or staying in after school. However, he should not be kept in during a break, since he will need the opportunity to get rid of pent-up energy or he will become more fidgety, impulsive and impossible.
- The child should be taught basic skills in self-monitoring of behaviour and should be praised when, for example, he puts up his hand instead of shouting out.

- Classroom activities need to be well-organised, predictable and structured. A daily timetable should be displayed in a prominent place. Teachers should plan ahead, paying attention to situations which could trigger difficulties for the child. He is likely to experience problems during transitions in activities and needs to be made aware of changes well ahead of time.
- He needs to be constantly reminded of the rules of expected behaviour and about the rewards and consequences which apply to each situation. A colourful visual display of class rules is helpful.
- Classmates should be encouraged to ignore unacceptable behaviour and to praise more positive behaviour to reduce the likelihood of the repetition of less desirable behaviour. They will need an explanation of why the child is rewarded differently to them but it is not appropriate to use diagnostic labels or to set them up for being teased in any way.

- **Help them improve self-esteem**

Teachers can help by providing regular and frequent encouragement and support. They should praise his efforts, suitable performance and work output and should give positive feedback for acceptable behaviour. The child should be rewarded for appropriate interaction with his peers. Giving him special responsibilities will give him the opportunity to be seen behaving positively by his peers. One of the greatest enemies to self-esteem is the *'put down'*: *"Here comes Hyper-Henry"* or *"You're the sloppiest student I've ever had in my class"*.

- **Coordinate coordination**

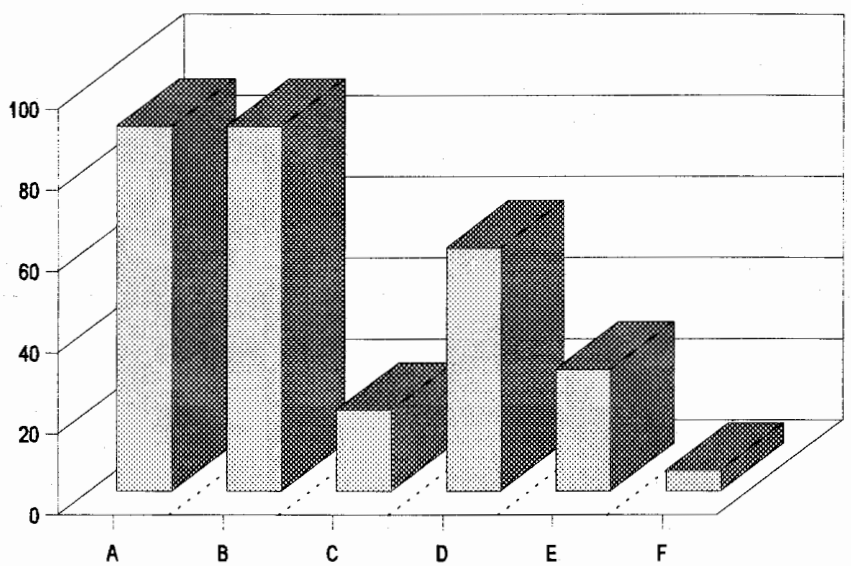
The child should not be punished for untidy handwriting if it is due to visual-motor deficits.

- **Be aware of possible learning difficulties**

Where learning difficulties are suspected, a full academic assessment should be carried out. Remedial education and other therapies are often very effective, particularly when initiated at an early age. It is important to take action quickly before the situation gets out of control.

Some of the learning problems associated with ADHD are the product of poor motivation and low self-esteem, often the result of the inappropriate way that these children are sometimes treated by teachers and parents. Munden and Arcelus (1999:113) refer to findings in the USA, that children with ADHD exhibit the following learning problems:

Graph 1: Learning Problems in Children with ADHD



A: 90 per cent are under-productive in school work
B: 90 per cent under-achieve in school
C: 20 per cent have reading difficulties
D: 60 per cent have serious handwriting difficulties
E: 30 per cent drop out of school
F: 5 per cent complete a four-year degree course in a college or university compared with approximately 25 per cent of the general population.

- **Assist medical staff**

The observations of the teacher are important when deciding upon effective medication doses and the spacing of doses. Cooperation regarding subsequent recommendations for adjustments in school work and in the classroom situation is necessary.

- **Enlist the assistance of the parents**

The parents need to know that their child is understood and that the teacher is looking for solutions. Parents play a most central role in the treatment of the child. When parents understand that their input can make a difference, they are usually far more prepared to take responsibility. *"Liaison between home and school must be very close to establish a unified method of handling the child's difficulties"* (Gilbert 1998:55). A vast number of videos and books are currently available to educate parents and teachers.

- **Find alternative schooling**

Exclusion from school should be avoided because of the irreversible devastating effects of such a move. The child could be sent to a private school where the student-teacher ratio is typically lower so he can receive more individual attention. He could be sent outside the regular classroom so that learning problems can be remediated or placed in a specialised education school, such as a remedial school. However, Bain (1991:139) warns that special classes may stigmatise children further and lead them to internalise a sense of being different. A school which is inflexible in its educational approach or academic demands should be avoided (Bain 1991:142).

3.4.2 **Management at Home**

According to Gilbert (1998:40), unless lines of communication between carers at school and at home are good, the child will be confused and manipulative. She stresses the importance of following the same behaviour-plan at home and at school and highlights the fact that each family situation is unique and will need a specific treatment approach. Wallace (1996:188) believes that it is as unproductive for teachers to attack parents as it is for parents to be seriously critical of teachers. He attributes the recent gains made in clinics across Australia to the goodwill and cooperation between parents, schools and professionals. The parents of a child with educational and behavioural weaknesses have to firstly, ensure that the school is addressing the child's specific needs appropriately, and secondly, reinforce at home the kind of behaviour that is expected in the school setting (Diller 1998:237).

Diller (1998:216) reports that intervention seldom succeeds when one parent is against it and underlines the importance of both parents making a commitment. Once a form of treatment has been chosen, parents need to stick to it, even though some of the most effective interventions may make things worse to begin with. Taking a firm stand on behaviour may cause tantrums to escalate in intensity.

The following recommendations adapted from the works of Armstrong (1995); Gilbert (1998:47-54); Ingersoll (1998:156-16); Nash (1994:113-122); Picton (1998:115-116) and Wallace (1996:147-162) are suggested to help parents manage their child at home:

* The parents should seek an outside evaluation from a family doctor or educational and behavioural specialist to help them understand the problems and support their attempts to obtain special help at school.

* Parents need to be consistent in their approach towards their child and should always be fully in agreement, since the child's behaviour is likely to deteriorate if he gets different messages from each parent.

* Negotiate with the child rather than struggle with him. He is likely to be far more cooperative if his opinion is given some cognisance. Armstrong (1995:231) believes that when children labelled ADHD are given choices and allowed some say in the decision-making regarding their school careers, their motivation level increases and their behaviour becomes more appropriate. However, Ingersoll (1998:161) warns that children with ADHD are not ***'reasonable creatures'*** and that parents should only negotiate when they hold the winning cards. She claims that *"Often, a simple declarative statement such as **'This is not a choice'** is an effective way to end the conversation"*.

* Teach alternative ways of acting when children misbehave, since children with ADHD do not automatically know this. They need to know what will happen if they choose an alternative form of behaviour and how it will be helpful.

* A routine should be established and maintained, as children with ADHD function much better in a structured, predictable environment. The bedtime routine could include a relaxation exercise or a focusing technique, for example:

  - listening to the sounds of daily life around (a kettle boiling or a clock striking)
  - smelling what is happening around (a sweet scented flower or newly mown lawn)
  - touching (remembering the feel of a woolly blanket or the shape of a pencil)
  - looking at and then holding in the mind a favourite picture or the memory of a happy event

* For children who are disorganised, a list could be written down of the expected sequence of events, for example, the morning routine could be written up as follows:

  - get out of bed
  - wash
  - dress (write down the order in which clothes should be put on)
  - brush hair
  - eat breakfast
  - clean teeth

  Initially, the child will need a great deal of support but this can gradually be withdrawn so that ultimately, he is taking responsibility himself.

* Encourage responsibility. If he is old enough to get up on his own in the morning, encourage him to do so, perhaps aided by an alarm clock which he can set. Allow him to suffer the consequences of his disorganised behaviour, for example, by making his own alternative arrangements to get to school if he has missed the school bus.

* Help the child to organise himself. Clear out the clutter in his bedroom so that it is easier to keep clean. Break tasks, for example, tidying the room, down into smaller increments, such as make the bed, then pick up the dirty clothes from the floor, and so on. Set time limits and give appropriate rewards/praise for satisfactory completion of a task.

* Set priorities and keep things in perspective. If parents wear themselves out with cooking, shopping, baking and so on, there will be little energy or patience left to deal with the child with ADHD. If they lock horns over every little issue, the relationship is likely to deteriorate. They need to hold their ground for those issues that really matter and ignore the others.

* Parents should recognise and respect the child's limits and not put him into a position of assured failure. Parents who constantly find they are frustrated and disappointed in the child should be alerted that they may be overestimating his abilities. They need to make their expectations fit the child and to be realistic when doing so.
* Show an interest in the child's school work and be supportive.
* Make a concerted effort to attend school functions, such as sporting activities, in an effort to show the child he is cared about.
* Teach him responsibility for doing homework, giving him some choice about the time, but not allowing fun activities before homework is completed. Most children with ADHD will need some time to play / take a short break before starting homework after a busy school day.
* Physical exercise is very important for the child with ADHD. Encourage judo, martial arts, dancing, swimming and cycling. Avoid team sports if the child finds it difficult to share and take turns. Adult supervision is necessary when the child is playing with others.
* Find a suitable location for homework. The child should work at a desk or table and have good lighting, a comfortable chair and the appropriate materials close at hand.
* Break homework time up into a few short sessions, which for the very little child may be as short as five minutes.
* Assist with homework but do not do the homework for them. When homework becomes a time of arguing and nagging, alternative solutions should be sought. Another responsible adult can be asked to attend to the homework.
* Label the child's clothing since the child with ADHD has a tendency to be forgetful and regularly loses things.
* Help the child develop social skills. Encourage friendships with children who have similar interests. Remember that adult supervision will probably be necessary and to start with, suggest only one friend at a time for only short periods of time.

* Boost the child's self-esteem. Whilst failures should not be ignored nor condoned, they should be played down. Rather provide encouragement that next time may be more successful and acknowledge each successful moment. Praise need not be lavish, but could just be a simple *'thanks'*. Provide the child with opportunities for success by fostering any activity in which he excels, such as sports, music or art. Get the older child a pet. They offer unconditional love. However, do not assume that the child will take full responsibility for the pet, in spite of promises to the contrary.
* Spend quality time with the child, giving him one-on-one attention on a regular basis. Discuss his feelings regularly and try to understand important issues from his point of view. However, since children with ADHD tend to over-react to everything, we should try to focus on solutions rather than feelings, letting the child know we can help him overcome the problem. These children to do not see the sequence of events necessary to solve problems and need to be taught the precise and sequential steps towards a solution. Listen to what he has to say. Real listening means making eye contact and refraining from doing anything else at the same time.
* Use touch to soothe and calm, firstly because children with ADHD have a need for stimulation, which includes tactile and kinaesthetic stimulation, secondly, because these children experience a great deal of stress, and thirdly, because touch can bring them back to the here and now. Nourishing touch experiences include back rubs, hugs, foot massage and light back scratching.
* As the authority figures in the family, parents should protect the property rights and physical security of all members of the family. Enforce the rule of no physical contact or name-calling. Ingersoll (1998:163) suggests the following tactic when there is a war of words:

Tell the children that you understand their need to express their angry feelings. Take them into a remote part of the house, give them a tape recorder, and instruct them to spend exactly thirty minutes calling each other names. Tell them that you will listen to the tape on your way to work the next day and that if there are any blank spots on the tape, they will have to do the entire exercise again.

* Stress cooperation rather than competition between family members by, for example, giving all the children a reward when they are all ready for bed on time. However, take care that the child with ADHD is able to meet the demands set. Keep expectations reasonable. The children who do not have ADHD cannot be expected to tolerate annoying behaviour from their sibling with ADHD.
* Limit the amount of television watching and video game play to at most, an hour per day in the week and two hours over the weekends. Some researchers believe that the high-impact audio and visual information presented in short blasts may undermine natural attentional mechanisms in the human mind. It can also promote aggressiveness in children (Armstrong 1995:76). However, it should not be eliminated altogether since television and video games do connect children to society and can also lead to increased abilities in visual-spatial and critical thinking skills.
* Get professional help and join a support group.

3.5 ALTERNATIVE TREATMENTS

According to Garber et al. (1996:57), alternative interventions centre on three elements of change which have relevancy for the child with ADHD both at home and at school:

- *Making changes at home or at school to improve functioning*
- *Altering the task to improve production*
- *Adopting behavioral interventions that help the individual modify ADHD behavior patterns.*

A wide range of solutions are offered by a number of different people. However Garber et al. (1996:187) warn that there are no quick fixes and almost all the remedies advocated require time, effort and cost. Ingersoll (1998:127) refers to research that she did with Sam Goldstein into controversial treatments, including:

- Controlled diets
- Megavitamin and mineral supplements
- Anti-motion sickness pills, antifungal medications, amino acids and essential fatty acids
- EEG biofeedback, cognitive therapy, sensory integrative therapy and optometric vision training
- Chiropractics, Irlen lenses, osteopathic treatment.

They concluded that not one of these treatment approaches met scientifically acceptable standards to be considered effective in treating ADHD.

3.5.1 **Diet**

Whilst Munden and Arcelus (1999:64-65) believe that it is worth avoiding some foods that aggravate the symptoms of ADHD, they advise that *"current medical opinion is of the belief that dietary change is unlikely to be of much benefit"*. They point out that those children who suffer eczema, asthma and other allergic conditions have been demonstrated to be sensitive to a certain extent to certain additives. In particular, **yellow colorants** seem to increase activity levels. They caution that exclusion diets result in a limited diet which is sometimes neither healthy nor

nutritious. However, there are those professionals who continue to advocate diet as an essential component of the treatment plan (Armstrong 1995; Block 1996; Debroitner & Hart 1997; Diller 1998; Picton 1998).

Doctor Ben Feingold, a San Franciscan allergist, devised a diet that avoided **synthetic flavours** and **colorants**, some **preservatives** and **certain natural foods** which he noticed improved the behaviour of hyperactive children. Improvements on this original eating plan have been made and research has shown that **chemical antioxidants** and **fried foods** should be avoided and **vitamin**, **mineral** and **essential fatty acid supplementation** are important for maximum effect. **Unrefined** and **unprocessed foods** are preferable. **Sugar** should be kept to a minimum. Where possible, brown sugar should be used but only when artificial colorants are not used. The Hyperactive Children's Support Group in England and South Africa recommend dietary changes (Picton 1998:39-44). Picton (1998:41) recommends that *"Parents should check for individual sensitivities"*. Whilst many children do tolerate the **natural salicylates** in fruits and vegetables, which have a chemical structure similar to that of aspirin, the behaviour and concentration of some children is adversely affected. Most hyperactive children cannot tolerate artificial salicylates found in **colorants** and **anti-oxidant preservatives** used in foods and medicines and these should be avoided.

3.5.2 Herbal Treatments

According to Hartmann (1997:96-97), herbal treatments focus on the **'nervine'** category of herbs, which contain an active ingredient traditionally regarded as **'relaxing'** or **'healing'** to the nervous system. These include skullcap, valerian, hops, blue cohosh, black cohosh, chamomile and lady's slipper. Occasionally, stimulant herbs, such as ginger root or licorice are recommended for ADD. Hartmann warns that herbs contain active ingredients which may be toxic in high doses and may

have side effects. Furthermore, they have not been subjected to rigorous studies which clearly demonstrated their viability as a therapy for ADD.

3.5.3 **Homeopathy**

Homeopathic remedies work through the **'vital force"** or **'life essence'** of a medication and present fewer risks of side effects than herbal treatments (Hartmann 1997:97). Whilst science has yet to produce an explanation for the way homeopathy works, homeopaths are adamant that it does work. It is important that remedies should be administered under the care of a licensed homeopath. According to Picton (1998:33&36), there are over four hundred registered homeopaths in South Africa who observe the whole child in terms of the following criteria:

- The child's thought processes
- The child's emotional state
- Physical aspects of the child
- The child's nutritional status

3.5.4 **Vitamins**

Hartmann (1997:97-98) refers to the development of the vitamin theory of deficiency disease by biochemists since 1912. They named certain substances **"vital amines".** In particular, with regard to ADD, the food supplement, **choline** has generated a great deal of interest. It is considered to be one of the few nutrients which can penetrate the blood-brain barrier where it is converted into the neurotransmitter acetylcholine. *"Several recent studies link high levels of acetylcholine to improved memory function, and imply benefits for attention span".* Choline is found in highest concentrations in egg yolks, wheat germ, whole grains, legumes, spinach, sweet potatoes and lecithin.

3.5.5 **EEG Neurofeedback**

According to Armstrong (1995:132), *"Biofeedback has been around for about twenty-five years and has become a standard part of the treatment program for many individuals with migraines and other kinds of pain."* Recently, it has been used with children who have ADHD. Garber et al. (1996:194) refer to the claim by proponents of EEG biofeedback that children who have attention deficit disorder are unable to concentrate because they have abnormal brain-wave patterns. *"Specifically, individuals with ADHD have decreased arousal stemming from increased theta-wave activity in the frontal and central lobes of the brain. These slower theta waves are typically associated with daydreaming, in contrast to the faster beta waves usually associated with arousal and concentration."*

Debroitner and Hart (1997:201-202) suggest that brain waves, like musical instruments, can be played harmoniously or discordantly. Whilst brain waves are not good or bad, certain ones are better suited to certain purposes than others. They describe the four basic brain wave patterns as follows:

- ***Alpha*** is associated with relaxation and creativity. The mind is receptive and nonjudging, imaginative and visual - a daydreaming state of mind.
- ***Beta*** is associated with the chattering voice in our heads which computes and solves concrete problems. Beta often gets out of control for people with ADHD symptoms, producing a stream of thoughts which rush by too fast for us to focus on any one.
- ***Theta*** can be thought of as the subconscious state which holds forgotten memories that affect us and contains our unexpressed creativity, deepest emotional pain and inspiration. Active ADD/ADHD symptoms respond to the taming of theta activity by, for example, deep relaxation.

- ***Delta*** brain waves are associated with a **sixth sense**, which is the unconscious, instinctual part of the mind that contains gut feelings and hunches, and gives us the capacity for empathy with others.

EEG neurofeedback involves the use of a rather complex machine which monitors the relative strengths of various brain-waves. When electrodes are placed on the head and the individual is sat in front of a computer screen attached to the EEG device, brainwaves can be seen. The theory behind this is that the brain can be trained to increase levels of **'focused-awareness"** brainwaves while decreasing the power of the **"distracted-awareness'** brain waves. Initial studies which claim that technology can 'train-away' many of the deficits associated with ADD behaviour indicated that thirty to fifty half-hour to one-hour sessions may be necessary (Hartmann 1997:98). According to Hartmann, EEG neurofeedback machines are the subject of a great many scientific studies, the results of which look promising. Such a treatment method has many attractive features for a child, since it works like a video game, with bright colours and sounds, provides immediate feedback and offers rewards for a job well done (Armstrong 1995:133-134). Armstrong believes this treatment has promise but warns that it should not be an exclusive form of intervention and also that it should not be used for children under seven years of age, or children who are clinically depressed or suffer from epileptic seizures or psychotic episodes.

3.5.6 **Meditation**

The root word of meditation comes from the Latin word for middle, or centre. According to Debroitner and Hart (1997:236), *"Meditation, as an activity, is a* ***natural antidote for problems of focusing and impulse control*** *because meditating involves quieting the mind, focusing inward, and mastering impulses"*. They recommend that the process should be approached in a spirit of fun, with as little as thirty seconds being all that is necessary for the child's first encounter. According to Hartmann

(1997:46), **'Hunters'** are often drawn to techniques like meditation because they enjoy 'little chunks' of silence. He refers to reports about their experience of meditation, which they claim gave them *'vivid new insights into how their mind and attentional mechanisms worked, and strengthened their ability to focus on other things"*.

3.5.7 Natural Brain Stimulation

Debroitner and Hart (1997:237) claim that people who suffer from ADD/ADHD require **more brain stimulation** and not less. They believe that teaching the child to **breathe deeply** from the belly will do much to keep the child's brain supplied with what it needs. They recommend the following activities to stimulate deep breathing: singing, hiking, dancing, martial arts, skating, trampoline bouncing, vigorous play, sack races, running, stage fighting, calisthenics, arm wrestling, badminton, tennis, bike riding, walking the dog, hand jive, electric slide and the macarena.

Loffredo et al. (Calhoun 1994:658) endorsed group relaxation training for children with ADHD, promoting a regimen of deep breathing exercises which focused on relaxing the entire body. They found that relaxation training exercises helped control hyperactivity and made the children feel better.

3.6 CONCLUSION

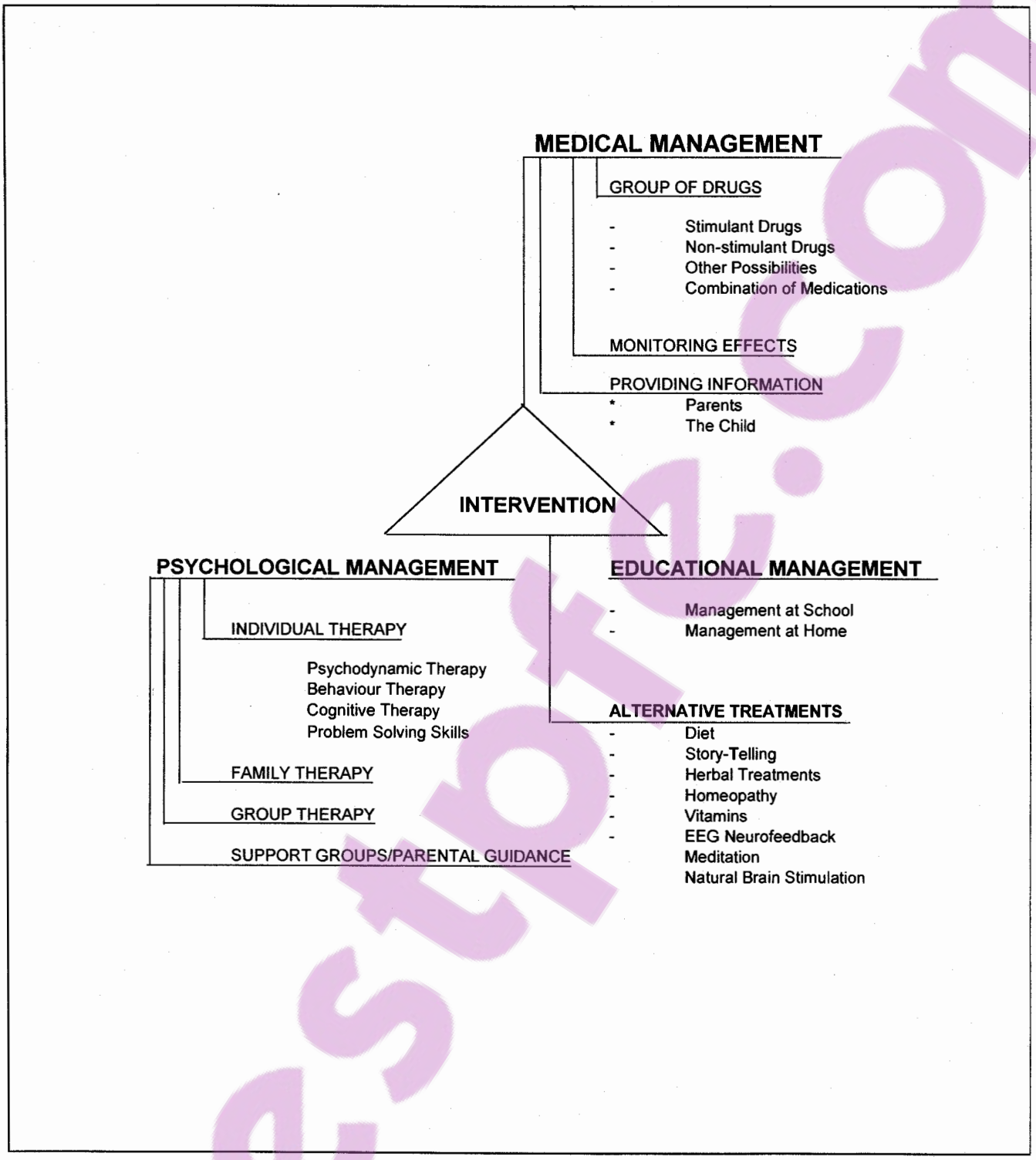
Throughout this chapter, the efficacy of well-established psychological, educational and behavioural treatments has been highlighted. Since ADHD is a disorder which is managed and not cured, each of the child's specific problems must be identified and treated. Goldstein and Goldstein (1998:443) maintain that the primary symptoms of ADHD are most effectively treated with medication. Burte and Burte (1994:3) claim that medication may reduce negative behaviours or create windows of opportunity for change. However, they stress that other forms of family and individual therapy are required to bring about permanent changes in

the child's self image and to reestablish family intactness. Furthermore in twenty to thirty percent of cases, pharmacotherapy is ineffective or contraindicated (Burte & Burte 1994:10).

Parents and professionals working with children with ADHD need to understand that one intervention alone is rarely effective in the management. A sensitivity to the complex and pervasive impact of ADHD on the child's daily functioning has to be developed if his ability to meet the expectations of his world is not to be compromised. Treatment for ADHD should consist of a partnership among the child, family, school personnel, and medical and para-medical professionals.

A diagrammatic representation of the aspects covered in this chapter is illustrated in the figure below.

Figure 3: Diagrammatic Summary of Chapter Three



Some of the ideas presented in this chapter will be used to design a programme for use in the schools which will be highlighted in the following chapter.

CHAPTER FOUR

DESCRIPTION OF THE EMPIRICAL STUDY

It is the close observation of little things which is the secret of success in business, in art, in science, and in every pursuit in life. Human knowledge is but an accumulation of small facts, made by successive generations of men - the little bits of knowledge and experience carefully treasured up and growing at length into a mighty pyramid.

Samuel Smiles (Barkley 1995:169)

4.1 INTRODUCTION

In Chapter One, the introductory orientation and statement of the problem have been covered, the problem has been explored, terms described and the study programme has been planned. The fact that the core symptoms of ADHD impact on all areas of the child's current and future life, resulting in an inability to meet situational demands in an age-appropriate fashion, has become evident. Whilst parents lack the knowledge and competent coping strategies to deal with the challenging problems, there is an abundance of literature available which can be put to good use to enable the child to attain his full developmental potential. The necessity for early intervention of stressful parent-child systems has been highlighted and a multi-modal intervention plan has been advocated to bring about the greatest success.

The second chapter covered the historical background, the nature, aetiology and the diagnosis of ADHD, and made mention of many of the associated problems and disorders. The developmental course of the disorder from the earliest mention to current conceptualizations was outlined, bearing in mind the controversy surrounding the definition and diagnosis of ADHD. An in-depth review and analysis was provided of the complex interaction of the symptoms of ADHD with a variety of biological, familial and experiential factors. The recognition that the symptoms overlap with a number of disorders was highlighted.

The various options regarding therapeutic intervention were explored in the third chapter. Firstly, the three main broad areas of medical, psychological and educational treatments

were focused upon, and then attention was devoted to some of the more popular alternative treatment options. The fact that ADHD cannot be cured was highlighted. However, it is possible to manage the disorder by improving the child's self-control. Although it was made clear that *"pills cannot substitute for skills"*, medication has been advocated as a first-line treatment by many professionals who are involved with children with ADHD, since there is evidence that has shown that ADHD is a clinical condition caused by a chemical imbalance. However, the best outcome in later years has been shown to be as a result of multi-modal interventions which include medication, as well as parent education and support, and various forms of help for the child. The likelihood of the child suffering from related conditions is quite high and all difficulties need to be addressed. In particular, many of these children experience learning difficulties. Since teachers have received little training regarding ADHD and they are overloaded in their classrooms because of current financial constraints, they also need help to adapt their teaching styles so they can accommodate the needs of the child.

Chapter Four will provide an outline of the programme to be applied in the empirical study.

4.2 HYPOTHESES

i The parents will be reassured to discover that they are not alone, and greatly relieved when they meet with others who understand their personal predicament and can empathise with them.

ii When parents are given the opportunity to meet with other parents whose children encounter similar problems, they are able to share ideas on how to handle their children and will learn something about compassionate management skills in a mutually supportive environment.

iii Parents will get their own feelings under control when they are given the opportunity to voice feelings of despair, fear, anger, guilt and anxiety within a warm empathic climate.

iv Parents will reclaim their power and triumph over the disorder that has previously caused so much misery in their family lives, when they are provided with a holistic understanding of ADHD and cohesive strategies and concrete tools to combat it.

v Parent Support Groups provide a forum by which parents can exchange information and experiences about raising an inattentive, impulsive and/or hyperactive child.

vi Early intervention of stressful parent-child systems will reduce the frequency and intensity of behavioural and emotional disturbances in the children with ADHD, enabling them to attain their developmental potential and a better quality of life.

vii A multi-modal treatment plan will enhance self-esteem and foster acceptance, approval and a sense of belonging, resulting in positive relations for the child with ADHD, leading ultimately to a better outcome.

viii When parents become involved with their child, spend time with him and feel connected, a close emotional bond develops and they have better adjusted children, harmony at home and a more functional family.

ix Adjustments in classroom procedures and work demands, sensitivity to self-esteem issues and regular parent-teacher contact will play an essential role in helping the child with ADHD in the classroom.

x The child with ADHD will be guided towards adulthood with the best possible education, good self-confidence, useful life skills and intact family relationships.

4.3 PURPOSE OF THE STUDY

4.3.1 Specific Aims

(a) An in-depth literature study will focus on:

* Attention Deficit Hyperactivity Disorder
* Therapeutic Intervention

(b) An empirical study will involve the following interventions:

(i) A support group comprising a small number of parents who meet once a week will be formed. An attempt will be made during these sessions:

* To empower the parents by providing them with information about attention deficit hyperactivity disorder, so that they gain some insight into the behaviours which manifest, and some effective strategies to deal with the problems.
* To provide the parents with an outlet for sharing their concerns and hardships with other parents who have similar problems.
* To give parents an opportunity to benefit from the support of other parents who truly understand their circumstances, and in turn, commiserate with these parents, within the safety of a therapeutic group setting.

(ii) Individual sessions will be planned with the children. During this time, an attempt will be made to focus the attention of the children on the therapeutic stories which will be read to them in an effort:

* To reduce levels of hyperactivity
* To reduce impulsive behaviour
* To increase focus of attention
* To improve oppositional behaviour
* To improve the child's relations

(iii) Contact will be made with the teachers of the children, and guidelines will be provided for dealing with some of the behavioural manifestations.

4.3.2 **Indirect Aims**

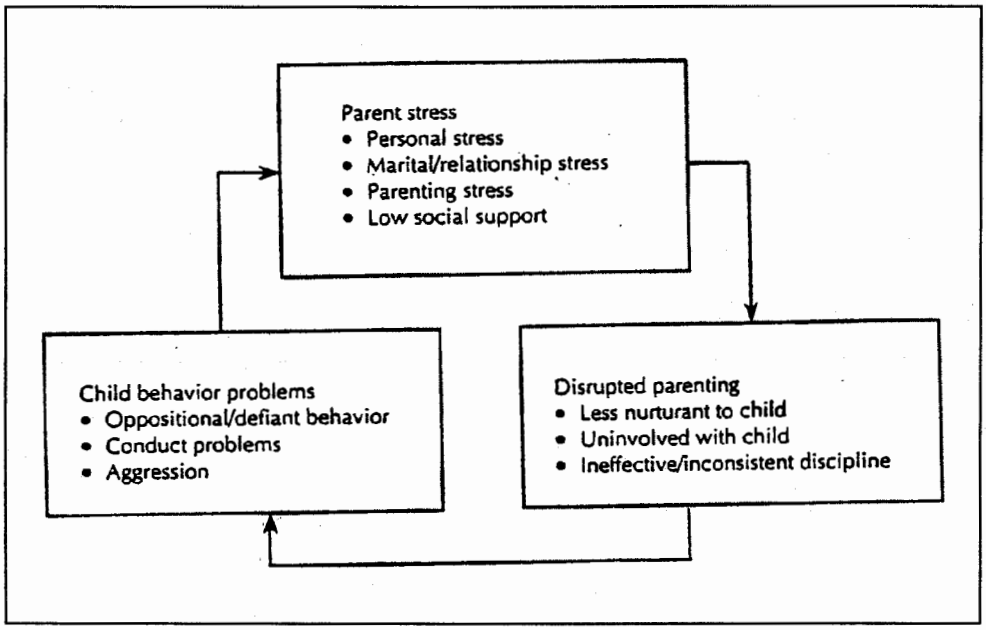
* To reduce levels of parental stress, making parents more competent to cope with their educational task.
* To improve the parent-child relationship initially, leading to more positive relations for the child with other family members, teachers, peers and self, so that the child can move towards adulthood with feelings of competence and self-worth.

4.4 RESEARCH DESIGN

4.4.1 Rationale for the Study

From the research findings presented thus far, it has become evident that children with ADHD present quite a challenge to their parents, who become exhausted and **'stressed out'**. Since parents fail to manage their own stress, they become less competent to provide what the child needs, and the disruption of parenting often leads to more behaviour problems for the child. Bearing the circular pattern depicted below in mind, Bloomquist (1996:33) stresses that *"The main lesson from this is that parents must take steps to reduce parental stress to deal effectively with a child's behavior problem"*.

Figure 4: Parent Stress and Child Behaviour Problems



Pelser (1987:37-38) believes that parents frequently use a trial-and-error approach to control their child's behaviour. She stresses that it is the task of the specialist to provide the parents with concrete guidelines to bring about harmony, based on the particular needs of each family. The specialist, in Nash's view must be able to communicate well with both

the parents and the child with ADHD, giving straightforward information about assessment, available treatment, costs involved and prospects for the future. They must be given the opportunity to ask questions, to clarify matters which are of concern to them. *"They must not be blamed for causing or being responsible for the child's difficulties"* (Nash 1994:99).

According to Parker (1998:13), help for the child with ADHD and his family is best provided through **multi-modal treatment**, delivered by a team of professionals who address the medical, emotional, behavioural and educational needs of the child. Such services and programmes may include:

* Medication to help improve attention and reduce levels of impulsivity and hyperactivity, as well as to treat overlapping associated medical conditions.
* Training parents to understand ADHD and be more effective managers and child advocates for their child.
* Training children in methods of self-control, attention focusing, learning strategies, organisational skills and social skills.
* Psychotherapy for demoralised or depressed children.
* Other interventions at home or in school which lead to more positive relations for the child.

Roberts (1993:39) defines educational psychology as *"The branch of **psychology** that is concerned with theories and problems of teaching and study. It covers such topics as learning theories, the assessment of **ability** and **aptitude**, principles of teacher training, and all aspects of psychology concerned with learning and with children and their social and **cognitive development**, as applied in an educational environment"*.

It is the writer's opinion that the educational psychologist is in the perfect position to be involved with the treatment of children with ADHD, having the necessary skills to work with the child and his family, and to liaise between the various team members. She equates the role of the educational psychologist, to a large extent, with that of the school guidance counsellor, who Petrick (1986:8) claims *"is responsible for providing the child-in-need with information and support on his way to full adulthood"*.

4.4.2 **Professional Perspectives**

* Goldstein and Goldstein (1998:479) refer to the findings of Kelly et al. (1989), who concluded after their study of twenty-one children, aged eight to twelve years, that **long-term multi-modal intervention**, which includes medication, increases self esteem for children with ADHD. No improvement in self esteem was noted after only one month. Satterfield et al. (1980, 1981) support the recommendation for long-term multi-modal treatment. Their own studies indicated that a combination of medication, special education, parent counselling and training in child management, classroom consultation and individual counselling of the children improved the prognosis, particularly for those with early aggression, when it was maintained over several years (Barkley 1990:124).

* In Thompson's view (1996:434-436), *"Medication is not the whole treatment for ADHD"*. Yet, psychostimulant medication, such as **Ritalin** (methylphenidate), is the most widely studied and cost-effective treatment, leading to improvement in on-task behaviour, impulsivity, social behaviour, compliance and academic productivity in as many as 70 - 80% of children with ADHD. Fachin (1996:441), a second grade teacher in specialised education, who sees medication as a last resort to be used in combination with a comprehensive behavioural academic programme, came to realise that the children with severe ADHD need something more to enable them to benefit from other interventions. She found that medication helped these children to achieve success in the classroom. Ingersoll (1998:83) believes that medication should be used as a first line treatment, and should be the treatment of choice for uncomplicated ADHD.

* Block (1996:27-28) reports that there is a noticeable improvement in the signs and symptoms of ADHD when drugs are administered. However, she believes that they do nothing to fix the underlying cause and merely cover up the symptoms. She states, *"Drugs are a short-term answer to treating long-term symptoms, and they carry the potential of serious side-effects"*. Debroitner and Hart (1997 :14-15) echo this sentiment and say, *"Wanting to believe that the disorder is primarily physically based and can be corrected by a substance is an all too human mistake"*. They believe that the internal chemistry of human beings is

sensitive to many factors - magnetic and electrical fields, nutrition, information from the senses, phases of the moon, exercise, light, thought and emotions, sleep patterns, breathing patterns, psychotherapy, and even the thoughts and feelings of others in the environment. They recommend that we should alter the everyday human experiences of the individuals suffering from ADHD to alter their biology.

* In a survey conducted by the ADHD research team at the University of North Texas on parental perspectives on ADHD, most parents reported an awareness of ADHD at age 4,1. A majority reported that having a child with ADHD affected their parenting and their families, and adversely affected their marriages. The respondents reported an average of four intervention approaches, including medication, parent training, educational intervention, psychotherapy and diet modification, with medication emerging as the most frequently used and the most effective intervention. The parents noted that the primary positive resource that they had successfully accessed was educational material and support networks. Rather sadly, ***"The most often cited resource that had not proven helpful was schools and school personnel"*** (Kottman et al. 1995:143-147). This illuminates the impact of school counsellors on the behaviour and academic performance of the children with ADHD in their school, and the need to improve their understanding, and the understanding of other school personnel, of these children and their parents. In particular, teachers in the early grades should receive training to familiarise themselves with the symptoms of ADHD, so that they can make adaptations within their classroom and suggestions to the parents. Since ADHD is not an educational diagnosis, but rather a psychological and medical one, based on the DSM-IV (APA 1994), teachers should responsibly make referrals to psychologists and/or medical specialists.

* Kottman et al. (1995:142-143) report that teachers frequently find that parents of children with ADHD are ***"resistant, angry and uncooperative"***. They attribute these attitudes and the uneasy relationships that exist between parents and school personnel to the amount of stress experienced by the parents. Mash and Johnstone (1983) found that *"The parents of children with ADHD report more stress in their families and in their parenting role, and more marital discord and maternal depression than parents of non-ADHD children"*. Sobol et al. (1989)

conclude that the parents of children with ADHD hold themselves responsible for the non-compliant behaviour of their children. Abidin (1995:1) points to research on the development of behaviour disorders which suggests that excessively stressful characteristics of the child, and stress in the parenting system, particularly in the first three years of life, are critical in relation to the child's emotional/behavioural development and to the developing parent-child relationship. *"The natural consequence of dysfunctional parenting is that children often develop emotional problems themselves"* (Abidin 1995:iv).

* Hartmann (1997) presents a refreshing approach to ADHD. He sees sufferers as "**hunters**" who are totally focused on movement, constantly monitoring their environment and exhibiting incredible bursts of energy. As such, he believes that ADHD may be beneficial and not problematic, particularly when the characteristics are correctly channelled to create an overall positive effect. In comparison, he refers to non-ADHD people as "**farmers**" who are cautious, slow and steady workers. In Hartmann's view (1997:86), ADHD is a problem for hunters when they are stuck in farmer life-situations, and have no way out of them, for example, when they are in jobs that require an entire days concentration at one desk and on one task, when they have *"a set of skills ideally suited to being an entrepreneur, or a writer, or a detective"*.

* Brett (1988:26) believes that stories offer a learning experience to the child who can absorb the message at his own rate, on his journey towards hope and understanding. Lankton (1989:397) states that *"The unconscious mind of the child, as with the adult, is set to the purpose of learning to cope with and master the ecosystemic demands which face them"*. Mills and Crowley (1986:xviii-xix) underline the fact that children are generally receptive to story-telling, preferring this to being "talked at" by some parent. They found that, because of the child's natural receptivity to metaphor, *"a conscious and directed application of a therapeutic metaphor via story-telling produced effective and gratifying results"*.

4.4.3 Therapeutic Point of Departure

Geldard and Geldard (1997:2) believe that the counsellor provides the environment in which to undergo the therapeutic change that we hope to achieve for the client. In O'Connor's view (Kaduson & Schaefer 1997:6), the primary goal of therapy is to help the client learn new and effective strategies for getting personal needs met in ways that do not interfere with others getting their needs met. The client and therapist must identify needs and current factors which prevent those needs from being met, and then identify and master effective new strategies to address the needs. As Clark (1995:153) points out, the parent-child relationship has a significant influence on the child's becoming, particularly in the formative years. It is essential that the parents are helped with their educational task and that they and their children with ADHD have their needs met effectively, so that healthy relationships between them are enhanced. In this way, it is hoped that the child's self-actualisation will be optimised.

The intended method of approach in this study will be through the states of **awareness**, **exploration** and **personalisation**. Macnab (1993:9) believes that *"The therapy becomes a process of establishing awareness and relevance of the context in which change and growth can take place. The task of the therapist is to help the client hear and decide what the problem is, in what areas of life it is experienced, how it affects functioning, feelings and fantasy, what coping strategies have been employed, and what resources are available"* (Macnab 1993:15). The enquiry embraces the experienced deficits and difficulties within the person, their relationships and their environment and includes an exploration of where the person would like to be and how to actualise those aspirations.

4.4.4 Method of Research

A literature as well as an ideographic study characterises the investigation.

The literature study involved a discussion of ADHD with regard to historical background, etiology, associated disorders, multidisciplinary assessment, parental stress and the effect on the parent-child relationship, the task of the educators from a psycho-pedagogical perspective, and intervention aimed at improving, firstly, the parent-child relationship, and ultimately, the negative behaviour of the child with ADHD.

The literature study was performed in an effort to prepare for the role of facilitator of the parent support group, as therapist of the children, and as advisor to the teachers. In view of the explosion of scientific interest in ADHD over the past decade, which has resulted in increased understanding and profound changes in treatment, rendering them so much more effective, the writer considers it crucial that **recent contributions** of scientists and clinicians should be extensively consulted, to build onto the already existing foundation of knowledge from previous years.

The ideographic research, the nature of which was described in Chapter One, will involve the forming of a support group consisting of parents of children with ADHD, facilitated by the researcher. A programme will be followed, within this supportive environment, in an attempt to accommodate the needs of the parents of children with ADHD, based on current research finding and available resource material. It is hoped that the parents will be empowered with knowledge and understanding, so that their stress levels are reduced, and that this will lead to improved parent-child relationships, and that, in a circular flow of change, the child will behave more appropriately, in turn enhancing the parent-child relationship.

In addition, the children will attend sessions, during which time the therapist will read a therapeutic story to them. The purpose of the stories is to put across an important message regarding their inappropriate behaviours. Garth (1995:9) believes that the mind is a most valuable asset, a tool, which determines who we are, based on what we think. She states that *"When we work on our inner resources, we can change patterns that have been there for years"*.

The teachers of the children will also be involved in the study. Kottman et al. (1995:142) state that parents, teachers, school counsellors and even the children with ADHD recognise the need for help from school personnel, as well as family members, if they are to succeed in school. Reid et al. (1994:195) emphasise the importance of providing teachers with information about ADHD *"since the classroom teacher is viewed as the major factor in the success or failure of any student and particularly those with ADHD"*. Thompson (1996:436), a medical doctor and parent of a child with ADHD, says *"From*

my standpoint as a parent, the most important gift that educators can give my ADHD child is understanding. The most important gift they can give me is regular, open communication".

4.4.4.1 Selection of Group Participants

The Parent Support Group will be comprised of eight to ten parents of children with ADHD, and will be facilitated by the researcher. As such, the diagnosis of ADHD will already have been made by a medical specialist. In addition, parents included will be those who have expressed high levels of stress related to their child's difficult behavioural manifestations, and negative parent-child relationships. Since Cordoni (1991:48) reports that participation by both parents is particularly beneficial to the family, an attempt will be made to involve both mothers and fathers.

Abidin (1995:1) stresses that **early intervention** of stressful parent-child systems is necessary to reduce the frequency and intensity of behavioural and emotional disturbance among children. For this reason, children included in the programme will be in their preschool or early junior primary phase, in the hope that severe adjustment problems will be prevented, or at least reduced, when academic demands become greater in the senior primary phase.

In an effort to reduce the number of variables at play, which may affect results, only children whose intellectual range falls within the average or high average category, as described by Madge (1981:81), will be included in the study.

Table 9: Madge's Description of Average Intelligence

IQ RANGE	DESCRIPTION
110 to 119	High Average
90 to 109	Average
80 to 89	Low Average

4.4.4.2 Time and Duration

The parent support group will meet in the early evening over a period of seven weeks, giving fathers the opportunity to attend. In view of the frenetic lifestyles which place extreme time pressures on most families, the sessions will last for about an hour, not exceeding one and a half hours.

The children will attend a weekly session of half an hour for eight sessions. The time of the session will be consistent each week, arranged to suit each child and his family.

4.4.4.3 The Role of the Educational Psychologist

Therapeutic sessions with the parents will be facilitated by the researcher, an educational psychologist. However, being the parent of a son with ADHD, the status of the group leader in this study will be both as group facilitator and parent. Taylor (1994:4) makes the following suggestions for the facilitator of a group session:

- Welcome each participant individually and try to find out enough about their reasons for attendance so that comments can be personalized as the discussion is led.
- Be sensitive to the levels of comprehension of the audience and strive to address them at those levels.
- Set a tone of respect by encouraging participants to agree on confidentiality within the group.

Geldard and Geldard (1997:2) point out the obvious - that children cannot be counselled in the same way we counsel adults, by sitting down with them and inviting them to talk with us. They believe that, in order to engage children so that they can deal with issues, counsellors, or child therapists, as they will be referred to in this study, should provide a suitable environment in which they can undergo therapeutic change. This is made possible by combining the use of verbal skills with other strategies, such as play, miniature animals, clay, art, story-telling or taking the child on an imaginary journey. For the purpose of this study, the child therapist will use a story-telling approach.

Geldard and Geldard (1997:6) highlight the belief by others who work as child therapists, that *"the child-counsellor relationship is crucial to the process of therapeutic change"*. The relationship is primarily about connecting with the child, working from within the child's framework, without judgement, affirmation or condemnation. According to Geldard and Geldard (1997:26), desirable attributes for a child therapist are that he/she must be:

* congruent
* in touch with his/her own inner child
* accepting
* emotionally detached

Guidance and counselling is the personal assistance given by an adequately trained person. *"It is informative, advisory, diagnostic, therapeutic, preventative, supportive, orientative and includes analysis, placement and follow-up"* (van den Aardweg & van den Aardweg 1988:104). It *"is a comprehensive, pedagogical, ancillary service involving goal-directed, conscious, purposeful effort of an educator to support and advise the student/pupil in all aspects of his becoming so that he can reach his potential"*. This definition epitomises the task of the educational psychologist in this particular study.

4.4.4.4 **The Therapeutic Programme**

A programme will be followed, within a supportive environment, in an attempt to accommodate the specific needs of parents of children with ADHD, based on current research findings. Bearing in mind the large number of resources available which aid with the effective management and parenting of a child with ADHD, a programme will be planned based on **available resource material**.

The first session with the children will be used to establish **rapport**. Roberts (1993:115) defines rapport as *"A term used in a very similar way to how it is used in everyday English, for a friendly comfortable relationship between two people. Within the context of **psychoanalysis, psychotherapy,** and **counselling,** it is usually applied to the relationship that ideally develops between the analyst, therapist, or counsellor and the client or patient - involving empathy on the one hand, and trust on the other."* For the

following seven sessions, a therapeutic story will be read to the children, following an attention-focusing exercise. Music will be played softly in the background to create a peaceful atmosphere which is conducive to relaxation and focus of attention.

The teachers of the children will also be involved in the study to a limited extent. They will be contacted and the purpose of the study will be explained to them. They will be given guidelines on how to deal with some of the behaviours displayed and a daily report card which they can use to record their observations should this be deemed necessary.

The effectiveness of the programme will be evaluated by **pre-**and **post-testing**. The ADHDT questionnaires will be completed by both parents and the teacher of each child at the start and at the conclusion of the programme. The parents will also complete the PSI before and after the programme. In addition, the parents will complete a questionnaire based on their subjective experiences of the programme on completion of the programme.

The Attention-Deficit/Hyperactivity Disorder Test (Appendix F) will be used to evaluate the improvement of each child's behaviour. The ADHDT is a norm-referenced test, designed to evaluate the behaviour of persons with ADHD or persons with behavioural problems. It is easily completed by parents and professionals and provides information about problems of hyperactivity, impulsivity, and inattention (Gilliam 1995:5-6). *"Because of its sound construction and its strong technical characteristics, the ADHDT can be used with confidence for the following purposes: (a) to identify persons with ADHD, (b) to assess persons referred for behavioral problems, (c) to document progress in the problem areas as a consequence of special intervention programs, (d) to target goals for change and intervention on the student's individualized education program (IEP), and (e) to measure ADHD in research projects."*

Gilliam (1995:2) points out the DSM-IV criterion that some impairment from the symptoms should be present in **two or more settings**. For this reason, parents and teachers will be asked to complete the questionnaire before and after the programme, based on their own observations of the child's behaviour at those stages. As Thompson (1996:434) points out, since there is no definitive diagnostic test for ADHD, the most reliable diagnostic tool is information elicited from parents and teachers. Bearing in mind

the subjective nature of the responses, both parents will be requested to complete the questionnaires individually. These results will be compared with the parental levels of stress reflected on the PSI.

The parents will each complete the Parenting Stress Index (Appendix E) at the start and at the conclusion of the programme, in an effort to establish the effect of the programme on their stress levels. The PSI is suggested for use by clinicians and researchers who work with parents of children ranging in age from one to twelve years. According to Abidin (1995:iv), the primary categories for use are:

- screening for early identification
- assessment for individual diagnosis
- pre-post measurement of intervention effectiveness, and
- research aimed at studying the effects of stress on parent-child interactions and in relation to other psychological variables

In addition, at the end of the programme, the parents will be asked to complete a short questionnaire (Appendix J) on their subjective experiences. These questionnaires will be analysed qualitatively.

4.4.4.5 **Procedures**

The following procedures will be adopted:

* Parents who have phoned to express exasperation as a result of their child's behavioural difficulties at home and at school will be targeted, along with their children, as participants in the study. The parents will be contacted telephonically, the purpose of the study will be explained to them and their participation will be requested.

* Parents who indicate interest in the study will be formally invited by means of a letter (Appendix A).

* Once sufficient affirmative replies have been received, the parents will again be contacted telephonically to inform them of the time decided upon and the date of commencement of the sessions. Times will be arranged for the individual sessions with the children.

* Relevant data regarding the children concerned will be obtained in order for the psychologist to compile a case history for each one. In the event that any of the children have not been formally evaluated, this will be arranged to ensure that all children meet with the criteria for selection.

* Parents will be asked to complete the following:

  - Historical background of their child (Appendix B)
  - List of their children's favourite things (Appendix C)
  - Behaviours that need targeting (Appendix D)
  - Parenting Stress Index (Appendix E)
  - Attention-Deficit/Hyperactivity Disorder Test (Appendix F)

* The teacher of each child will be contacted telephonically and the purpose of the programme will be explained. They will be asked to complete the ADHDT (Appendix F) for each child at the start of the programme. They will be asked to report positive or negative changes during the research period to the psychologist. They will also be provided with guidelines (Appendix G) on how to address some of the typically negative behaviours which manifest in children with ADHD in the classroom. They will be given a copy of the Daily Report Card (Appendix H).

* Towle (1980:166) is of the opinion that the format of meetings chosen must appeal to the participants. Parents indicated time pressures. Feeling somewhat out of control in the situation they currently found themselves in, they also expressed a reluctance to expose their own weaknesses in front of a group of relevant strangers. For this reason, it was decided to adopt a structured information-giving approach, allowing some time at the end of each session for sharing, should parents have the need and feel comfortable enough to do so.

For the purpose of this study, the following format will be adopted:

- Informal chat
- Information-giving by means of a video, audio-tape or demonstration
- Time of sharing
- Relevant handouts will be distributed
- Relevant books will be recommended
- Closure

* The programme will be evaluated by post testing. The parents will be asked to complete the following:

  - Parenting Stress Index (Appendix E)
  - Attention-Deficit/Hyperactivity Disorder Test (Appendix F)
  - Parent Questionnaire (Appendix J)

* The Teachers will be asked to complete the Attention-Deficit/Hyperactivity Disorder Test (Appendix F) and they will be asked for feedback on the child's behaviour.

4.4.4.6 **Venue**

Meetings with the parents will be held at the home of the investigator. The room chosen for the meetings will be in a part of the house where disturbing influences will be minimised. The participants will be seated on comfortable chairs, arranged in a circle to ensure that everyone can see and hear each other, to enhance rapport and encourage personal involvement. In addition, the chairs will be positioned so that everyone can comfortably see the TV screen or the demonstration being held.

The children will be seen in the psychologist's office, where there is a comfortable chair for them to occupy, the necessary audio-visual media are easily accessible and where there are few distracting auditory and visual stimuli.

4.5 CONCLUSION

The literature study conducted in the previous chapters has acclaimed multi-modal intervention as a positive treatment plan for children with ADHD. Since parents cannot fulfill their parenting role when their levels of stress are high, the necessity to provide them with support and knowledge on ADHD, as well as effective coping strategies is very evident. The fact that a better prognosis is likely when early intervenion is initiated has been highlighted. The need for therapeutic intervention is great, yet, as van Niekerk (1998:5-6) so aptly points out, resources in South Africa are very limited in present times, and teachers are often forced to give some form of assistance to children in need, whether they like it or not. Very often, they feel helpless and inadequate, believing they do not have the skills or the resources to help these children. Hence the importance of designing a programme aimed at offering practical skills to teachers who are truly concerned about the total child with whom they come into contact. When one considers the reported increase in the number of children diagnosed with ADHD, the nessity to create such programmes for teachers to use in a wide variety of settings becomes imperative.

Since it is considered important that professionals in the field of education should assist teachers and parents to obtain information and support, a programme has been devised to address this need. The following chapter will be devoted to the application of the ideographic research which has been outlined in this chapter.

CHAPTER FIVE

THE IDEOGRAPHIC STUDY

Children are educated by what the grown-up is, and not by what he says
CJ Jung Collected Works Vol 9 (Alexander 1998:iv)

5.1 INTRODUCTION

The ideographic study which forms the empirical research, as outlined in the previous chapter, will be addressed in this chapter.

Throughout the literature study, it has become very clear that the parents of children with ADHD face extremely challenging moments. The sheer physical exhaustion the parents suffer at the end of the day frequently culminates in feelings of guilt related to their child. They blame themselves for the poor behaviour. Professionals sometimes affirm these beliefs, quoting reasons as lack of parental discipline and involvement, as well as a lack of ability to care properly for the child. This attitude adds to the despair of the parents who may become further depressed and less able to cope with the demands. Many parents do not receive positive help in dealing with their child with ADHD (Gilbert 1998:41). Hallowell and Ratey (1994:51) stress that the notion that ADHD is someone's fault must be dispelled, but they point out that inadequate parenting can exacerbate the situation. Thus it becomes clear, that the parents do need help in managing the child.

Shapiro (1994:110) points out the recent interest in parents joining **support groups** which help with children's problems. He confirms the usefulness of these programmes where information is provided to help parents understand the problems, and which act as a source of emotional support and practical help for parents who might otherwise suffer feelings of isolation and despair. Shapiro (1994:132) also reinforces Gardner's finding that reading **stories** which contain a message to children can prove to be a very useful therapeutic technique. Since it is the behaviour of the child in particular that causes so much despair, it was strongly felt that this should be addressed with the children, and it was decided to include them in the current programme. A **multi-modal** approach has

been strongly advocated as leading to a better outcome for the child with ADHD. This was already acknowledged in the seventies by Feighner and Feighner (1974:460) and has recently become a very popular concept.

With these views in mind, a multi-modal programme has been planned, according to the particular needs of the parents and the child with ADHD. An effort will be made to foster **awareness** of parent and child, in the hopes that it will lead effectively to a process of **exploration** and **personalisation**, ultimately so that positive changes come about which improve the parent-child relationship.

5.2 METHOD OF RESEARCH

A discussion of the method of research, previously outlined, as it occurred during the programme, follows.

5.2.1 Selection of Group Participants

Three couples and a single mother agreed to participate in the programme. All four children are boys. All the children fall in the average or high average intellectual range, classified as such according to Madge (1981:81). All had recently been diagnosed with ADHD and all the parents involved were experiencing stress as a result of their child's poor behaviour, exacerbated by the negative feedback they were getting from the child's teachers.

One father attended only the first session, openly displaying his feelings of anger and aggressively expressing his denial of the fact that there was "**anything wrong**" with his son. His wife attended four sessions and then withdrew herself and her child from the programme.

The single mother was accompanied by her partner, with whom she lives but who is not the biological father of Child C. They attended five out of the seven sessions, reporting work commitments as the reason for the first absence, and heavy rain with consequent traffic delays as the reason for the second absence.

The mother of child A attended six sessions, and her husband five. They cited previously planned work engagements as the reason for non-attendance.

Child B's parents attended six of the seven sessions, failing to attend the first session as a result of the sudden death of a close family friend.

Table 10: Child Participants

	CHILD A	CHILD B	CHILD C	CHILD D
Date of Birth	1994-06-07	1992-02-01	1990-07-25	1992-01-02
Chronological Age	4 years 4 months	6 years 8 months	8 years 2 months	6 years 9 months
Level of Education	Nursery School	Grade i Private Mainstream	Grade ii Remedial School	Transfer back to Pre-School
Position in Family	Only Child	Fourth of six	Only Child	First of two
Medication	None	Ritalin 5 mg (x2 daily)	None	None
IQ				
Verbal	Average	High Average	Average	Average
Performance	High Average	Average	High Average	High Average
Global	High Average	High Average	Average	Average
Numerical	Superior	Average	Average	High Average
Memory	High Average	Average	High Average	Average
Discrepancy	Significant in favour of performance	Non-significant in favour of verbal	Significant in favour of performance	Significant in favour of performance

5.2.2 Time and Duration

The parent meetings took place on a Thursday evening over a seven week period. Each meeting lasted for about an hour and a half. The children attended eight half-hour sessions.

5.2.3 Time Schedule

Parent Support Group Programme

18:00	Informal chat / Feedback on previous session and problems which may have arisen at home
18:15	Video / Demonstration and Information-Giving
18:30	Time of sharing
19:00	Integration
	Handouts
	Recommended Books
19:15	Closure

Individual Therapy

Half hour sessions were organised for the children. The time was organised to fit in with the routines of the child within his own family system.

5.2.4 Venue

The parent meetings were held at the home of the investigator. Being centrally situated with regard to the homes of the participants, this was considered suitable by everyone. Furthermore, the comfort of the sitting room created the informal environment that was desired. There were no disturbing influences and it was also possible to seat everyone in a circle, so that each individual was exposed to the whole group, as recommended by Gazda (1968:100). The children were seen in the office of the investigator where the necessary equipment and materials were easily accessible.

5.2.5 The Educational Psychologist

The role of the educational psychologist was, in the first instance, as a **facilitator** of the support group. As such, it was necessary for a programme to be planned which would suit the needs of the parents, being both interesting and enlightening. In view of the fact that so many videotapes are currently available on topics of parenting, it was decided to

make use of these. Parents also needed support and an opportunity to voice disappointment and concerns. The facilitator was able to provide this opportunity for them within a **warm, trusting, empathic climate**. Secondly, the role of the educational psychologist was as a **parent** of a child with ADHD, who has completed his secondary education and is currently working. This gave her the opportunity to voice some of her own disappointments and concerns. It was also possible to speak with experience about matters, and to offer parents hope that there is some light at the end of the tunnel.

The educational psychologist's role in the programme was also one of a **child therapist**. Bearing in mind the recognition of Geldard and Geldard (1997:5), that the **relationship** between therapist and child is a critical factor with regard to therapeutic outcomes, the first session was used to complete drawings and to chat informally to the children in an effort to establish a comfortable rapport. Shapiro (1994:6) reminds us that children are often aware that they are seeing a therapist because they have acted badly, and so may be reluctant to be there. Their inevitably mixed feelings of apprehension, anxiety and embarrassment must be treated with sympathy. The therapist must try to put the child at ease and establish a relationship built on **trust** and **compassion**, even though, with some children, this may be a formidable task. During the following seven sessions, therapeutic stories were read to the children.

5.2.6 **The Programme for the Parents**

In view of the fact that parents had expressed time pressures, it was decided to show a video or give a demonstration, followed by brief discussion and then provide parents with information in the form of a hand-out, which they could take home and read at their leisure. Relevant books were recommended. The parents would be free to discuss any issues at the end of the session, or at the start of the following session. In compiling the handouts given to parents, extensive use was made of the following sources: Armstrong (1995); Clark (1995); Ingersoll (1998); Parker (1994); Pierangelo (1994); Ravat (1995); Taylor (1994); Teeter (1991).

5.2.6.1 Session One: Introduction and ADHD

Ingersoll (1998:151) says that *"Life with an ADHD child is like a roller-coaster ride"*, with lots of highs and lows, *"And unlike a roller coaster in an amusement park, you don't have any choice about going along for the ride"*. In fact, life can be really hard for every member of the family, even the pet dog. Very often, relationships with extended family members suffer (Ingersoll 1998:153). The nature of ADHD and its effect on the family and the child with ADHD formed the point of departure for discussion in the first session.

Goals

* To become acquainted
* To create a safe atmosphere
* To introduce the programme
* To give the parents an opportunity to voice concerns and express feelings
* To provide parents with information on ADHD
* To provide the parents with a list of guidelines for the class teachers

Introduction

* The facilitator introduced herself and explained her reasons for the study. Members were encouraged to participate fully in their sharing of experiences, feelings and advice. The issue of confidentiality was discussed.
* The parents were asked to introduce themselves and to give reasons for their participation.
* Practical aspects were given consideration. Parents were asked to commit themselves to bringing their children each week for the therapeutic story telling, to attend each of the parent group sessions, and to encourage the child's teacher's involvement. The importance of punctuality was stressed.
* The topics which were to be covered in the following sessions were named.

Educational Phase

*	Video-tape:	Restless Minds, Restless Kids. Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (Connors & March 1998)

Exploration and Personalisation

* Time of sharing

Close of Session

*	Integration	
*	Handouts:	Attention Deficit Hyperactivity Disorder (Appendix F) Guidelines for the class teachers (Appendix G) Daily Report Card (Appendix H)
*	Recommended Reading:	*No More Ritalin* by Mary Ann Block (1996) *Understanding Attention Deficit Disorder* by Christopher Green (1995) *Daredevils and Daydreamers* by Barbara Ingersoll (1998) *Hyperactive Children* by Heather Picton (1997) *The Hidden Handicap* by Gordon Serfontein (1990)

Overview of Session One

All but one of the parents who attended this session seemed enthusiastic about their participation. Many expressed a hopefulness that they would get much needed support and information which would enhance their parenting task. There was still some grappling with the '**acceptance**', as reflected in comments which suggested denial.

5.2.6.2 Session Two: Self-Esteem

The feelings and beliefs a child has about himself will determine how successful he is. Richards and Taylor (1994) underline the vital role the parents have in their child's development of self-esteem. Ginott (1956:233-234) believes that *"The personality of a child is coloured by the emotional atmosphere of his home"*. Furthermore, *"Personality and character only flourish when methods of child-rearing are imbued with respect and sympathy"*. Shapiro (1994:114) recognises that a low self-esteem contributes towards the development of psychological problems. Children with good self-esteem *"see themselves as valuable people whose sense of self-worth and belonging are reflected by their internal sense of success and mastery, as well as from the approval of their family, community and society at large"*.

However, **low self-esteem** is the constant companion of the child with ADHD, affecting all those with whom he interacts. The feeling of inadequacy results in negative behaviours and blocks his path to new possibilities and positive action (Debroitner and Hart 1997:8). As a result, the child employs various techniques to gain acceptance by the peer group and he may be easily influenced and led by other children (Serfontein 1990:57). Hence the need for the inclusion of this topic in the parent support group programme.

Goals

* To create an awareness of the characteristics of children with high self-esteem
* To enhance self-awareness
* To emphasise the effect in the home of the parents' own self-esteem
* To provide guidelines for improving the child's self-esteem

Educational Phase

*	Video-tape:	Successful Parenting Part One: Self-Esteem is the Key (Richards and Taylor 1994)
*	Handout:	My Personal Plan (Appendix I2.l)

Exploration and Personalisation

* Time of sharing

Close of Session

* Integration
* Handouts: Ten Suggestions for Enhancing the Self-Esteem of your Child (Appendix I2.2)
  Letter of appreciation (I2.3)
* Recommended Reading: *Living, Loving and Learning* by Leo Buscaglia (1982)
  How to Really Love your Child by R. Campbell (1977)
  Self Esteem by James Dobson (1995)
  Liberated Parents Liberated Children by Adele Faber and Elaine Mazlish (1990)

Overview of Session Two

The parents became very aware of the effect of what they said to their children, and the way they acted towards them, on the development of the self-esteem. They expressed a wish to remain calm and more positive, and also realised the importance of giving themselves opportunities to enhance their own self concepts.

5.2.6.3 Session Three: Communication

In the video tape presented by Richards and Taylor (1994) on communication, they suggest that when **mutual trust, love** and **respect** are present in the communication between parent and child, understanding and cooperation result. They stress the importance of parents encouraging children to talk openly, to express feelings and to problem-solve. They encourage **active listening** to a child and warn that humiliating comments damage the self-esteem of the child, as well as future communication, which

is likely to damage the parent-child relationship. Shapiro (1994:26) recognises that better ways to communicate foster more meaningful and productive relationships.

The child with ADHD may struggle to express himself, and, as a result of his difficulties with communication, he may become very frustrated. **Behaviour problems** may be the symptom of this frustration (Picton 1998:134). Furthermore, problems with detecting important **nonverbal cues** in interaction lead to difficulties with interpersonal relationships (Ingersoll 1998:40). Hence the importance of highlighting parental styles of communication, both on a verbal and non-verbal level, and the effect of this communication on their relationship with the child with ADHD.

Goals

* To enhance awareness of the type of communication taking place within the home, including non-verbal communication
* To provide ideas for improving communication

Educational Phase

* Video-tape: Successful Parenting
  Part Two: Communication is Crucial (Richards and Taylor 1994)
* Handout: My Personal Plan (Appendix I2.1)

Exploration and Personalisation

* Time of sharing

Close of Session

* Integration

*	Handouts:	Eight Suggestions for Improving Communication with your Child (Appendix I3.1) Communication (Appendix I3.2)
*	Recommended Reading:	*How to Talk so Kids will Listen and Listen so Kids will Talk* by Adele Faber and Elaine Mazlish (1980) *Between Parent and Child* by Haim Ginott (1956)

Overview of Session Three

The parents expressed an awareness of the effect of their words and non-verbal communications on their children. They came to understand the importance of really '**listening**', in an effort to provide the child with an opportunity to release negative feelings.

5.2.6.4 Session Four: Discipline

According to Dobson (1995:6-7), *"Children thrive best in an atmosphere of genuine love, undergirded by reasonable, consistent discipline"*. He stresses the importance of parents learning how to set limits *"within the framework of love and affection"*. However, he acknowledges the difficulty involved in this and points out the parents' need for **courage, consistency, conviction, diligence and enthusiasm in their efforts**. Phelan (1995:2) reminds us that children do not come with a training manual. He believes that parents must learn how to manage the difficult behaviour, and whilst he agrees that this may be a difficult task, he states that *"it is critical to peaceful co-existence and to each child's ability to enjoy life and maintain healthy self-esteem"*. Families are different, and each child is **unique**. Furthermore, situations change as children grow up, and for this reason, Richards and Taylor (1994) believe that *"parents need to understand and be ready to use a variety of different discipline techniques"*. The focus of this session will be on discipline, with particular attention being paid to the setting of limits and time-out as a non-abusive consequence of the child's negative behaviour.

Goals

* To create an awareness of the need to discipline consistently and firmly, but reasonably and lovingly
* To provide ideas on improving behaviour
* To provide ideas on how to discipline effectively without harsh verbal or physical punishment

Educational Phase

*	Video-tape:	Successful Parenting Part Three: Discipline Makes the Difference (Richards and Taylor 1994)
*	Handout:	My Personal Plan (Appendix I2.1)

Exploration and Personalisation

* Time of sharing

Close of Session

*	Integration	
*	Handouts:	Ten Suggestions for Disciplining your Children (Appendix I4.1) Time-Out Procedure (Appendix I4.2) Three Steps to Limit Setting (Appendix I4.3)
*	Recommended Reading:	*The New Dare to Discipline* by James Dobson (1995) *Discipline without anger or tears* by Derek Jackson (1991) *1-2-3- MAGIC - Effective Discipline for Children 2 - 12* by Thomas Phelan (1995)

Overview of Session Four

Parents seemed to feel that many of the suggestions offered were just 'too easy' and not a permanent solution to the problem. It was very clear that they did not view '**love**' as part and parcel of discipline. They became very aware of the **inconsistency** of their style of disciplining and of the tendency to work against each other as parents, rather than maintaining a united front.

5.2.6.5 Session Five: Parenting Skills

Whilst it is well-recognised that one needs education and training to develop skills necessary to meet advanced technological goals, such as those which have led to space travel and the conquering of certain diseases, it is only recently that people have realised the need to prepare men and women for raising children effectively. Abidin (1996:v-vi) points out that the only requirement for the practice of parenting is biological. He stresses that *"Parents must be given the opportunity to develop the knowledge and specific skills necessary to rear their children effectively in whatever environment they find themselves"*.

Goals

* To enhance awareness of individual styles of parenting
* To offer alternative ideas on parenting based on the principle of unconditional love

Educational Phase

* Video-tape: Power in Parenting: The Young Child (James Dobson Undated)

Exploration and Personalisation

* Time of sharing

Close of Session

* Integration
* Recommended Reading: *Taking Charge of* ADHD by R.A. Barkley (1995)
  The ADD Hyperactivity Workbook for Parents, Teachers and Kids by H.C. Parker (1994)
  How *to Help Children with Common Problems* by C.E. Schaefer and H.L. Millman (1981)
  Parent Burnout by Derek Jackson (1992)

Overview of Session Five

James Dobson provides a light-hearted discussion on parenting which created a safe atmosphere for the parents to become aware of and acknowledge some of their own mistakes in parenting. The parents seemed comfortable with each other at this stage, and openly spoke about their problems and offered advice to the others.

5.2.6.6 Session Six: Parent Involvement

Gottman's investigation into family dynamics has yielded evidence that the **emotional interactions** between parent and child have a great impact on his long-term well-being. He believes that the key to successful parenting lies not in complex theories, but begins in the heart, demonstrated through **love** and **affection**. *"The heart of parenting is being there in a particular way when it really counts"* (Gottman 1997:15-18).

Goals

* To create an awareness of the parent's quality of involvement with their child
* To encourage parents to spend quality time with the child
* To encourage parents to make appropriate physical contact with their child, who, due to his high activity levels and impulsivity, may often be rejected by family and friends

Educational Phase

*	Demonstration:	Body Massage by an aromatherapist Essential Oil: Hypokid (Lilian Terry)

Exploration and Personalisation

* Time of sharing

Close of Session

*	Integration	
*	Handouts:	Parent Involvement Checklist (Appendix I6.1) Brochure on Homeopathic Complexes (Lilian Terry)
*	Recommended Reading:	*The Heart of Parenting* by John Gottman (1997) *Emotional Intelligence* by Daniel Goleman (1995)

Overview of Session Six

The parents saw the massage and the time spent together as an exciting prospect and were hopeful that this would be one means of avoiding the administration of medication. They later reported many moments of 'closeness' with their children, which they really felt was beneficial to the parent-child relationship, and noted a definite improvement in their child's ability to stay still and relax. However, over the next few weeks, after massaging twice daily, they did not notice a significant difference overall in activity levels.

5.2.6.7 Session Seven: Relaxation Exercise

In the introduction to his book, Jackson (1992) stresses that one of the most significant things that has happened on the health front in more recent times is the realisation that stress, particularly the type that arises from mental or emotional sources, can have very damaging effects on the body as well as the mind. He claims that, whilst we think it only happens in response to major traumatic events in our life, it more frequently develops as

the result of constant daily hassles that tax our coping resources to the limit. He believes that the answer to mastering stress lies in learning techniques that help you relax in all situations in life, and echoes the thoughts of the Roman poet Juvenal who in 130 AD wrote: *'Orandum est ut sit mens sana in corpore sano'* - *'Your prayer must be that you may have a sound mind in a sound body'.*

Goals

* To provide the parents with an opportunity to experience a moment of relaxation
* To create an awareness of the effects of relaxation on their functioning

Educational Phase

* Group Relaxation Exercise - Simon Roos 1996 (Appendix M)

  Music: *Peace and Tranquillity* - Phil Coulter
  What a Wonderful World - Louis Armstrong

Exploration and Personalisation

* Time of sharing

Close of Session and Group Closure

* Integration
* Handouts: Review of the Programme (Appendix J)
* Recommended Reading: *Making Dreams Come True* by Vicki Bennett (1996)
  Sunshine by Mary Garth (1994)
  Inner Space by Mary Garth (1995)
  Staying Well with GUIDED IMAGERY by Belleruth Naparstek (1994)

Overview of Session Seven and the Programme

The parents were all able to relax very effectively during the exercise . They reported feeling 'wonderful' thereafter, and also came to realise the importance of making the time to relax themselves. They realised that if they could make their minds and bodies relax in this way, it was surely beneficial for their children to do the same. Parents expressed much gratitude for having been included in the programme. They reported a greater awareness of the difficulties and an understanding of their children. They reported definite benefits to the family functioning, which was commented on by several of their friends and family members. Most of all, they realised that a combination of interventions is the most effective approach. In particular, they were more accepting of the idea of including **medication** as one of the forms of intervention, provided it was carefully controlled. The parents who remained in the programme to the end all expressed the need for **on-going support** and **guidance**.

5.2.7 The Therapeutic Stories with the Children

An attention-focussing exercise was done prior to the reading of all but the first story, which is quite long and is a relaxation exercise. These exercises were decided upon, taking the **ages** of the children into account. The stories read to the children were also adapted to suit each one of them, taking their **needs**, **ages**, **style of language**, **interests** and **favourite things** into account. The stories were taped onto audio-tapes each week to give the children the opportunity to listen to them a few times during the week. The parents were asked to provide the children with an opportunity to listen and the availability of a tape recorder. Kohen et al. (1984:21-24) point to Milton Erickson's emphasis of the naturalistic skills of children in using **mental imagery**. They assessed outcomes of relaxation-mental imagery in the management of 505 paediatric behaviour encounters and concluded that it was a useful **therapeutic tool**. However, they reported that parental reinforcement of practice is commonly associated with its cessation. They emphasise the child's **control** and **mastery** and suggest that parental reminders negate that. For this reason, the parents were cautioned against insisting on the child's listening.

Table 11: Therapeutic Stories with the Children

WEEK	CHILD A	CHILD B	CHILD C	CHILD D
ONE	* Annie Story	* Annie Story	* Annie Story	* Annie Story
TWO	* Star Prelude * The Car that Wouldn't Stay on the Road	* Star Prelude * The Car that Wouldn't Stay on the Road	* Star Prelude * The Car that Wouldn't Stay on the Road	* Star Prelude * The Car that Wouldn't Stay on the Road
THREE	* Study Space Pictures * Visualisation space journey * The Red Tow Truck	* Study Space Pictures * Painting * Visualisation - space journey * The Red Tow Truck	* Study Space Pictures * Painting * Visualisation - space journey * The Red Tow Truck	* Study Space Pictures * Painting * Visualisation - space journey * The Red Tow Truck
FOUR	* Bubble Blowing * Pink Bubble of Love * The Adventures of Blue Sparkle	* Bubble Blowing * Pink Bubble of Love * The Adventures of Blue Sparkle	* Bubble Blowing * Pink Bubble of Love * The Adventures of Blue Sparkle	* Bubble Blowing * Pink Bubble of Love * The Adventures of Blue Sparkle
FIVE	* Furry Material - Favourite Animal * Little Bunny Runs Away	* Computer Screen - Eye Fixation * Non-directive Painting Activity * Rainbow the Puppy	* Computer Screen - Eye Fixation * The Brown Leaves (Encopresis)	* Computer Screen - Eye Fixation * The Little Elephant (Enuresis)
SIX	* Body Awareness * The Tiger in the Cage	* Body Awareness * Non-directive Clay Activity * The Tiger in the Cage	* Body Awareness * The Tiger in the Cage	* Failed to Attend
SEVEN	* Flying in the Clouds * The Red Car	* Cloud Car Journey * Non-directive Play Dough Activity * The Red Car	* Cloud Car Journey * The Red Car	* Failed to Attend
EIGHT	* Star Prelude * The Monster in the Mirror	* Breathing Awareness * The Monster in the Mirror	* Breathing Awareness * The Monster in the Mirror	* Failed to Attend

5.3 RESULTS OF THE PROGRAMME

5.3.1 Quantitative Analysis

Table 12: The Results of the ADHDT

ATTENTION DEFICIT / HYPERACTIVITY TEST

	RYAN									MICHAEL									GREGORY									GABRIEL					
	MOM			DAD			TEACHER			MOM			DAD			TEACHER			MOM			TEACHER			MOM			DAD			TEACHER
	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C	A	A		A	A		A
ADHD Quotient	109	100	-9	111	85	-26	100	79	-21	76	70	-6	102	87	-15	66	96	+30	104	83	-21	96	89	-7	79		66	79		66		
Hyperactivity	11	10	-1	12	8	-4	11	7	-4	6	6	0	10	8	-2	5	11	+6	10	8	-2	8	9	+1	6		5	6		5		
Impulsivity	13	10	-3	14	9	-5	12	8	-4	7	6	-1	12	8	-4	5	9	+4	12	7	-5	11	7	-4	7		6	8		6		
Inattention	10	10	0	9	6	-3	7	5	-2	6	4	-2	9	8	-1	4	8	+4	10	8	-2	9	9	0	7		3	6		3		

An explanation of Table 12 follows:

A	:	Scores from initial administration
B	:	Scores from final administration
C	:	Difference between the two scores
ADHD Quotient	:	According to Gilliam (1995:14), the best overall estimate of a subject's behaviour is the ADHDT Quotient. A person probably has ADHD if the ADHD quotient is 90 or above. ADHD Quotients equal to or greater than 111 are highly indicative of ADHD. An ADHD quotient of 80 through 89 is below average for subjects with ADHD and represents borderline scores in terms of the likelihood of ADHD.
Subtest Scores	:	Standard scores of 8 through 12 are within the average range for subjects with ADHD in the normative sample. Standard scores above 12 are highly indicative of ADHD whereas scores of 6 and 7 represent borderline scores in terms of the likelihood of ADHD (Gilliam 1995:14).

Table 13: The Results of the PSI

PARENTING STRESS INDEX																		
	RYAN-MOM			RYAN-DAD			MICHAEL-MOM			MICHAEL-DAD			GREG-MOM			GABRIEL-MOM		
	A	B	C	A	B	C	A	B	C	A	B	C	A	B	C	A		
Defensive Responding	34	36	+2	30	38	+8	23	21	-2	22	23	+1	49	30	-19	41		
Total Stress	83	70	-13	77	76	-1	5	4	-1	13	7	-6	96	33	-63	73		
Life Stress	40	65	+25	96	96	0	65	82	+17	90	90	0	95	40	-55	97		
CHILD DOMAIN	98	93	-5	97	87	-10	10	7	-3	63	23	-40	99+	50	-49	87		
Distractibility/Hyperactivity	99+	92	-7	95	90	-5	35	7	-28	95	60	-35	88	80	-8	65		
Adaptability	97	84	-13	96	95	-1	25	25	0	25	35	+10	95	80	-15	70		
Reinforces Parent	65	55	-10	55	55	0	30	45	+15	65	55	-10	97	55	-42	97		
Demandingness	99+	97	-2	99	85	-14	5	10	+5	45	45	0	99+	75	-24	75		
Mood	75	85	+10	60	85	+25	25	25	0	75	1	-74	95	25	-70	75		
Acceptability	80	90	+10	90	60	-30	10	10	0	40	10	-30	99+	85	-14	95		
PARENT DOMAIN	38	30	-8	42	65	+23	7	6	-1	2	2	0	93	23	-70	55		
Competence	70	45	-25	70	87	+17	15	25	+10	1	3	+2	99+	86	-13	30		
Isolation	10	10	0	35	5	-20	15	5	-10	15	15	0	50	5	-45	75		
Attachment	50	25	-25	65	90	+25	1	35	+34	10	1	-9	85	25	-60	50		
Health	3	25	+22	20	10	-10	10	3	-7	20	3	-17	35	3	-32	20		
Role Restriction	65	10	-55	30	65	+35	20	10	-10	15	30	+15	70	30	-40	25		
Depression	50	50	0	35	80	+45	3	10	7	5	12	+17	90	60	-30	91		
Spouse	50	50	0	65	55	-10	25	10	-15	5	9	+4	97	68	-29	70		

An explanation of Table 13 follows:

A	:	Score from initial administration
B	:	Score from final administration
C	:	Difference between the two scores

Defensive Responding:		A Defensive Responding score of 24 or less indicates that the individual may be responding in a defensive manner. Low Defensive Responding scores indicate high levels of defensive responding.
Total Stress	:	The Total Stress score is of primary importance in identifying parent-child systems that are under stress and at risk for the development of dysfunctional parenting behaviours or behaviour problems in the child involved. When the Total Stress score is above 86, professional intervention is probably necessary.
Life Stress	:	The Life Stress scale provides some index of the amount of stress outside the parent-child relationship that the parent is currently experiencing and which is often beyond their control, such as the death of a relative or the loss of a job.
Parent Domain	:	High scores in the Parent Domain suggest that sources of stress and potential dysfunction of the parent-child system may be related to dimensions of the parent's functioning.
Child Domain	:	High scores in the Child Domain may be associated with children who display qualities that make it difficult for parents to fulfill their parenting roles. When the Child Domain score is elevated in comparison to the Parent Domain and Life Stress scale scores, the interpretation may be made that child characteristics are major factors in contributing to the overall stress in the parent-child system.

5.3.2 **Qualitative Analysis**

CHILD A

	MOTHER	FATHER
AGE	29 years	35 years
OCCUPATION	Bookkeeper	Trade Manager
HIGHEST QUALIFICATION	Matriculation Certificate	Matriculation Certificate

Functional Image

Child A is the only child of his biological parents. It is their first marriage. His parents reported that he is a very active child who is exhausted by the end of the day, and sleeps well. He is a clumsy child who frequently spills or drops things. He spends extremely limited amounts of time on activities and gives up very easily when he perceives tasks to be challenging. He fails to compromise and does not listen to requests. He is sensitive to loud noises. Child A was reportedly very aggressive and demanding. He was removed from one nursery school at the age of four years as a result of complaints about his very aggressive behaviour. The nursery school teacher at the new nursery school is extremely accommodating and willing to follow any advice given to improve his behaviour. She reported that he has extremely poor impulse control and that he bullies the other children. He fails to wait his turn and is extremely demanding. Mother of Child A reported that she was very stressed as a result of her child's poor behaviour and the negative feedback she constantly received. She reported that she frequently lost control, resorting to beatings to address her child's poor behaviour. She expressed concern about the effect of her reactions on his emotional and physical self if she did not receive guidance soon. His father reported total intolerance. He failed to understand why his child did not respond to discipline as other children do.

Initial Observations of the Therapist

Child A presented as friendly and very lively. He easily separated from his mother, chatting away comfortably to the therapist from the start. He was very restless and

talkative, and his approach to drawing was very impulsive. It was necessary to set firm limits to stop him rushing around the room in an uncontrolled fashion, but he responded favourably to this.

Final Analysis

Mother of Child A felt that she was more relaxed after attending the parent support group programme and expressed greater competence at dealing with her child's difficult behaviour. She felt too that she was more unconditionally accepting of her child and reported an ability to maintain control in the face of volatile situations with **"love, patience, tolerance and firmness"**. The information given provided her with ideas on how to adapt to certain situations and stilled some of her many fears with regard to eventual outcome. She expressed gratitude that she was given an opportunity to vent frustrations and to get support and advice from other parents in a similar situation. She noted a very positive change in her child after he had listened to the stories on the tape. He seemed much calmer and more pleasant to be around. However, she felt the effect was short-lived and she continued to feel concern over his poor behaviour, particularly the aggression that he displayed with peers at nursery school.

Father of Child A recognised similar characteristics in his son that were portrayed by the children in the videos and this enhanced awareness of their own situation. He noted more positive changes in his son than his wife had, and reported that his son was much more relaxed than previously, particularly after listening to the tapes. He felt that now they as parents were more skilled in their parenting and, as a result, the family system was happier. He also reported that the occupational therapist with whom the child attended therapy had reported positive changes.

Child A enthusiastically entered the office for each session. Despite his high activity levels, and much to the surprise of all who know him, he settled into the chair to listen to the stories quite willingly. He sucked his thumb and twirled his hair and appeared to listen intently. On occasion, he became a little restless and sometimes, although infrequently, he made comments in-between. His mother reported that he had made negative comments about attending, but this was never seen by the therapist. His teacher reported a slight

improvement but she still experienced many difficulties with him and it was recommended that the paediatric neurologist be consulted for further opinion. Previously, the parents were reluctant to administer medication, but they were willing to give it a try once they had more knowledge about it. The medication has made a big difference to his performance at school and his behaviour in all environments. The behaviour modification is still being applied. However, he is still upset by changes to his routine and parents and teacher report occasional bad days. Both parents expressed a need for on-going support and guidance.

CHILD B

	MOTHER	FATHER
AGE	40 years	40 years
OCCUPATION	Housewife	Self-Employed
HIGHEST QUALIFICATION	Higher Diploma in Education	Matriculation Certificate

Functional Image

Child B is the fourth child in a sibship of six. It is the first marriage of his biological parents. The marriage is stable and the family is very loving and close. The parents felt that they were coping reasonably well with their child who had recently been diagnosed with ADHD, following the teacher's recommendation that they consult a neurologist. It should, however, be noted, that neither parent is rigid or structured and that they encourage their children to openly express their opinions. They did, however report that Child B does not always respond to requests / instructions immediately, that he hates tidying up, fights going to bed, and is always late getting ready for school in the morning. What concerned the parents most was the negative feedback they received from the child's teacher regarding his behaviour. Ritalin was being administered, as prescribed by the neurologist, but the parents administered it reluctantly. They expressed a need to understand what ADHD was all about and the hope that their child's behaviour would improve enough for them to discontinue the medication. Child B's teacher reported extreme frustration over his behaviour prior to the administration of Ritalin. He was extremely restless, impulsive, and lacking in self-control and frequently attention-seeking. He was poorly organized, which resulted in the incompletion of certain tasks and his

listening skills were poor so that he seldom followed instructions accurately. She also reported poor social skills and noted that he experienced difficulty forming relations with his peers. An immediate improvement was noted when the child was put onto Ritalin. His behaviour improved and he coped competently and confidently with scholastic demands. He still experienced some difficulty socialising with his peers.

Initial Observations of the Therapist

Child B presented as confident, although resistant. He expressed an unwillingness to attend the therapeutic story-telling sessions. He made little spontaneous conversation and failed to become fully involved in his drawings, displaying a certain amount of obstinacy. Some distractibility was noted and some impulsivity. He was very restless.

Final Analysis

Mother of Child B felt that she had gained a greater understanding of ADHD and practical ideas on how to deal with problems which arise. In particular, she felt that the video presentations were helpful, as seeing the problem situation acted out was more meaningful to her than reading about it. Whilst she herself had gained a great deal from attending the parent support group, she was not sure how beneficial the story-telling had been for her child. Nevertheless, she expressed that he had a greater awareness of his own ability to **"own his problem"**. She expressed a need for more sessions giving concrete guidelines on dealing with discipline and other problems. Father of Child B reviewed the programme positively, but felt the need for on-going sessions. He had noted a positive change in his son, although could not be specific regarding the change. He felt that the videos were informative and reported a **"mirror of reflection"** of their own situation. He claimed an ability to broaden his methods and reactions depending on specific situations.

Child B eventually accepted that he would be attending the therapeutic story-telling sessions and his parents reported that he would remind them of the sessions on the morning he was coming and was always ready on time. The therapist, however, felt that he was passively uncooperative, feigning disinterest, and choosing to sit in another chair to that which was offered. He was very restless and distractible. In view of the fact that he enjoys art and pottery, activities were arranged for him, and he happily painted or

modeled as the story was read. His teacher reported continued progress. As a result, the parents discontinued the medication during the latter part of the programme. They failed to give the teacher the ADHDT questionnaire to complete at the specified time, but gave it during the last week of the school term. The results of this questionnaire reflect a deterioration in behaviour. However, cognisance must be taken of the facts that Ritalin was administered during the time of the initial questionnaire and discontinued before the final questionnaire was completed, and that the final questionnaire was completed when school activities were less structured, just prior to the Christmas break. Thus, the results are considered to have been contaminated, to a certain extent.

The parents decided to transfer their child to another private school where they felt that his individual differences would be better accommodated, and although they were more prepared to administer the Ritalin if need be, the new teacher felt that his progress was satisfactory without it.

CHILD C

	MOTHER	**FATHER**
AGE	28 years	45 years
OCCUPATION	Sales	Printer
HIGHEST QUALIFICATION	Matriculation Certificate	Matriculation Certificate

Functional Image

Child C is the only child out of the relationship of his biological parents who never married. He has had no contact with his biological father and lives with his biological mother and her partner, who is divorced and has two older children from his previous marriage. The relationship appears to be stormy, with frequent separations. Child C's mother reported that many of the problems which arise are as a result of her child's difficult behaviour. She expressed great concern about her child and a complete helplessness in knowing how to deal with the problems. Whilst she hoped that her partner would attend the sessions with her, she was sure he would not. However, he surprised her by joining her at the last minute. He expressed great frustration over the child's difficult behaviour and a willingness to learn ways to better deal with it. Child C's mother reported that as an infant, he slept for only short periods and was put back to sleep with

great difficulty. His nursery school teacher reported a limited span of concentration. His progress in his first year of school was limited. His teacher reported difficulties in all scholastic areas, poor concentration, a slow work pace, hyperactivity and disruptive behaviour. He was transferred to a remedial school where they reported similar difficulties. Initially, his mother went along with the paediatrician's recommendation to administer medication, but then she discontinued it, citing fears about possible side effects as the reason. Child C also suffers encopresis and his mother reports whining, aggressive and destructive behaviour. She expressed particular concern about the negative relationship between her child and her partner, since he was the only father-figure the child had ever had.

Initial Observations of the Therapist

Child C presented as friendly and confident. He had been assessed by the therapist a year previously and so felt quite comfortable in her presence. He was noted to be extremely externally distractible, taking note of every sound and movement, and commenting on them. He was very restless. He also made frequent, irrelevant comments, suggesting an internal distractibility. His responses were non-reflective and impulsive. It was necessary to set firm limits, to which he responded favourably.

Final Analysis

In her review of the programme, Child C's mother reported a better understanding of ADHD and felt that she had learnt ways to handle a hyperactive child. She felt less isolated knowing that other parents experienced similar difficulties and she expressed gratitude for the ideas that she had been given by other parents. In particular, she found that, as parents, they were coping better with their child. He was less restless and more attentive. There were hardly any episodes of encopresis. She was more open to the idea of medication being administered, having greater understanding of the implications thereof, and expressed a willingness to put him on another trial period. She subsequently reported further positive changes. She felt that her partner was exercising greater tolerance and that this was also having a positive effect on their relationship, to the benefit of the entire family system.

The therapist found Child C a willing participant, seeming to enjoy the individual attention he received. He was very restless and distractible, but very cooperative. He also made changes to improve his distractibility, such as taking his watch off when he found that he was fiddling with it, suggesting an awareness of his problem and a willingness to take some control. Giving him play dough to play with relieved his tendency to fidget considerably. He always expressed enjoyment of the stories afterwards, pointing out parts that he especially liked. His teachers noted an improvement. They had been considering keeping him back at the end of the year, but decided against it after noting the progress that had been made.

CHILD D

	MOTHER	FATHER
AGE	28 years	37 years
OCCUPATION	Internal Sales	Sales Consultant
HIGHEST QUALIFICATION	Matriculation Certificate	Matriculation Certificate

Functional Image

Child D is the older of two children. He has a younger sister. It is the first marriage of his biological parents and the marriage is reported to be stable, although the parents openly expressed differences of opinion regarding the ADHD diagnosis of their son in a rather aggressive fashion. Whilst his mother reported feelings of anxiety regarding the negative feedback she had received about her child's behaviour, his father blamed the teachers for their lack of understanding and did not accept the diagnosis which had been given. He reported having similar difficulties as a child and felt that he had overcome the difficulties without any assistance. He felt that, despite the fact that he was impulsive and impatient, these were the *"traits of a **normal intelligent** child"*. Mother of Child D reported that he is a clumsy child, who frequently walks into things. He displays destructive behaviour and sulks when reprimanded. He quickly loses interest in tasks and works at a slow pace. He finds it difficult to sit still for long periods. His teachers at school reported that he did not respond favourably to authority. He experienced difficulty learning to read, his attention span was limited and he was fidgety and impulsive. He was

untidy and disorganised. In particular, concern was felt about his poor behaviour. His mother decided, in retrospect, that he was not ready for formal schooling and transferred him back to a pre-school environment.

Initial Observations of the Therapist

Child D presented as reserved when he arrived for the first session. He easily separated from his mother but made little spontaneous conversation. Some distractibility was noted and some impulsivity. He was restless. Concentration was limited and he seemed insecure.

Final Analysis

Child D seemed very resistant throughout the time he attended the story-telling sessions, and displayed very restless behaviour. Judging from comments he made, such as, *"There's nothing wrong with me, you know"*, it was felt that his father may have been communicating negative messages to him regarding the therapy. His mother initially reported a great sense of relief at being offered support and an improvement in her child's behaviour. She failed to telephone to excuse herself and her child from the programme, sending a message via a friend to say that they were all coping so much better and it was no longer necessary for them to attend. A follow-up enquiry a few months later yielded similarly positive results.

Some concern is felt by the therapist that these parents, particularly the father, are still in a state of denial and that with re-entry into a formal school environment, some of the problems which Child D previously experienced may re-surface. According to reports received, they had not followed up on any of the recommendations made by the therapist, such as a comprehensive occupational therapy assessment and a visual examination, and still refused to consider the neurologist's recommendation to administer Ritalin. They also failed to establish a routine within their home environment and continued to discipline inconsistently.

A study of the comparison between PSI and ADHDT scores before and after the programme yields the following salient features:

- Both parents of Child B scored below 24 for **defensive responding** which indicates that they may have been a little defensive in their responses. This possibly contributes to the difference between their reports of their child's behaviour and the teacher's more negative feedback.

- Mothers of Child A and Child C were experiencing significantly high **Total Stress** before the programme was implemented. The **Total Stress** score decreased for all parents who completed the programme from one to sixty-three points. Cognisance should be taken of the fact that the **Life Stress** score remained high or increased significantly for those parents whose **Total Stress** score improved by only one to six points. The **Life Stress** scale provides some index of the amount of stress outside the parent-child relationship that the parent is currently experiencing.

- High scores in the **Child Domain** may be associated with children who display qualities that make it difficult for parents to fulfill their parenting roles. Parents of Child A, C and D all had significantly high scores to begin with. These scores improved for all parents but particularly for mother of Child C. Although slightly improved, scores remained significantly high for both parents of Child A.

- Within the **Child Domain**, scores for **Distractibility/Hyperactivity** improved by five to thirty-five points. Father of Child B found that his son **adapted** to change with greater difficulty towards the end of the programme. He was, however, slightly less defensive at the end of the programme, and this may have resulted in a more realistic response. Mother of Child B experienced an absence of **reinforcement** from her child and found him slightly more demanding, which may have been related to the increased **Life Stress** she was experiencing at that time.

- Both parents of Child A found him to be more **moody**. Mother of Child A also found it more difficult to **accept** that many of his characteristics were not as she had expected or hoped they would be. In view of the fact

that their child is still young and there has not been any previous intervention, this is not a surprising result.

- High scores in the **Parent Domain** suggest that the sources of stress and potential dysfunction of the parent-child system may be related to dimensions of the parent's functioning. Mother of Child C obtained a significantly high score before the programme, which improved dramatically by the end of the programme. In particular, within this domain, she felt **incompetent** as a parent, she did not feel a sense of **emotional closeness** to the child, she felt **depressed** and she believed that **active support** from her **partner** in the area of child management was lacking. All these aspects improved significantly over the eight weeks. Father of Child A felt less **competent** at the end of the programme. He reinforced this by expressing the need for more sessions in his review of the programme. He also felt **less close** to his child.

- The negative behaviour of all children except for Child D is reflected in the high **ADHD Quotients** based on the initial questionnaires. The results of mother of Child B suggest a **low possibility of dysfunction**. However, she is a tolerant mother of six who was also a little **defensive**. Interestingly, despite the diagnosis of ADHD for Child D and the difficult behaviours he displayed at home and at school, parents and teacher rated him low in all areas.

- The ADHD Quotient of all children who remained with the programme was lower on completion of the programme in the opinion of the parents, reflecting an **overall improvement in behaviour**. The teachers of two children noted an improvement. As mentioned previously, the second questionnaire on Child C was completed by the teacher during the excitement of Christmas preparations, when **medication** had been discontinued, whereas, the initial questionnaire was completed whilst he was on medication. These results are, therefore, considered to have been contaminated to a certain extent.

- Despite the fact that there was an overall improvement in behaviour on completion of the programme, the **ADHD Quotients** were still mostly quite high. This reinforces the fact that **medication** should be part of the treatment plan and also that **long-term intervention** is necessary.

- Whilst progress has been noted in most areas, sometimes quite dramatically, what is very evident is that a short-term programme is not enough for most parents of children with ADHD. In particular, for young parents with little parenting experience, **intensive on-going intervention** is required.

5.4 CONCLUSION

The results of the ideographic study undertaken reinforce the findings of a previous study conducted by the writer, which specifically targeted the parents of learning disabled children (Clark 1995:217), in which she found that if parents are to be *"available to meet the needs of the child and other family members, their own needs first have to be met"*. It seems clear that *"the parents benefit from a support group programme, which provides them with information, teaches them parenting skills and offers them the support of others who are in a similar situation to themselves"*. The fact that the parents seemed less stressed after the programme has been highlighted by the results of the Parenting Stress Index, as well as by the comments recorded in their reviews of the programme, reflected in the final analysis of the **Qualitative Analysis** (5.3.2).

Furthermore, it was found that the perceptions of parents and teachers are that the behaviour of the children improved after their participation in the programme. The results of the **Attention-Deficit/Hyperactivity Disorder Test** qualify this statement.

The summary, conclusions and recommendations of the empirical study will be outlined in the final chapter.

CHAPTER SIX

SUMMARY, RECOMMENDATIONS AND CONCLUSION

If a man does not keep pace with his companions,
perhaps it is because he hears a different drummer.
Let him step to the music which he hears,
however measured or far away.
Henry David Thorean (Clark et al. 1989)

6.1 INTRODUCTION

In Chapter One, the introductory orientation and statement of the problem were covered, the problem was explored, terms described and the study programme planned.

The second chapter covered the historical background, the nature, aetiology and the diagnosis of ADHD, and made mention of many of the associated problems and disorders. An important educational foundation was laid to enable the educational psychologist to facilitate the understanding of parents and teachers.

The various options regarding therapeutic intervention were explored in the third chapter. Firstly, the three main broad areas of medical, psychological and educational treatments were focused upon, and then attention was devoted to some of the more popular alternative treatment options. Since ADHD can be managed but not cured, the need for parents, child and professionals to work together is crucial.

Chapter Four provided an outline of the programme to be applied in the empirical study. The hypotheses formulated for acceptance or rejection were recorded in this chapter.

In the fifth chapter, the ideographic study which formed the empirical research, as outlined in chapter four, was detailed.

The summary, conclusions and recommendations of the empirical study will be outlined in this chapter. The hypotheses recorded in Chapter Four will be used as a basis for evaluating the programme in this chapter. The limitations of the study and recommendations for future study will also be mentioned.

6.2 MOTIVATION FOR THE STUDY

The researcher's first awareness of Attention-Deficit/Hyperactivity Disorder involved **painful personal experience** when she was faced with her own son's diagnosis and subsequent learning difficulties. A friendship with the mother of another child with the same condition proved to be a considerable source of comfort, highlighting the need to bond with other parents who find themselves in a similar situation. Later, in her involvement with children, firstly in a remedial school environment and then in private practice, the researcher realised that not only do the parents of children with ADHD find it extremely challenging to cope with their demands, but so do the teachers. The parents experience a number of **emotional reactions** to the child's behaviour and also to the suggestion of a diagnosis of ADHD. When children enter into therapy, their progress is often impeded by their parents, who, perhaps quite subconsciously, sabotage the process in various ways. Their treatment of the child and the treatment by teachers frequently exacerbates the behavioural difficulties.

Since the child is **immature** and needs the guidance of adult educators to lead him towards adulthood, it became obvious that the needs of the adult caregivers should first be met so that they are better able to assume their role of educating the child, who can then be led towards successful transition into adulthood. A previous study by the writer (Clark 1995) revealed the effectiveness of a **parent support group** for the parents of **learning disabled** children. The parents felt *"less isolated and more competent to cope with their educational task"* after a six week programme (Clark 1995:ii). Given this success and with the current trend towards multi-modal intervention, it was decided to expand on the parent support group programme by combining it with other interventions which would improve the effectiveness of teachers and parents, as well as improve the behaviour of the child with ADHD. The goal was to **improve relationships** for the child so that ultimately, his relations with self could become more positive and he could be guided more effectively towards a **productive adulthood**.

6.3 THE PURPOSE OF THE STUDY

The present study sought to determine the effects of a multi-modal treatment plan on the behaviour of the child with ADHD. The aims of the study were as follows:

6.3.1 Specific Aims

(a) An in-depth literature study focused on:

* Attention Deficit Hyperactivity Disorder
* Therapeutic Intervention

(b) An empirical study involved the following interventions:

(i) A support group comprising eight parents who met once a week was formed. An attempt was made during these sessions:

* To empower the parents by providing them with information about attention deficit hyperactivity disorder, so that they could gain some insight into the behaviours which manifest, and some effective strategies to deal with the problems.
* To provide the parents with an outlet for sharing their concerns and hardships with other parents who have similar problems.
* To give parents an opportunity to benefit from the support of other parents who truly understand their circumstances, and in turn, commiserate with these parents, within the safety of a therapeutic group setting.

(ii) Individual sessions were planned with the children. During this time, an attempt was made to focus the attention of the children on the therapeutic stories which were read to them in an effort:

* To reduce levels of hyperactivity
* To reduce impulsive behaviour
* To increase focus of attention
* To improve oppositional behaviour
* To improve the child's relations

(iii) Contact was made with the teachers of the children, and guidelines were provided on dealing with some of the behavioural manifestations.

6.3.2 Indirect Aims

* To reduce levels of parental stress, making parents more competent to cope with their educational task.
* To improve the parent-child relationship initially, leading to more positive relations for the child with other family members, teachers, peers and self, so that the child is able to move towards adulthood with feelings of competence and self-worth.

6.4 METHOD OF RESEARCH

In order to meet the aims of the study, it was considered necessary to perform a literature as well as an ideographic study.

6.4.1 The Literature Study

6.4.1.1 Attention-Deficit/Hyperactivity Disorder

The symptoms of ADHD have been described since biblical times. More recently, in 1845, the German physician Hoffman wrote a story about a little boy who presented with features of ADHD. In the last decade, considerable attention has been paid to the disorder which has brought dramatic advances in our understanding. Sweeping changes in the way in which the needs of individuals with ADHD have been addressed have also come about.

Still controversy rages regarding aetiology, diagnosis and treatment. Whilst media publicity has heightened awareness of the disorder, in some instances it has increased confusion through inaccurate information. The behavioural difficulties associated with ADHD are no longer attributed to brain damage, but rather to multiple causes and various modes of treatment are recommended. The need for a number of professional disciplines to work together in concert over longer periods of time has been pointed out. The belief that treatment should be extended to include parents and family, as well as to control children's anger and improve their social skills has been shown to result in a more positive outcome.

An important change in thinking came about in the eighties and nineties when the idea became popular that ADHD is a **lifetime disorder** which affects all areas of an individual's functioning. Furthermore, it has become evident that a large number of these children are daydreamers who find it difficult to organize themselves and focus on the tasks at hand. They are not always diagnosed because they are less active and disruptive. They frequently present with mood, affect and emotional problems. Their inability to focus hinders their capacity to form relations.

There continues to be disagreement about terminology and the suggestion has been made that the disorder may be reconceptualised in DSM-V. What is clear is that the individuals diagnosed with ADHD represent a poor fit between society's expectations and their abilities to meet these expectations. The terms ADD and ADHD in fact refer to a **cluster of symptoms** rather than to a specific disease. The chronic difficulties of inattention, impulsivity and overactivity have been referred to as the '***holy trinity of ADHD***'. Some people are hyperactive and impulsive, some are inattentive and some have a combination of all three of these traits. The characteristics of these traits have been named, as published in the DSM-IV (Parker 1994:4). The criteria for diagnosis include a presence of the symptoms before age seven, with impairment in two or more settings. There must be evidence of impairment in social and academic functioning and the difficulties should not be as a result of other psychiatric disorders.

The evolution of ADHD through the developmental stages has been described. One of the major difficulties is that what works well in one stage may not work at all in another stage. Whilst as many as 57% of preschool children may be diagnosed, the symptoms of

many of these children may improve. In the elementary school stage, the major areas of concern are a **lack of social skills** and **learning difficulties**. Whilst it was assumed previously that children outgrow the symptoms by the teenage years, we know now that many children typically do not. Many display serious **behavioural** and/or **learning difficulties**. They continue to have **problems with peers**, **lack confidence** and become **depressed**. There is growing recognition of the presence of the disorder in many adults.

There is still no test which validly and reliably diagnoses ADHD. Although many parents initially avoid a diagnosis, it has been pointed out that the prognosis is better when **early intervention** is initiated. Yet, there does appear to be a tendency by some professionals to misdiagnose some children as having ADHD, drugging them to alleviate symptoms, when, in fact, the symptoms may present due to other difficulties.

The need for a **comprehensive assessment** carried out by various professionals has been stressed. A **multidisciplinary team** should include, along with the parents and the child, some or all of the following professionals:

- Medical Specialist
- Psychologist
- Class Teacher
- Remedial Teacher/Therapist
- Occupational Therapist
- Speech and Language Therapist
- Optometrist
- Social Worker

There has been considerable debate over whether **Nature** or **Nurture** plays the most significant role in the disorder. Whilst parents and/or teachers have commonly been blamed for the child's difficult behaviour, a new awareness has dawned of the **hereditary** nature of the disorder and of the fact that ADHD results from an **imbalance of neurotransmitters** in the brain. Nevertheless, **environmental factors** and the **family situation** have been shown to have an effect. A number of possible causes have been put forward by researchers in recent publications and some of the popular notions have been discussed.

The phenomenon referred to as **comorbidity** was also addressed, in view of the fact that it has become evident that about 80% of children with ADHD do not have only one disorder. The fact that so many of the symptoms of the various conditions overlap complicates the diagnosis. Very often, ADHD, ODD and CD exist in combination with each other. Untreated ODD can deteriorate into CD and so the importance of timely and appropriate intervention has been stressed. A large number of children with ADHD suffer specific weaknesses in learning, resulting in difficulties with reading, spelling and mathematics. Often, learning and performance profiles are **scattered**, indicating incredible **strengths** in some areas and **weaknesses** in others. It has become evident that, whilst previously such problems were attributed to visual processing difficulties, individuals with dyslexia commonly have problems with language processing. Some children do have problems organizing visual information and coordinating visual information with motor activity. Some have difficulty with spatial relations which impacts on spelling and handwriting and leads to difficulty reading maps. These children are notorious for being disorganized.

It has also become clear that these children socialise poorly. They cannot detect important non-verbal cues and this creates problems with social skills and interpersonal relationships. Very often, they have an external locus of control and fail to take responsibility for events that happen. Their problems often lead to anxiety or depression. The importance of treating these disorders as primary conditions alongside the comorbid ADHD has been highlighted. A small percentage of children, mainly boys, suffer from Tourette syndrome, the major symptom being the presence of motor or vocal tics. Some may have OCD and are troubled by obsessions and compulsions.

6.4.1.2 Therapeutic Intervention

Since children are **immature**, **unformed** and **dependent** by nature, they have to be assisted on the road towards adulthood by adult educators. The fact that ADHD cannot be cured but that the child can be helped to **gain control** so that they are able to function effectively at home, school and socially has been underlined. Management which enables the child to attain his full potential in the full range of activities, despite the disability, is essential. The unique situation in which each child finds himself has been highlighted and

it has been emphasised that the various treatments initiated must be adapted to suit the child's individual needs and those of his family.

Three main broad groups of treatment, which utilise various **medical**, **psychological** and **educational** methods, have been advocated. The need to combine interventions in the case of severe forms of ADHD has been stressed.

Medical Management

Although the administration of medication for ADHD is met with skepticism by many, even some of those professionals with wide-ranging experience treating attention deficit disorder, and cognisance is taken of the fact that we cannot find motivation and success in a pill, this crucial debate has not been extensively addressed in this section of the work. Rather, it was felt that it would be more useful to discuss some of the ideas of those professionals who have found drug therapy to be used successfully to help children reach their full potential.

Research findings have led to the belief that ADHD is a **clinical condition**, caused by a chemical imbalance. Two main groups of drug are commonly used - **stimulants** and **antidepressants**. Stimulants have been used since 1937. **Ritalin**, which has been described by some as dangerous and addictive, is the most commonly used drug and has, in fact, been found to be the most effective with the least side-effects. Children who suffer anxiety or depression in addition to the ADHD may not respond to stimulants and non-stimulant drugs may be considered in such cases. A number of new medications are currently being studied in an effort to reduce symptoms of ADHD with the fewest possible side-effects. Sometimes it is necessary to combine a number of medications for the best effect. The need to monitor the effects of medication was stressed in view of the changing nature of the condition of the disorder and needs of the child.

Since parents and children often have difficulty in accepting the long-term use of medication, it is essential that knowledgeable professionals educate and reassure them. They need to know that medication does not cure but merely ameliorates the problems. Furthermore, medication is not successful in the treatment of all cases of ADHD.

Psychological Management

Parents and families are severely troubled and stressed when they have to deal with the **behavioural** and/or **learning difficulties** presented by ADHD. Many professionals reinforce the need for psychological intervention, for such families, as well as for the teachers and the child himself.

A number of successful psychological interventions were explored in this section. In particular, attention was paid to **parent support groups**, **individual therapy**, in the form of **therapeutic story-telling** for the children and **behaviour therapy**. Research has shown that parents are empowered when they receive training by a qualified professional, particularly within a support group where they can share ideas and experiences with other parents who are going through similar problems. Story telling has been demonstrated to be an effective therapeutic tool which helps to change inappropriate behaviours to more acceptable behaviour patterns within a particular society. Behaviour modification has been prescribed as suitable for children with ADHD. The over-riding principle is that behaviour is strongly affected by consequences that follow the behaviour. Whilst negative consequences are sometimes necessary, positive consequences have been advocated to be the most potent tool.

Educational Management

The most frequently expressed concern of parents regarding their child with ADHD relates to his performance at school. A number of professionals have noted improved performance when **accommodations** are made to suit the needs of the individual child. It has been suggested that our schools are currently set up along ***'Farmer'*** lines with children having to toe the line and conform. The idea has been put forward that ADHD may become an **irrelevant medical classification** if children are allowed to express ***'Hunter'*** characteristics, such as voracious curiosity, continual scanning of the environment and broad-based interest.

A number of practical guidelines to improve the management of children with ADHD at home and at school have been recorded in this section.

Alternative Treatments

Although many professionals have expressed the doubtfulness of alternative treatments leading to improvement in the overall functioning of the child with ADHD, some do acclaim their success. Some of these treatments have been briefly mentioned since they may prove to have a positive influence on the child's behaviour, if used in combination with other strategies.

Whilst many professionals do not advocate **dietary change**, many believe it is worth avoiding some foods which may aggravate the symptoms of ADHD. In particular, synthetic flavours and colorants, some preservatives and certain natural foods containing salicylates, which have a chemical composition similar to aspirin, may have an adverse effect on the performance of the child. Improvements have been noted when chemical antioxidants and fried and processed foods are avoided, and vitamin, mineral and essential fatty acids are supplemented. Sugar should be kept to a minimum.

Herbal treatments have been reported to relax and heal. However, in high doses, they may become toxic and many professionals caution their use, since they have not been subjected to rigorous studies which demonstrate their viability.

Homeopathic remedies present fewer risks and side-effects. There are over four hundred registered homeopaths in South Africa who treat the whole child.

Vitamins have also been recommended, in particular choline, which seems to improve memory and attention span.

EEG Neurofeedback has recently been applied to children with ADHD and appears to be showing promise. Some suggest that it is possible to change brain waves so that levels of focused-awareness can be increased and distracted-awareness brainwaves can be decreased.

Meditation has been recommended as a favourable treatment. The process involves quieting the mind, focusing inward and mastering impulses in an effort to strengthen the ability to focus on other things.

Since children with ADHD need more stimulation rather than less, activities which **naturally stimulate the brain** through deep breathing are suggested so that the child's brain is supplied with its needs.

6.4.2 The Empirical Study

6.4.2.1 Selection of Group Participants

Eight adults initially entered into the programme and gave permission for their children to participate. Seven were the biological parents of the children and one was the partner of one of the mothers. All the children were boys. Prerequisite for attendance was a **prior diagnosis of ADHD** for the child who would be involved in the programme. Both parents of each child were encouraged to attend. One of the fathers attended only one session. His wife attended five sessions and then withdrew herself and her child from the programme.

6.4.2.2 Procedure

The parents of children who had expressed negative emotional reactions to their child's difficult behaviour as a result of ADHD were invited to participate. The parents attended seven group sessions during which information was imparted to them and they were given opportunities to share and commiserate with others in a similar position. The children attended eight sessions. The first session was used to establish rapport with the children and during the following seven sessions, therapeutic stories were read to them. The teacher of each child was involved to a limited extent. They were given guidelines on how to deal with the child in the classroom and were asked to observe the child's behaviour so that their input could be included in the evaluation of the programme.

6.4.2.3 The Parent Support Group Programme

Session One: Introduction and ADHD

The nature of ADHD and its effect on family members and the child with ADHD was presented. A video portraying children with features of ADHD was shown to stimulate discussion.

Session Two: Self-Esteem

The effect of a child's feelings and beliefs about himself on his success in life was highlighted in this session. The important role of the parents in this regard was emphasised and the need for the parents to feel good about themselves was pointed out. A video on self-esteem was used to demonstrate ways of improving a child's self-esteem.

Session Three: Communication

Effective communication, including active listening, was stressed in this session. A video was used to increase awareness of effective styles of parental communication.

Session Four: Discipline

A video was used as a stimulus to discuss effective strategies of discipline. Behaviour modification was described as a means of eliminating maladaptive behaviour. Attention was paid to the setting of limits and time-out as a non-abusive consequence of the child's negative behaviour.

Session Five: Parenting Skills

Since there is a recent awareness that parents need support and training to raise children effectively, the focus of this session was on styles and skills of parenting. A video by James Dobson provided a light-hearted discussion on parenting which created an opportunity for parents to discuss their own strengths and weaknesses in their particular styles of parenting.

Session Six: Parental Involvement

Since children who are difficult and over-active frequently repel others from them, they often lack loving, physical contact with a care-giver. A demonstration of how a body massage should be done was carried out by a qualified beauty and aromatherapist. Hypokid, promoted by Lilian Terry as an effective oil to calm active children was used for the massage.

Session Seven: Group Relaxation Exercise

In an effort to point out the importance of making time for the self and to demonstrate the effectiveness of a period of relaxation, an exercise was done with the parents. Music was played softly in the background to enhance a calming environment.

6.4.2.4 Therapeutic Stories with the Children

The stories with the children were adapted from the works of various writers in an effort to address the child in his unique situation. The intention of the stories, which were read whilst music played softly in the background, was to initiate positive changes in the behavioural patterns of the children, in an effort to improve relations with parents and other family members, teachers, peers and self.

6.4.2.5 Guidelines for the Teachers

The teachers were provided with a few basic guidelines to improve the behaviour of the child in the classroom. The focus of the guidelines was the need to accommodate the child's individual differences and to provide ways to keep the child on task.

6.5 THE RESULTS OF THE EMPIRICAL STUDY

The writer feels confident that the programme was useful. Feedback from parents with regard to the programme was extremely positive, although most expressed a need for on-going support.

6.5.1 **Hypotheses**

Hypotheses were formulated during the planning of the multi-modal treatment programme, recorded in Chapter Four. Using the hypotheses as a basis, the outcome of the programme will be detailed in the section which follows. The validity of each hypotheses will be confirmed or rejected.

i The parents will be reassured to discover that they are not alone, and greatly relieved when they meet with others who understand their personal predicament and can empathise with them.

The results of the research support this hypothesis.

ii When parents are given the opportunity to meet with other parents whose children encounter similar problems, they are able to share ideas on how to handle their children and will learn something about compassionate management skills in a mutually supportive environment.

The results of the research support this hypothesis.

iii Parents will get their own feelings under control when they are given the opportunity to voice feelings of despair, fear, anger, guilt and anxiety within a warm empathic climate.

The results of the research support this hypothesis.

iv Parents will reclaim their power and triumph over the disorder that had previously caused so much misery in their family lives, when they are provided with a holistic understanding of ADHD and cohesive strategies and concrete tools to combat it.

The results of the research support this hypothesis to a certain extent. In view of the fact that ADHD is a chronic disorder which may well persist into adulthood, the need for on-going support must be recognised. Parents felt better able to cope but expressed a need for on-going support.

v Parent Support Groups provide a forum by which parents can exchange information and experiences about raising an inattentive, impulsive and/or hyperactive child.

The results of the research support this hypothesis.

vi Early intervention of stressful parent-child systems will reduce the frequency and intensity of behavioural and emotional disturbances in the children with ADHD, enabling them to attain their developmental potential and a better quality of life.

The results of the research partly support this hypothesis. The long-term effects of early intervention have to be evaluated in the coming years after children have been closely monitored throughout their school careers. Hopefully, the awareness gained through the programme will highlight the importance of the parents' involvement in their child's interventions and the need for them to obtain continued support in their educational role.

vii A multi-modal treatment plan will enhance self-esteem and foster acceptance, approval and a sense of belonging, resulting in positive relations for the child with ADHD, leading ultimately to a better outcome.

Initial findings of the research support this hypothesis. The final outcome will have to be evaluated as the child enters the adult phase of his life, after the completion of his school career.

viii When parents become involved with their child, spend time with him and feel connected, a close emotional bond develops and they have better adjusted children, harmony at home and a more functional family.

The results of the research support this hypothesis.

ix Adjustments in classroom procedures and work demands, sensitivity to self-esteem issues and regular parent-teacher contact will play an essential role in helping the child with ADHD in the classroom.

The results of the research support this hypothesis.

x The child with ADHD will be guided towards adulthood with the best possible education, good self-confidence, useful life skills and intact family relationships.

The results of the research partly support this hypothesis. Once again, the situation will have to be carefully monitored throughout the child's school career, after which the hypothesis can be more effectively evaluated.

6.5.2 The Results of the Parenting Stress Index

The **Total Stress** scores of all parents who completed the programme improved, one quite dramatically. In those cases where there was only a small improvement, **Life Stress** scores, which provide an indication of stress outside of the parent-child relationship, were high. Scores within the **Child Domain**, which reflect the ability of the parents to fulfil their parenting roles, improved for all parents. The need for a long-term programme involving intensive on-going intervention was highlighted by the results.

6.5.3 The Results of the Attention-Deficit/Hyperactivity Disorder Test

The results of the **ADHDT** reflected an improvement noted in the child's behaviour for all three children who completed the programme. The results of one child indicated a deterioration in the classroom. However, Ritalin had been administered prior to his commencement of the programme and the initial questionnaire was completed by the teacher when medication was given. Due to the improvements noted by the parents, they discontinued the medication, and the final questionnaire was completed by the teacher when the child was not on medication. Furthermore, the questionnaire was not given at the time requested, but only a couple of weeks later, during the last week of the school year when there was much excitement due to Christmas celebrations.

6.5.4 Limitations of this Research

* Cognisance must be taken of the fact that this was an ideographic study and that the findings cannot be generalised to a wider population. Furthermore, with regard to questionnaire type research, as pointed out by Porter (1954:179), reinforced by Abidin (1996:6) and Armstrong (1995:14), certain limitations present. The responses may be affected by the respondent's needs or feelings or they may be defensive in their response.

* ADHD is a chronic disorder and the difficulties experienced by parents, siblings and extended family members, teachers and the child himself cannot be effectively addressed by a short-term programme.

6.6 RECOMMENDATIONS FOR FURTHER RESEARCH

The research carried out in this study has led to the awareness of a number of problems which merit further investigation. It is recommended that research be undertaken in the following areas:

* When one considers the importance of early intervention on final outcome, the significance of effective teacher training becomes obvious. A study should be conducted which highlights the quality of current teacher training, specifically taking into account training regarding awareness of ADHD and learning problems as well as possible interventions. The writer feels that a survey of this nature will reveal certain deficiencies in our training, and, only once these have been established, will it be possible to effectively address the problems.

* Since the unmet needs of children result in a lost sense of self, with the natural consequence being behavioural and/or emotional difficulties (Oaklander 1978:58), it is imperative that teachers in the classroom make adaptations which accommodate individual differences so that children can be made strong within themselves. The challenge to the teachers in our schools is to be more humanistic in their teaching approach and less mechanistic, in an effort to reduce harmful

effects on the learning process. Such a model of teaching for application in our schools, with their current lack of funds, needs to be designed by a qualified and knowledgeable professional, such as an educational psychologist.

* Hartmann (1997:43) believes that if changes are made in the classrooms which are more appealing to the ***'Hunters'*** in our society, ADHD may cease to exist as a disorder. Since, as Debroitner and Hart (1997:201) point out, emotional states can change the chemical balance of the brain, ways should be devised to do this in our classrooms, thereby reducing or perhaps even eliminating the need for drug therapy.

* There is a tremendous amount of material emerging on ADHD from other countries, yet there seems to be very little based on South African conditions. Our public, in particular the parents of difficult children and all teachers, need to be educated regarding the disorder and made aware of the various, effective treatment options. A book or video should be produced, which specifically addresses the South African family where there is a child with ADHD and which provides practical and easy to understand guidelines for use at home and at school.

* A comprehensive multi-modal treatment plan which specifically targets the South African child and his family should be developed. Whilst medical and educational managements have been fairly comprehensively addressed in this work, it is felt that many more options within the area of psychological management should be explored. Social skills development within a group situation should be included. Alternative forms of individual therapy should be applied in order to improve final outcome. In particular, the writer would be interested to know of any improvement in the overall functioning of the child when hypnotherapy is included.

* In view of the fact that children with ADHD do not easily conform to the structure imposed on them in a typical twentieth century classroom, research should be done to identify schools and careers which best suit the individual by allowing for his creative expression. This would surely lead the individual to attain his full potential and thereby experience a successful and happy lifestyle.

6.7 CONCLUSION

The parents of children with ADHD often experience tremendous heartache and considerable stress before a diagnosis is made. According to Hallowell and Ratey (1994:216), *"Hope begins with the diagnosis"* which, in itself, often exerts a powerful therapeutic effect. Yet, there are many parents who are prepared to suffer enormous misery for years rather than accept that their child's behaviour is rooted in a medical disorder (Train 1996:59).

Early recognition is vital for a successful outcome in dealing with the disorder. Once a diagnosis has been established, every avenue should be explored to help the child and his family. Parents who are knowledgeable about the causes and ramifications of ADHD and who possess a repertoire of treatment options respond better to intervention. Whilst there is no definite cure for the disorder, help in many forms can be given to enable sufferers to gain better control so that social, relationship and educational difficulties which arise can be alleviated.

In view of the controversial and sometimes inaccurate information which is written about ADHD and its treatment, as well as the many changes in the thinking of people who have studied the subject in the past decade, a wide search of current scientific literature was conducted in an effort to present a concise, comprehensive and accurate account of theoretical and practical aspects. Practical ideas to lead parents and professionals to a deeper understanding of ADHD have been recorded.

Effective treatment for ADHD has been cited as multidisciplinary and multi-modal. The efficacy of psychological, educational and behavioural treatments combined with medication has been well-established by research which has been outlined throughout this work. Goldstein and Goldstein (1998:454) emphasize that *"the use of multiple treatment modalities in ADHD produces therapeutic benefit greater than the sum of each modality's contribution"*. Due to the chronic nature of the disorder, treatment should be long-term. It is also now recognised that, whilst some people *'grow out'* of the symptoms over time, ADHD can persist into adulthood, and certain individuals continue to have significant difficulties throughout life.

In the foreword to Hartmann's book, Michael Popkin states that *"the purpose of parenting is 'to protect and to prepare children to survive and to thrive in the kind of society in which they live'"* (Hartmann 1997:xxxvi). The current study aimed to assist parents with their educational task, providing them with knowledge and coping techniques so that, despite the disorder, their children are able to attain their full developmental potential. Cognisance was taken of the fact that parents are unable take responsibility for guiding the child effectively towards adulthood if they themselves do not feel competent and worthy, and this was addressed within the warm, empathic environment provided by a support group. The behavioural difficulties manifested by the children were addressed through therapeutic story-telling.

The results of the ideographic study provide firm support for the findings of the literature study. Parents were less stressed after the programme and more tolerant of their children. Furthermore, they observed that their children's behaviour had improved to a certain extent. However, they expressed a need for more knowledge regarding the disorder and its treatment than was afforded by a short-term programme.

In conclusion, to quote Hartmann (1997:124), *"The future for people with ADHD need not be bleak. By taking stock of the child's strengths and weaknesses, and ensuring that they receive appropriate help, families and professionals can work together to ensure that the young person realises their full potential, and goes on to lead a happy and successful life"*. We need to go forward from here into a future where people with ADHD are not embarrassed or ashamed to say they feel different but where each child is helped in schools with appropriate interventions and tailored educational environments, allowing him to ***step to the music which he hears, even if he does hear a different drummer***.

APPENDIX A

LETTER TO PARENTS

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Dear Parent

As a parent of a child with features of attention deficit hyperactivity disorder, I became acutely aware of the difficulties we, as parents, face at home with our children. My work in a remedial educational setting brought about the awareness of the difficulties which arise in a formal school environment. The controversial issue of medicating such children to improve their behaviour and scholastic performance led to a search for alternative therapies. As a result, as part of the requirements for my doctoral degree in educational psychology, which I am currently completing through the University of South Africa, I have decided to use a multi-modal approach to improve the behaviour of children with features of attention deficit hyperactivity disorder. I have felt it necessary to include parents, in a group setting, to provide them with information on the disorder and effective guidelines on dealing with certain behavioural issues which may arise, as well as to give them an opportunity to share concerns with others who are in the same predicament. The therapeutic sessions with the children will involve a weekly session of half an hour, arranged at a time which is mutually convenient to you and me, over a period of eight weeks, using in particular, a story-telling approach.

The aims of the sessions with your children will be as follows:

* to improve their ability to relax
* to increase their span of attention
* to decrease activity levels
* to decrease impulsivity
* to decrease oppositional behaviour
* to improve confidence and self-esteem
* to improve socialisation with peers
* to address specific behavioural problems of the individual child

The information-giving sessions with the parents will take place weekly over a seven week period. These sessions should provide parents with the following opportunities:

* to gain information about attention deficit hyperactivity disorder and the implications of being the parents of a child with some of these features
* to discover ways of assisting our children on the path towards adulthood
* to share with others our feelings about and experiences of being the parents of a child with features of attention deficit hyperactivity disorder
* to benefit from the support of other parents who are faced with similar problems

Since the therapeutic story-telling sessions with your children and the participation in information-giving sessions with the parents will form part of the requirements for my doctoral degree, regular attendance is necessary. Furthermore, you may be required to complete questionnaires from time to time. You may rest assured, however, that all information obtained from yourselves and your children will be treated as strictly confidential. Whilst it will be necessary to record the information obtained, and submit it to the university, no information will be recorded under specific names.

Whilst the approach to be used is of an experimental nature, I feel sure that the children and the parents will benefit by participating, and that the results will be beneficial to other families with children who have features of attention deficit hyperactivity disorder. If you have any questions regarding the programme, please feel free to contact me.

Yours sincerely

M. CLARK

APPENDIX B

HISTORICAL BACKGROUND

CASE HISTORY

Please paste a photo of your child here.

DATE : .....
NAME OF PUPIL : .....
NURSERY SCHOOL/SCHOOL: .....
GRADE : .....

DATE OF BIRTH :				MALE/FEMALE
STREET ADDRESS:				
POSTAL ADDRESS:			CODE:	
TELEPHONE : [H]	[B-M]	[B-F]	(CELL)	
MEDICAL AID :				NO:
CURRENT MEDICATION :		DOSE :		
REFERRED BY:				
REASON FOR REFERRAL:				

The following questions have been posed to help in compiling a more complete picture of your child during the developmental stages of infancy, early childhood and at present. Please complete the questionnaire as accurately as possible.

1. GENERAL INFORMATION

HOME CIRCUMSTANCES			
HOME LANGUAGE :	Pupil :	Mother:	Father :
LANGUAGE OF INSTRUCTION:			
OTHER LANGUAGE/S TO WHICH THE CHILD IS EXPOSED:			

	FATHER	MOTHER
CHRISTIAN NAMES:		
DATE OF BIRTH:		
OCCUPATION:		
HIGHEST QUALIFICATION:		

(PLEASE TICK RELEVANT SQUARE) (✔)

MARITAL STATUS OF PARENTS	
First Marriage	
Second Marriage	
Divorced	
Widow/er	
Single Parent	

PARENT[S]	
Biological	
Stepfather	
Stepmother	
Foster Parents	
Adoptive Parents	

* If the parents are divorced, does the child have contact with the non-custodial parent? . . . . . .

How often? . . . . . .

* Position in family: . . . . . child of . . . . . .

child/ren.

NAMES OF SIBLINGS	DATES OF BIRTH	SCHOOL AND STANDARD

* Conditions During Pregnancy (✔)

Anaemia		Psychological trauma (Explain)	
Amniocentesis		German Measles	
Bleed/threatened miscarriage		Severe nausea and vomiting	
High blood pressure		Smoking (more than five a day)	
Excessive alcohol/drugs		Thyroid treatment	
Fertility drugs		Viral infections/flu	
Multiple birth		Medication	
Kidney infection		X-rays	
Nutritional deficiencies		Other problems experienced :	
Physical trauma (Explain)			

2. BIRTH HISTORY

(✔) where applicable

Was the baby planned?	Yes	No
Was the baby born before or after expected date?	Before	After

How long before/after? .....

Length of labour to the nearest hour : .....

Was labour induced? (✔)	Yes	No

TYPE OF DELIVERY(✓)

Normal		Suction	
Forceps		Caesarian	

PRESENTATION(✓)

Breech	
Vertex	
Placenta Praevia	

* Baby's birth weight : .....

* Conditions at birth or immediately after (in first week). (✓)

Anoxia		Jaundice	
Respiratory Difficulties		Severe Jaundice	
Convulsions		Signs of Injury	
Initial Crying Abnormal		Cord around neck	
Congenital Defect		Apgar Score	

Colour at Birth .....

Other : .....

* Treatment immediately after birth: (✓)

Oxygen administered		Child in incubator	
Blood transfusion performed		How long?	

Medication : .....

Other : .....

3. SLEEPING AND FEEDING ROUTINE AND MEDICAL HISTORY

3.1 SLEEPING ROUTINE

Infant Years: (Describe)

.....

Currently:

What time does he/she go to bed? .....

Does he/she go to bed without a fuss? .....

How are mother and father involved at bedtime? .....

Does he/she wake up during the night? ..... If so, how many times? .....

Why does he/she wake up? .....

How do you handle the situation? .....

3.2 FEEDING ROUTINE

Was the child breastfed? (✓)	YES	NO

Difficulties in feeding were/are experienced with:

	Infancy	At Present
Sucking		
Swallowing		
Regurgitation of some foods/Persistent vomiting		
Chewing		
Milk allergy		
Hypersensitivity to some foods		
Other :		

Describe your child's appetite : .....

3.3 CHILDHOOD ILLNESSES/PROBLEMS

(Please tick relevant square and state age)

ILLNESS		AGE	ILLNESS		AGE
Measles			Chicken Pox		
Diphtheria			Mumps		
German Measles			Rheumatic Fever		
Whooping Cough			Scarlet Fever		
Constant Colds			Convulsions		
High Temperature			Injury (Explain)		
Other: (Please state age)					

4. DEVELOPMENTAL HISTORY

4.1 PHYSICAL DEVELOPMENT

(Age at commencement)

DEVELOPMENTAL MILESTONES	AGE	
Sat at		
Crawled at		
Walked at		
Toilet Control:	Problems:	
Bowel		
Bladder		

4.2 SENSORY-MOTOR-INTEGRATION :

DOES THE CHILD?

* Dislike being touched or cuddled? . . . . . .
* Seem clumsy, often fall or walk into things, spill fluids, accident prone? Specify. . . . . .
* Avoid balancing activities e.g. Does the child seem anxious when climbing steps, on jungle gym, slide, escalator, riding a bicycle, etc.? Specify. . . . . .
* Ride a bicycle confidently without fairy wheels? State age at commencement. . . . . .
* Enjoy fine motor activities, colouring in, cutting out, construction games, etc.? Specify. . . . . .
* Complete tasks in the allocated time? . . . . . .
* Keep him/herself busy, playing creatively?. . . . . .

4.3 PERCEPTION

* Does the child play educational games with insight? Specify: . . . . . .
* What does the child play with in his/her free time?
  i) Indoors : . . . . . .
  ii) Outdoors : . . . . . .
* What sort of games or activities does he/she avoid?
  . . . . . .
* Are you aware of any specific problems? Specify.
  . . . . . .

4.4 SPEECH DEVELOPMENT (Tick relevant square)

Speech and language developed in a delayed/deviant way.	
Speech and language developed normally and then became deviant.	
Speech and language developed normally.	
Speech is intelligible.	
Description of speech and language at present:	

4.5 VISION

Have the child's eyes been tested?(✔)	Yes	No
By Whom:	Tel. No:	
Date :	Date of Follow-up visit :	
Result of test :		

4.6 HEARING (Tick ✓)

Has a hearing test been administered?	Yes	No
By whom?	Tel. No:	
Date :	Result:	
	Yes	No
Do you think your child's hearing is normal?		
Has the child had any ear infections?		
Grommets		
Antibiotics		
Other: (Specify)		

5. PREVIOUS EVALUATIONS

	AGE	NAME OF PRACTITIONER	TEL.NO.	TREATMENT
MEDICAL				
NEUROLOGIST				
E.E.G				
PSYCHOLOGICAL				
SPEECH				
OCCUPATIONAL				
OTHER				

6. ACADEMIC BACKGROUND

6.1

Nursery School/s attended:

Language medium of Nursery School: Language medium of class:

Problems experienced at Nursery School :

6.2

Is the child considered to be school ready? (✓) where applicable				
Your opinion :	YES		NO	
Nursery School Teacher's opinion.	YES		NO	
Other :				
Is there a family history of learning problems/ADHD?				

6.3 Your child's intelligence appears to be: (✓)

under average	
average	
above average	

6.4 PROBLEMS EXPERIENCED AT NURSERY SCHOOL/SCHOOL

(Please tick relevant square and give a brief explanation)

		EXPLANATION
Attention Span		
Hyperactivity		
Impulsivity		
Fidgetiness		
Lack of Perseverance		
Unwilling to Venture		
Behaviour		
Poor Socialisation		
Other		

7. BEHAVIOUR AND EMOTIONAL STATE

7.1 Discipline

* How often does your child need to be punished? . . . . . .
* State general misbehaviour: . . . . . .
* What type of punishment is the most effective? . . . . . .
* Who punishes the child? . . . . . .
* Do parents agree on discipline? . . . . . .
* Are parents consistent with regard to discipline? . . . . . .

7.2 Attitude towards work (Complete where applicable)

* Describe your child's attitude towards tasks given to him in the everyday situation, e.g. helping in the home, tidying his/her own toys. . . . . .

7.3 Independence

Is your child able to undertake the following activities independently?(✓) where applicable

	YES	NO
Get dressed		
Get undressed		
Fasten buttons		
Tie shoelaces		
Eat with a knife and fork		

Child separated from parents because of :

* Has the child ever been hospitalized? . . . . . How did he/she cope? . . . . . .

* Does the child separate easily from parents for long periods? If not, give details.

. . . . . .

7.4 DOES YOUR CHILD SHOW ANY OF THE FOLLOWING BEHAVIOUR IN ANY ENVIRONMENT?

(Please tick only when the behaviour is extreme)

Aggression		**Destructive behaviour**	
Jealousy		**Lying**	
Bed-wetting		**Anxiety**	
Stealing		**Extreme fears**	
Extreme shyness		**Temper tantrums**	
Thumb sucking		**Insomnia**	
Whining		**Stutter**	
Overdependence			
Other			

7.5 RELATIONSHIPS

FAMILY INTERACTION: (Report briefly)

. . . . . .

. . . . . .

What do parents and child enjoy doing together and when?

Father/child : . . . . . .

Mother/child . . . . . .

* **Describe the relationship with siblings (brothers and sisters). (Describe each one separately.)**

. . . . . .

. . . . . .

* **Describe the relationship with step-siblings if applicable.**

. . . . . .

. . . . . .

* **Relationship with friends:**

Does your child have any friends? . . . . . .

Are they older/younger? . . . . . .

Does he/she follow or take the lead? . . . . . .

Does he/she often fight with friends. Is so, explain. . . . . . .

* **Relationship with Self:**

Confidence and self-esteem (Describe) . . . . . .

. . . . . .

Does he/she tend to be a perfectionist - to be obsessive? . . . . . .

Thank you for your cooperation!

APPENDIX C

LIST OF FAVOURITE THINGS

Please complete the following information about your child, if there is a preference, and return on the day of his first session.

Name: _____ Date: _____

1. Favourite colour _____
2. Favourite TV programme _____
3. Favourite toy _____
4. Favourite food _____
5. Favourite game / sport _____
6. Best interest _____
7. Best friend's name _____
8. Pet's names and sexes _____
9. Hobby _____
10. Favourite movie _____
11. Favourite story _____
12. Favourite cartoon character _____
13. Favourite event _____
14. Favourite relative _____
15. Any other special likes/interests _____

_____

_____

_____

APPENDIX D

BEHAVIOUR TARGET

APPENDIX E

PARENTING STRESS INDEX

PSI Item Booklet

Instructions:

On the PSI Answer Sheet, please write your name, gender, date of birth, ethnic group, marital status, child's name, child's gender, child's date of birth, and today's date. Please mark all your responses on the answer sheet. **DO NOT WRITE ON THIS BOOKLET**.

This questionnaire contains 120 statements. Read each statement carefully. For each statement, please focus on the child you are most concerned about, and circle the response which best represents your opinion.

Circle the SA if you strongly agree with the statement. Circle the A if you agree with the statement.
Circle the NS if you are not sure.
Circle the D if you disagree with the statement.
Circle the SD if you strongly disagree with the statement.

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies. **SA** **A** **NS** **D** **SD**

While you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.

Circle only one response for each statement, and respond to all statements. DO NOT ERASE! If you need to change an answer, make an 'X" through the incorrect answer and circle the correct response. For example:

I enjoy going to the movies. **SA** **A** **NS** **D** **SD**

1. When my child wants something, my child usually keeps trying to get it.
2. My child is so active that it exhausts me.
3. My child appears disorganized and is easily distracted.
4. Compared to most, my child has more difficulty concentrating and paying attention.
5. My child will often stay occupied with a toy for more than 10 minutes.
6. My child wanders away much more than I expected.

7. My child is much more active than I expected.

8. My child squirms and kicks a great deal when being dressed or bathed.

9. My child can be easily distracted from wanting something.

10. My child rarely does things for me that make me feel good.

11. Most times I feel that my child likes me and wants to be close to me.

12. Sometimes I feel my child doesn't like me and doesn't want to be close to me.

13. My child smiles at me much less than I expected.

14. When I do things for my child, I get the feeling that my efforts are not appreciated very much.

For statement 15, choose a response from choices 1 to 4 below.

15. Which statement best describes your child?
1. almost always likes to play with me
2. sometimes likes to play with me
3. usually doesn't like to play with me
4. almost never likes to play with me

For statement 16, choose a response from choices 1 to 5 below.

16. My child cries and fusses:
1. much less than I had expected
2. less than I expected
3. about as much as I expected
4. much more than I expected
5. it seems almost constant

17. My child seems to cry or fuss more often than most children.

18. When playing, my child doesn't often giggle or laugh.

19. My child generally wakes up in a bad mood.

20. I feel that my child is very moody and easily upset.

21. My child looks a little different than I expected and it bothers me at times.

22. In some areas, my child seems to have forgotten past learnings and has gone back to doing things characteristic of younger children.

23. My child doesn't seem to learn as quickly as most children.

24. My child doesn't seem to smile as much as most children.

25. My child does a few things which bother me a great deal.

26. My child is not able to do as much as I expected.

27. My child does not like to be cuddled or touched very much.

28. When my child came home from the hospital, I had doubtful feelings about my ability to handle being a parent.

29. Being a parent is harder than I thought it would be.

30. I feel capable and on top of things when I am caring for my child.

31. Compared to the average child, my child has a great deal of difficulty in getting used to changes in schedules or changes around the house.

32. My child reacts very strongly when something happens that my child doesn't like.

33. Leaving my child with a babysitter is usually a problem.

34. My child gets upset easily over the smallest thing.

35. My child easily notices and overreacts to loud sounds and bright lights.

36. My child's sleeping or eating schedule was much harder to establish than I expected.

37. My child usually avoids a new toy for a while before beginning to play with it.

38. It takes a long time and it is very hard for my child to get used to new things.

39. My child doesn't seem comfortable when meeting strangers.

For statement 40, choose from choices 1 to 4 below.

40. When upset, my child is:
1. easy to calm down
2. harder to calm down than I expected
3. very difficult to calm down
4. nothing I do helps to calm my child

For statement 41, choose from choices 1 to 5 below.

41. I have found that getting my child to do something or stop doing something is:
1. much harder than I expected
2. somewhat harder than I expected
3. about as hard as I expected
4. somewhat easier than I expected
5. much easier than I expected

For statement 42, choose from choices 1 to 5 below.

42. Think carefully and count the number of things which your child does that bothers you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. Please circle the number which includes the number of things you counted.
1. 1-3
2. 4-5
3. 6-7
4. 8-9
5. 10+

For statement 43, choose from choices 1 to 5 below.

43. When my child cries, it usually lasts:
1. less than 2 minutes
2. 2-5 minutes
3. 5-10 minutes
4. 10-15 minutes
5. more than 15 minutes

44. There are some things my child does that really bother me a lot.

45. My child has had more health problems than I expected.

46. As my child has grown older and become more independent, I find myself more worried that my child will get hurt or into trouble.

47 My child turned out to be more of a problem than I had expected.

48. My child seems to be much harder to care for than most.

49. My child is always hanging on me.

50. My child makes more demands on me than most children.

51. I can't make decisions without help.

52. I have had many more problems raising children than I expected.

53. I enjoy being a parent.

54. I feel that I am successful most of the time when I try to get my child to do or not do something.

55. Since I brought my last child home from the hospital, I find that I am not able to take care of this child as well as I thought I could. I need help.

56. I often have the feeling that I cannot handle things very well.

For statement 57, choose from choices 1 to 5 below.

57. When I think about myself as a parent I believe:
1. I can handle anything that happens
2. I can handle most things pretty well
3. Sometimes I have doubts, but find that I handle most things without any problems
4. I have some doubts about being able to handle things
5. I don't think I handle things very well at all

For statement 58, choose from choices 1 to 5 below.

58. I feel that I am:
1. a very good parent
2. a better than average parent
3. an average parent
4. a person who has some trouble being a parent
5. not very good at being a parent

For questions 59 and 60, choose from choices 1 to 5 below.

59. What were the highest levels in school or college you and the child's father/mother have completed?

Mother:
1. lst to 8th grade
2. 9th to 12th grade
3. vocational or some college
4. college graduate
5. graduate or professional school

60. Father:
1. lst to 8th grade
2. 9th to 12th grade
3 vocational or some college
4. college graduate
5. graduate or professional school

For question 61, choose from choices 1 to 5 below.

61. How easy is it for you to understand what your child wants or needs?
1. very easy
2. easy
3. somewhat difficult
4. it is very hard
5. I usually can't figure out what the problem is

62. It takes a long time for parents to develop close, warm feelings for their children.

63. I expected to have closer and warmer feelings for my child than I do and this bothers me.

64. Sometimes my child does things that bother me just to be mean.

65. When I was young, I never felt comfortable holding or taking care of children.

66. My child knows I am his or her parent and wants me more than other people.

67. The number of children that I have now is too many.

68. Most of my life is spent doing things for my child.

69. I find myself giving up more of my life to meet my children's needs than I ever expected.

70. I feel trapped by my responsibilities as a parent.

71. I often feel that my child's needs control my life.

72. Since having this child, I have been unable to do new and different things.

73. Since having a child, I feel that I am almost never able to do things that I like to do.

74. It is hard to find a place in our home where I can go to be by myself

75. When I think about the kind of parent I am, I often feel guilty or bad about myself.

76. I am unhappy with the last purchase of clothing I made for myself.

77. When my child misbehaves or fusses too much, I feel responsible, as if I didn't do something right.

78. I feel every time my child does something wrong, it is really my fault.

79. I often feel guilty about the way I feel toward my child.

80. There are quite a few things that bother me about my life.

81. I felt sadder and more depressed than I expected after leaving the hospital with my baby.

82. I wind up feeling guilty when I get angry at my child and this bothers me.

83. After my child had been home from the hospital for about a month, I noticed that I was feeling more sad and depressed than I had expected.

84. Since having my child, my spouse (or male/female friend) has not given me as much help and support as I expected.

85. Having a child has caused more problems than I expected in my relationship with my spouse (or male/female friend).

86. Since having a child, my spouse (or male/female friend) and I don't do as many things together.

87. Since having a child, my spouse (or male/female friend) and I don't spend as much time together as a family as I had expected.

88. Since having my last child, I have had less interest in sex.

89. Having a child seems to have increased the number of problems we have with in-laws and relatives.

90. Having children has been much more expensive than I had expected.

92. When I go to a party, I usually expect not to enjoy myself

93. I am not as interested in people as I used to be.

94. I often have the feeling that other people my own age don't particularly like my company.

95. When I run into a problem taking care of my children, I have a lot of people to whom I can talk to get help or advice.

96. Since having children, I have a lot fewer chances to see my friends and to make new friends.

97. During the past six months, I have been sicker than usual or have had more aches and pains than I normally do.

98. Physically, I feel good most of the time.

99. Having a child has caused changes in the way I sleep.

100. I don't enjoy things as I used to.

For statement 101, choose from choices 1 to 4 below.

101. Since I've had my child:
1. I have been sick a great deal
2. I haven't felt as good
3. I haven't noticed any change in my health
4. I have been healthier

For statements 102 to 120, choose from choices Y for "Yes" and N for "No."

During the last 12 months, have -any of the following events occurred in your immediate family?

102. Divorce
103. Marital reconciliation
104. Marriage
105. Separation
106. Pregnancy
107. Other relative moved into household
108. Income increased substantially (20% or more)
109. Went deeply into debt
110. Moved to new location
111. Promotion at work
112. Income decreased substantially
113. Alcohol or drug problem
114. Death of close family friend
115. Began new job
116. Entered new school
117. Trouble with superiors at work
118. Trouble with teachers at school
119. Legal problems
120. Death of immediate family member

APPENDIX F

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER TEST

ADHDT

Attention-Deficit/ Hyperactivity Disorder Test

A Method for Identifying Individuals with ADHD

SUMMARY/RESPONSE FORM

Section I. Identifying Information

Subject's Name _____

Address _____

_____

Rater's Name _____

Relationship to Subject _____

Examiner's Name and Title _____

Date of ADHDT Rating _____ Year _____ Month

Subject's Date of Birth _____ Year _____ Month

Subject's Age _____ Year _____ Month

Section II. Score Summary

Subtests	Raw Score	SS	%	SE_M
Hyperactivity	____	____	____	1
Impulsivity	____	____	____	1
Inattention	____	____	____	1
Sum of Standard Scores		____		
ADHD Quotient		____	____	3

Section III. Interpretation Guide

Subtest Standard Scores	ADHD Quotient	Degree of Severity	Probability of ADHD
17–19	131+	High	Very High
15–16	121–130		High
13–14	111–120		Above Average
8–12	90–110		Average
6–7	80–89		Below Average
4–5	70–79		Low
1–3	≤69	Low	Very Low

Section IV. Profile of Scores

Subtest Standard Scores	ADHDT Subtests: Hyperactivity	Impulsivity	Inattention	Composite Quotients	ADHDT Composite: ADHD Quotient	Other Measures of Intelligence, Achievement, or Behavior: Test Used ____	Test Used ____	Test Used ____	Test Used ____	Test Used ____
20				160						
19				155						
18				150						
17				145						
16				140						
15				135						
14				130						
13				125						
12				120						
11				115						
10				110						
9				105						
8				100						
7				95						
6				90						
5				85						
4				80						
3				75						
2				70						
1				65						
				60						
				55						

Additional copies of this form (#6882) are available from PRO-ED
8700 Shoal Creek Blvd., Austin, TX 78757, 512/451-3246

Section V. Response Form

DIRECTIONS: Please indicate which of the following behaviors/characteristics are a problem for this individual. Mark or circle 0 if the behavior is *not a problem* (the subject rarely demonstrates this problem, and it does not impair his or her functioning) or if you have not had the opportunity to observe the behavior. Mark or circle 1 if the item refers to a behavior that is a *mild* problem (the subject sometimes demonstrates this behavior, and it occasionally causes problems and impairs his or her functioning.) Mark or circle 2 if the item refers to a behavior that is a *severe* problem for this individual (the subject frequently demonstrates this behavior, and it usually causes problems and impairs his or her functioning.) Do not skip any items.

Hyperactivity Subtest

	Not a Problem	Mild Problem	Severe Problem
1. Loud	0	1	2
2. Constantly "on-the-go"	0	1	2
3. Excessive running, jumping, climbing	0	1	2
4. Twisting and wiggling in seat	0	1	2
5. Easily excited	0	1	2
6. Grabs objects	0	1	2
7. Excessive talking	0	1	2
8. Difficulty remaining seated	0	1	2
9. Constantly manipulating objects	0	1	2
10. Inability to play quietly	0	1	2
11. Fidgets	0	1	2
12. Restless	0	1	2
13. Squirms	0	1	2

Hyperactivity Sum [ ]

Impulsivity Subtest

	Not a Problem	Mild Problem	Severe Problem
14. Acts before thinking	0	1	2
15. Shifts from one activity to the next	0	1	2
16. Fails to wait for one's turn	0	1	2
17. Difficulty waiting turn	0	1	2
18. Blurts out answers	0	1	2
19. Impulsive	0	1	2
20. Interrupts conversations	0	1	2
21. Intrudes on others	0	1	2
22. Does not wait for directions	0	1	2
23. Fails to follow rules of games	0	1	2
Impulsivity Sum			

Inattention Subtest

	Not a Problem	Mild Problem	Severe Problem
24. Poor concentration	0	1	2
25. Fails to finish projects	0	1	2
26. Disorganized	0	1	2
27. Poor planning ability	0	1	2
28. Absentminded	0	1	2
29. Inattentive	0	1	2
30. Difficulty following directions	0	1	2
31. Short attention span	0	1	2
32. Easily distracted	0	1	2
33. Difficulty sustaining attention	0	1	2
34. Difficulty staying on task	0	1	2
35. Difficulty completing tasks	0	1	2
36. Frequently loses things	0	1	2
Inattention Sum			

Section VI. Key Questions

1. Does the person demonstrate six or more symptoms of inattention, or six or more symptoms of hyperactivity, or impulsivity listed in each subtest?
2. Does the person exhibit the behavioral problems in a variety of environments?
3. Does the person demonstrate the behaviors considerably more frequently than do most people of the same mental age?
4. Has the person demonstrated the behaviors for at least 6 months?
5. Did the person first demonstrate the behaviors before age 7?
6. Is the person's functioning (at school, home, and work) significantly impaired?
7. Are there other conditions that could possibly be causing the behavioral problems? If yes, what are the conditions?
8. Who has previously evaluated this person and what were the results?
9. What specific interventions have been attempted to treat the person's problems?
10. What additional information needs to be collected?

Section VII. Recommendations and Comments

APPENDIX G

GUIDELINES FOR THE TEACHERS

* **Build a relationship with the child in which he feels safe and unconditionally accepted.**

* **Encourage relationships with the child's peers.**

* **Establish structure in the classroom**
  - **provide the child with a daily schedule**
  - **clear, concise and specific rules should be provided**

* **Seating arrangement**
  - **near the teacher**
  - **away from other children who may be a disturbing influence**
  - **away from other distractions**
  - **next to a class buddy who can monitor performance**

* **Ensure that he has all the necessary requirements close at hand.**

* **Structure the day so that difficult tasks which require sustained focus of attention occur early.**

* **Alternate between tasks which require physical involvement and those which are more passive.**

* **Vary presentation formats and task materials to increase and maintain child's interest. Teach in novel ways with lots of humour. Use all the senses. Include colour.**

* **Give short, one step directions. Ensure the child has understood what is expected. Make eye contact, or even physical contact, to ensure you have the child's attention.**

* **Break tasks down into small manageable parts.**

* **Set realistic time limits.**

* **Use short verbal cues, subtle non-verbal prompts, attention checks and/or a kitchen timer to assist students to focus their attention on a task. A useful example of a nonverbal signal is a green circle placed on child's desk to indicate he must start/continue with a task.**

* **Give short breaks in-between to help the child to refocus attention, e.g. walk to the tree outside and back quickly (1 minute).**

* **Give immediate feedback since ADHD involves difficulties with short-term memory.**
  - **use logical consequences for unwanted behaviour**
  - **praise small steps towards a final goal, not lavishly but always realistically**
  - **praise completion of a task within the given time**
  - **concrete reward e.g. stars on a star chart**
  - **take away token/reward or give time out for non-compliance/negative behaviour (not to be deprived of breaks since this will exacerbate problems)**

* **Encourage the child to self-monitor his performance.**

* **Create an awareness in the child of events which trigger inappropriate behaviour.**

* **Create opportunities for success, both within and outside of the academic environment.**

* **Ignore minor disruptions if it is felt the attention the child receives is maintaining the disruptive behaviour. However, a minor disruption should be addressed if it seems likely that it will lead to something greater.**

* **Give the child responsibility/put him in charge of something.**

* **Fill in checklist to monitor the situation objectively.**

APPENDIX H

DAILY REPORT CHART

Name: _____ **Week Ending:** _____

BEHAVIOUR TO BE MONITORED	YES	NO
Remembers to bring necessary materials to school		
Hands in homework completed		
Homework neat and accurate		
Remains seated		
Sits in seat appropriately		
Avoids disrupting		
Attends to lessons		
Follows instructions correctly		
Completes tasks within the given time limits		
Few errors in written work		
Works enthusiastically		
Works quietly		
Works independently		
Happy disposition		
Positive relations with peers		
Cooperates with others		
Conforms to rules		
Appropriate group participation		
Enters and leaves the class appropriately		

Comments: _____

_____

_____

_____

_____

APPENDIX I

PARENT HANDOUTS

APPENDIX I.1.1

PARENTING YOUNG CHILDREN WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER

HISTORICAL COURSE

Problem first described: almost 100 years ago in the UK by George Still, an English Paediatrician.
Initially sufferers were considered:

- learning disabled
- emotionally disturbed
- mentally retarded
- socially and culturally disadvantaged
- product of an unhealthy diet or poor parenting

1902:	Clear description of ADHD behaviours. Not considered to be caused by brain damage or poor parenting
1930's:	Brain damage considered the cause
1937:	Stimulant medication first used
1950's and 1960's:	Minimal brain dysfunction considered the cause Psychoanalytical child psychiatrists see it in terms of parents and environment
1957:	Ritalin introduced
1960-70:	Hyperactive Child Syndrome becomes popular
1970-75:	Inaccurate media claims raise concerns with medication
1980:	Benjamin Feingold's diet becomes popular Noted that many of these children had trouble with distractibility or impulsivity - found that attention deficit disorder could be with or without hyperactivity
1987:	American Psychiatric Association uses the term Attention Deficit Hyperactivity Disorder Misleading anti-medication media campaign
1990:	Positron Emission Tomography shows significant difference between the function of ADHD and non-ADHD brain
1994:	American Psychiatric Association redefines Attention Deficit Hyperactivity Disorder

DESCRIPTION OF ATTENTION DEFICIT HYPERACTIVITY DISORDER

ADHD is a neurobiological disorder characterized by:
attention skills that are developmentally inappropriate,
impulsivity, in some cases, and/or
hyperactivity.

Some people with ADHD are exceptionally hyperactive and impulsive, others are most notably inattentive, and still others have a combination of all three traits.

These different types of the disorder are described in the Fourth Edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM IV) published by the American Psychiatric Association in 1994:

* Attention-deficit/Hyperactivity Disorder, Predominantly Inattentive Type;
* Attention-deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type; and
* Attention-deficit/Hyperactivity Disorder, Combined Type.

The predominantly hyperactive-impulsive type, along with the combined type, make up the majority of children with attention-deficit/hyperactivity disorder. Probably a third of all children with the disorder are the predominantly inattentive type and do not show signs of impulsivity or hyperactivity.

Onset: Before age seven

Present: Two or more settings (i.e. at school, playground, at home). There must be evidence of impairment in social, academic, or occupational functioning. Furthermore, the symptoms must not be the result of another psychiatric disorder.

Prevalence: Conservatively estimated that 3% to 5% of school-aged children are affected
Some experts believe as many as 20 - 25%
Boys with ADHD significantly outnumber girls - 6:1
Some experts believe girls are probably under-diagnosed because they are less boisterous

Characteristics:

Inattention
While attention span is not as visible as hyperactivity or impulsivity, it is usually the symptom of ADHD which causes the most problems in school. A child with attention-deficit/hyperactivity disorder, predominantly inattentive type exhibits at least six of the characteristics of inattention described below:

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

Although frequently inattentive, the child with ADHD is not incapable of attending to situations which appeal to interests. They usually have an ample supply of attention when performing highly enjoyable activities, such as playing video games or watching television. During one-on-one activities, wherein the child with ADHD is being closely observed, attention span can be normal.

Hyperactivity-Impulsivity
This does not refer to the typical restlessness or energetic behaviour found in most young children. Hyperactive children usually exhibit far greater amounts of restlessness and overactivity, and in many more situations than their non-hyperactive peers. Their impulsivity is reflected in their inability to control their emotions and behaviour to a far greater degree than is typical of other children their age.

The child with attention-deficit/hyperactivity disorder, predominantly hyperactive-impulsive type exhibits at least six of the characteristics described below:

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

Impulsivity
* often blurts out answers to questions before questions have been completed
* often has difficulty waiting in lines or awaiting turn in games or group situations
* often interrupts or intrudes on others (e.g. butts into conversations or games)

DEVELOPMENT COURSE OF ADHD
Child Characteristics

Infancy
* Excessive crying, irritable, difficult, impossible to soothe, not cuddly, little smiling, unresponsive
* Sleep disturbances, restless sleep, awake easily, drowsiness
* Feeding problems, colic, poor sucking, crying while eating, irregular eating
* Undue sensitivity, aversive response to stimuli
* Late in babbling
* Early mother-child difficulties

Toddler
* Infants less compliant
* Moms feel negative toward child, interact less frequently, less affectionate
* Moms have high stress and lower self-esteem
* Mother/child interaction is stressful

Preschool
* Excessively active, everywhere at once and nowhere for very long
* Always touching something, always curious and needing supervision
* Never satisfied - demanding of parental attention
* Noncompliant, difficult to toilet train
* Shift activities in free play, never sticking with one thing for very long
* Respond impulsively
* Delays in motor development
* Temper tantrums
* Low adaptability
* Negative encounters between child and others
* Problems in day care
* Rejected by peers
* Parents have more frustration and stress than other parents
* Can be improved upon or worsened by the type of home environment parents create
* Number of referrals for hyperactivity increase for 3-4 year olds

Elementary School Children (6 - 8 years)
* Out-of-seat and off-task
* More disruptive
* Easily stimulated by surroundings
* Poor school performance
* LD may become apparent
* Low motivation
* Easily bored
* Low frustration tolerance
* Limited self-awareness - blame others
* Easily excitable
* Impaired metacognition

* Limited higher-order schemata (concepts and strategies)
* Poor social relations
* Negative impact on teacher and other children
* Aggressive, oppositional behaviour may appear
* Sibling rivalry
* Lower self-esteem and depression
* Engage in dangerous acts to gain attention
* Punitive home makes socialization less likely
* Consistent, supportive, structured home helps some but not all ADHD children
* Extremely sensitive to presence/absence reinforcers
* Symptoms change with situation
* More compliant and less disruptive with fathers
* Most referrals Grades 1-3

Related Conditions

The likelihood of having other problems with behaviour, learning, or social and emotional functioning is strong.

Approximately sixty percent of children with ADHD who are primarily hyperactive/impulsive are described by their parents as difficult to manage, strong-willed, stubborn and defiant. They exhibit such unusually high degrees of noncompliance that they are regarded as having an additional disturbance, namely, oppositional-defiant disorder (ODD).

Children or adolescents with ODD exhibit many of the following characteristics:

* often lose their temper
* often argue with adults
* often actively defy or refuse adult requests or rules
* deliberately do things that annoy others
* often blame others for their own mistakes
* are often touchy or easily annoyed by others
* often become angry or resentful
* often are spiteful or vindictive
* often swear or use obscene language

Between 30 and 50% of ADHD children between the ages of 7 - 10 develop a conduct disorder

Up to 25% of children with ADHD show evidence of a learning disability.

A learning disability is a deficit in one or more of the basic psychological processes involved in understanding or in using spoken or written language. These problems are the result of language impairment, perceptual dysfunctions or disturbances in the way information is processed and expressed in written or oral communications. Learning disabled students may show weaknesses in reading, writing, spelling and arithmetic skills

Children with ADHD may also exhibit a variety of social problems as a result of:

* high energy levels
* reckless nature
* impulsive nature
* short attention span
* low frustration tolerance
* immaturity
* lack of social graces

The above factors cause problems in structured play activities. They can have difficulty :

* taking turns
* following rules
* sharing ideas and materials
* controlling aggression

Potential Predictors of the Early Emergence and Persistence of ADHD in Children
(Listed in descending order of importance)

1. The early emergence of high activity level and demandingness in infancy and preschool years
2. Critical/directive behaviour by mothers in the child's early years when combined with above
3. Family history of ADHD
4. Smoking and alcohol consumption by and poor health of the mother during pregnancy
5. A greater-than-normal number of complications during pregnancy
6. Being a single parent and / or having less education than most
7. Poor health of the infant and delays in motor and language development

CAUSES OF ATTENTION DEFICIT HYPERACTIVITY DISORDER

Cause is often untraceable and unexplained, although, there is some evidence that it happens in the third, fourth or fifth months of pregnancy. In a small number of children, brain injury or brain dysfunction may be attributable to a known proper disease of acquired head injury. Some children may have suffered neurological damage as a result of birth injuries associated with difficulties during maternal pregnancy or labour and delivery. Others may have got ADHD as a result of being born to mothers who abused alcohol or drugs during their pregnancy. The problem is genetic in 60% of cases.

Many theories have been put forth to explain the cause of attention deficit disorder. While most of them come under scientific scrutiny and have either been accepted as having merit or have been discarded, some continue to receive attention despite the lack of any scientific evidence to support them.

Unproven Theories

* Diet
  Dr. Benjamin Feingold advocated that artificial flavourings and natural salicylates found in certain foods produced hyperactivity in children. He advised parents to put their hyperactive children on elimination diets to avoid these ingredients. Although a number of parents reported success with such diets, Feingold's theory, and the theories of other researchers, have not been supported by rigorous scientific investigation.
* Effects of fluorescent lighting
* Misalignment of the spine
* Low thyroid hormone levels
* Candida yeast infection
* Inner ear disorders which result in motion sickness
* Problems related to child rearing practices
  Some methods parents use in raising their child will affect the child's behaviour and development to some extent. However, while faulty child rearing practices may contribute to the problems of a child with ADHD, there is no scientific evidence to suggest they cause ADHD.

Neurobiological Theory

- Most widely accepted theory
- Tends to run in families - fairly common to have one or more biological relatives with the disorder
- Sometimes parents realize they had similar symptoms when they were children
- May continue to exhibit characteristics of ADHD as adults
- Emerging evidence to suggest:
  - Some form of dysfunction occurring in regions of the brain associated with the control and regulation of attention, arousal, and activity
  - Hyperactive symptoms could be modified by chemically causing changes to occur in how transmissions of sensory information are made within the brain
  - Such sensory information is sent to millions of different nerve cells in the brain, called neurons
  - Information is sent by neurotransmitter chemicals within the terminals of these neurons
  - Neurotransmitter chemicals have been found to be directly responsible for behaviour, emotion, and cognition in animals and humans
  - Larger amounts than normal or deficiencies of these neurotransmitter chemicals can have significant disruptive effects on our emotions and behaviour
  - Some of the neurochemical transmitters that may be involved are dopamine, norepinephrine, and serotonin

DIAGNOSING CHILDREN WITH ATTENTION DEFICIT DISORDER

Not all children who are hyperactive, impulsive, or inattentive have an attention deficit hyperactivity disorder.

These same symptoms can be the result of other factors such as:

- frustration with difficult schoolwork
- lack of motivation
- emotional concerns
- other medical conditions

A comprehensive assessment of ADHD usually requires input from various professionals working together with the child's parents as a team. Early diagnosis of a youngster suspected of having ADHD allows parents and teachers to intervene sooner in treating the disorder. Often children as young as four years of age can be accurately diagnosed.

The Physician's Role in the Assessment

The child's primary care doctor, paediatrician, or family physician is often the first person parents turn to for help when there is a medical problem. The doctor is usually familiar with the child's family and medical history and has knowledge of the child through previous treatment contact. The Medical Evaluation will involve the following:

* Medical and Social History
  - May alert the doctor when symptoms first appeared, in which situation, to what degree
  - genetic background
  - early birth history
  - developmental history
  - social history
* Parent and teacher rating scales to evaluate the child's behaviour in different settings
* Routine physical examination to rule out possibility of another medical illness
* Procedures such as chromosome studies, EEG, MRI or CAT scans may be requested if other conditions are suspected

The Psychologist's Role in the Assessment

The clinical or school psychologist is trained to administer and interpret psychological and educational tests that can provide important information about the child's intellectual ability, reasoning skills, use of language, perceptual development, impulsiveness, attention span, and emotional functioning.

The psychologist may administer tests to measure the following:

- intellectual functioning
- academic achievement
- perceptual skills such as visual-motor ability, memory, etc.
- self-esteem
- depression
- family stress

In addition psychologists collect information by conducting interviews with the child, parents and teachers. Parents and teachers are asked to complete behaviour rating scales about the child, and to directly observe the child's behaviour in the natural environment, i.e., at school or at home. Most of the rating scales used to assess ADHD provide standardized scores on a number of factors, usually related to attention span, self-control, learning ability, hyperactivity, aggression, social behaviour, anxiety, and so on. Such scales offer quantifiable, descriptive information about the child, providing a means by which to compare the child's behaviour to that of others of the same sex and age.

The Parents' Role in the Assessment

Optimally, both parents should be part of the assessment process. Having witnessed the child in a variety of situations throughout their life, parents have a unique perspective on their child's previous development and current adjustment. The assessment process can be emotionally difficult for both the parents and the child. Parents bring more than just objective information and records to the doctor's office when they proceed with an assessment. They also bring a mixture of emotions about themselves and their child. It has been reported that the child's prognosis for improvement is affected by the parents' commitment to change.

The Teacher's Role in the Assessment

Few adults spend as much time with the ADHD child as the teacher. The teacher's opinions are a critical part of the evaluation. The professional's should ask the teacher about the child's current academic and behaviour problems, relationships with classmates, behaviour in various school situations, especially those involving work, as well as those with limited or no supervision, such as breaks, outings.

The Child's Role in the Assessment

An interview with the child offers the clinician an opportunity to observe the child's behaviour and can yield valuable information as to the child's social and emotional adjustment, feelings about themselves and others, attitudes about school and other aspects of their life. Information of this sort can be obtained through in-depth interviews with the child and by asking the child to complete psychological tests which evaluate social and emotional adjustment.

Even children with ADHD often behave well during such interviews. Therefore, observations of the child's behaviour, level of activity, attentiveness, or compliance made during the interview sessions should not be taken as true of the child in other settings. Normal behaviour in a one-on-one setting does not diminish the likelihood of the child having an attention deficit disorder.

Children

- should be actively involved in the decision to administer medication
- should understand the reasons for administration
- should give feedback

The Team's Role After Assessment

Once the assessment is complete, members of the team should communicate with one another to review their findings and come to conclusions with respect to a diagnosis and recommendations. The physician may determine that medication be prescribed. The psychologist may recommend counselling, behaviour modification, or training in social and organizational skills. The school may recommend that accommodations be made by the teacher in the classroom to assist the child with ADHD or may make special programs available if the child is deemed to be in need of special education and related services on the basis of a handicapping condition.

If the child is found to have ADHD, assessment should not end once the initial evaluation is completed. There should be routine follow-up evaluations by members of the assessment and treatment team to determine how the child is progressing. ADHD, being a chronic condition, will often require long-term care and monitoring on a regular basis. Parents will need to coordinate activities of members of the treatment team to work together for the best interests of the child.

PARENTAL REACTIONS TO THE DIAGNOSIS

* Denial - the parents deny or minimize the extent of the problem until they can reevaluate the information they are receiving
* Relief - knowing that ADHD has a biological basis allows them to let go of the previous sense that they personally created the problem
* Anger - aimed at anyone who assured them that nothing was wrong, at those who blamed them or at those who first mentioned the possibility of the diagnosis.
* Grief - when confronted with the news that their child is handicapped in some way, parents grieve for the loss of normality
* Acceptance - acceptance of what your child is and may become and, equally, what your child may never become

TREATMENT OF CHILDREN WITH ATTENTION DEFICIT DISORDER

A multi-modal treatment plan is usually followed for successful treatment of the child or adolescent with ADHD. Thus those professionals who played an active part in the assessment may also be involved in the implementation of the treatment plan. The four cornerstones of the treatment plan will likely include medical management, educational planning, behaviour modification and psychological counselling.

Developmental Considerations
Several trends appear to be important to consider when designing treatment programs for children with ADHD; these are based on how the primary symptoms interact with the cognitive, social, and emotional demands that are prominent during each major developmental stage. First, during the Infancy and Toddler Stage treatment should focus on building positive parent-child relationships. Efforts should be made to increase the parents' awareness of ADHD and to help them develop ways of interacting despite their child's temperamental difficulties. Warm, responsive, flexible, and consistent parental interaction styles should be used.

* 80% of children will mature out of it at puberty
* 20% will continue to have it into adolescence and probably into adulthood
* Myth - Children do not need help after 13

MEDICAL MANAGEMENT

For many children with ADHD the basis of the medical program is management of medication to control symptoms of the disorder. Although most people would prefer alternatives to treatment with medication, the cautious use of certain medications for the child with ADHD has been well established as an effective component of the overall treatment plan. Not all children require medication to manage their behaviour, either because their environments both at school and at home are able to be arranged in such a way as to compensate for the child's attentional deficits (i.e., small classes, greater teacher supervision, shortened assignments, and so on).

* increasing norepinephrine in the brain stem causes the systems that function inefficiently to function normally
* depleting norepinephrine in the brain stem causes the system to work ineffectively
* must be used systematically
* is sometimes used in combination
* is prescribed using clinical judgement (time-consuming)
* does not get rid of learning problems but may improve learning skills
* function - to increase the amount of norepinephrine in the reticular activating system
* medication for ADHD may stop bed wetting as a spinoff because it controls impulsivity

EDUCATIONAL and BEHAVIOURAL MANAGEMENT

Perhaps the most frequently expressed concern that parents of children with ADHD have is with respect to their child's performance at school, where the children seem to have serious problems. Daily reports of poor school performance cause frustration and discouragement for children with ADHD and their parents.

Most children with ADHD can be accommodated in the regular classroom, provided the teachers are willing to make accommodations to meet the child's needs. For some children, behaviour modification programmes can help the student perform better. Such programmes usually involve cooperation between home and school.

PSYCHOLOGICAL COUNSELLING

For most families, psychological counselling is a necessary component of the treatment plan. By the time the child is evaluated and diagnosed, it is likely that the family has already gone through considerable stress in trying to cope with the behavioural or learning difficulties that the disorder presents. For most families, this stress usually results in confusion and controversy between family members as to how to deal with the child's behaviour.

Parent education about the disorder and related problems is an important part of the counselling process. Understanding usually reduces the frustrations and worries that often dishearten parents. Education provides parents with the skills they need to become empowered to better help their child. Support can be obtained from other parents in a support group where experiences and ideas can be shared.

The hyperactive child may also benefit from supportive counselling to help repair the injured self-esteem, overcome feelings of demoralization or depression, to learn more effective problem solving behaviour patterns, or to better understand the behaviour.

DIET

There is no data to suggest that diets work. However, when the blood sugar is too high, ADHD may develop. Some experts report that, whilst diet does not cause ADHD, it has a small part to play in the management of ADHD.

APPENDIX I 2.1

MY PERSONAL PLAN

THINGS I ALREADY DO WELL	THINGS I INTEND TO TRY

APPENDIX I 2.2

TEN SUGGESTIONS FOR ENHANCING THE SELF-ESTEEM OF YOUR CHILDREN

Taylor (1994:27)

* **Work on your own self-esteem.**
* **Praise efforts toward a goal.**
* **Understand and appreciate each child as an individual.**
* **Provide opportunities to feel success.**
* **Allow your children to make decisions.**
* **When correction is needed, do it in a positive way.**
* **Praise but don't judge.**
* **Help your children to feel lovable and capable.**
* **Establish effective communication.**
* **Catch them being good.**

APPENDIX I 2.3

LETTER OF APPRECIATION

Dear .....

Today I noticed that you .....

.....

.....

and I so appreciate your effort.

Thank you

Love

.....

APPENDIX I 3.1

EIGHT SUGGESTIONS FOR IMPROVING YOUR COMMUNICATION WITH YOUR CHILDREN

Taylor (1994:25)

* **Use good sending skills.**
* **Use good listening skills.**
* **If your child is bothering you, explain that.**
* **If your child has a problem, you need to listen.**
* **Ordering or threatening blocks communication.**
* **Try not to deny your child's feelings.**
* **Avoid judging, criticizing, blaming, shaming, ridiculing, or name-calling.**
* **Listen to your child with the same respect with which you'd listen to your friend, your co-worker, or even your boss.**

APPENDIX 1 3.2

COMMUNICATION

Adapted from Clark (1995:290-306)

Communication comes in many forms. What may start out as communication may wind up as a lecture, argument, or worse.

ROLES WE PLAY WHEN CHILDREN EXPRESS THEIR FEELINGS

COMMANDER IN CHIEF
Orders, commands, and threats are the tools the Commander uses to keep the upper hand.

MORALIST
The Moralist is a "shouldist!" He preaches.

KNOW-IT-ALL
These parents lecture, advise, make appeals to the child's reason, and try to show how superior they themselves are.

JUDGE
They are interested in proving that they are always right.

CRITIC
The critic relies on ridicule, name-calling, sarcasm, or jokes to put the child down.

PSYCHOLOGIST
The psychologist diagnoses, analyses and questions.

CONSOLER
Simple reassurance, a pat on the back and the pretence that all is well when it isn't are this parent's answer to a child's worries and anxieties.

BECOMING AN EFFECTIVE LISTENER

Becoming an effective listener requires concentration. It involves establishing eye contact and a posture which says, "I'm listening". Sometimes good listening requires us to be silent. Sometimes it requires us to respond.

REFLECTIVE LISTENING

Listening to our children requires letting them know that we recognise the feelings behind what they are saying and what they are not saying.

Reflect and clarify the child's feelings.

Communication between persons can be described in terms of closed and open responses. The child may wish to tell you more. The communication process is always non-verbal. Our actions, facial expressions, and tone of voice communicate whether or not we are listening.

RESPONDING TO NON-VERBAL MESSAGES

One must learn to catch the meanings of a child's behaviour by "tuning in" to more than his or her words. "When your face lights up that way, you look very happy."

SOME CAUTION ABOUT USING REFLECTIVE LISTENING

Keep your feedback statements tentative. Reflective listening can be overdone. Use discretion.

EFFECTIVE LISTENING

Closed Response: Denies children a right to their feelings by demonstrating listener's unwillingness to accept and understand.

Open Response: Acknowledges children's right to their feelings by demonstrating that the listener accepts what they feel as what they say. Indicates that the listener understands.

Child's Remark:	Closed Response:	Open Response:
I'm never going to play with her again!	Why don't you forget it; she probably didn't mean it.	You're really angry with her.
I can't do it!	Now, don't talk like that! You just got started!	It seems very difficult to you.
I wish I could go along. He always gets to go everywhere.	We've discussed this before - so, stop fussing.	It seems unfair to you.
Look at my new model!	That's nice...now will you please go...	You're pleased with your work on it.
I don't want to go to school today. Billy is mean!	Everyone has to go to school. It's the law.	You're afraid Billy will pick on you.
You're the meanest mother in the whole world!	Don't you ever talk to me that way!	You're very angry with me.

POINTS TO REMEMBER

1. Communication begins by listening and indicating you hear the child's feelings and meanings.
2. Effective listening involves establishing eye contact and posture which clearly indicate you are listening.
3. Avoid nagging, criticizing, threatening, lecturing, probing, and ridiculing.
4. Treat your children the way you treat your best friend.
5. Mutual respect involves accepting the child's feelings.
6. Reflective listening involves hearing the child's feelings and meanings and stating this so the child feels understood. It provides a mirror for the child to see himself or herself more clearly.
7. Learn to give open responses that accurately state what the other person feels and means.
8. Avoid closed responses which ignore the child's feelings, relaying that we have not heard or understood.
9. Let the child learn. Resist the impulse to impose your solutions.

EXPLORING ALTERNATIVES AND EXPRESSING YOUR IDEAS AND FEELINGS TO CHILDREN

Through your reflective listening, children can clarify their feelings and consider a problem more rationally. Sometimes they can discover their own solutions simply by being heard by an understanding adult. There are other times when children need help in considering various courses of action. The process of exploring alternatives should not be confused with giving advice. Giving advise, such as "Do this..." or "I think you should....." is not helpful, for the following reasons.

1. Advice does not help children learn to solve their own problems.
2. Many children resist taking advice.
3. If your advice doesn't work, guess who is held responsible.

To help a child explore alternatives means to help the child evaluate each course of action and then to obtain a commitment to action. The steps in exploring alternatives are:

1. USE REFLECTIVE LISTENING TO UNDERSTAND AND CLARIFY THE CHILD'S FEELINGS
2. EXPLORE ALTERNATIVES THROUGH BRAINSTORMING
   Get as many ideas from the child as possible.
3. ASSIST THE CHILD TO CHOOSE A SOLUTION
   Help the child evaluate the various possibilities.
4. DISCUSS THE PROBABLE RESULTS OF THE DECISION
5. OBTAIN A COMMITMENT
6. PLAN A TIME FOR EVALUATION

Be careful not to enter into exploring alternatives too soon. Offer suggestions in a tentative form. Keep suggestions to a minimum. Appropriate timing is essential.

CONCEPT OF PROBLEM OWNERSHIP

The techniques of reflective listening and exploring alternatives are especially helpful when the child is the one experiencing the problem. There remains a question of what to do when you are the one experiencing a problem with your children. To determine problem ownership, simply ask, whose problem is it? Dr Thomas Gordon defines problem ownership in the following manner:

1. The child has a problem because he is thwarted in satisfying a need.
2. The child is satisfying his own needs and his behaviour is not interfering with the parents. Therefore there is no problem in the relationship.
3. The child is satisfying his own needs. But his behaviour is a problem to the parents because it is interfering with them.

If your child owns the problem, you may decide to listen, to explore alternatives, or to allow the child to face the consequences independently. If you find that you are the owner of the problem, several other courses of action may be open to you.

I-MESSAGES

To influence your child, you must be able to communicate in a manner which makes it likely that your feelings, meanings and intentions are being understood. When talking with your children, it is helpful to think in terms of You-messages and I-messages.

* The You-message lays blame and conveys criticism of the child.
* An I-message simply describes how the child's behaviour makes you feel. I-messages are specific. In an I-message, the non-verbal elements, such as tone of voice, are crucial. I-messages require a nonjudgemental attitude.

CONSTRUCTING AN I-MESSAGE

Before expressing your feelings of displeasure to the child, consider this:

It is usually not the child's behaviour per se that's displeasing you; but, rather, the consequences the behaviour produces for you - how it interferes with your needs or rights.

Therefore, when you tell children how you feel about their behaviour, let them know that your feelings relate to the consequences of their behaviour. An I-message generally has three parts:

1. Describe the behaviour which is interfering with you.
2. State your feelings about the consequence the behaviour produces for you.
3. State the consequence.

The parts of the I-message do not have to be delivered in order.

COMMUNICATING TO CHILDREN THAT WE VALUE AND RESPECT THEM

If you want to improve your relationship with your child, find the proper time for a friendly talk. Communication based on mutual respect also rests on your willingness to admit the limits of your knowledge; to admit that you do not have all the answers. Sarcasm and ridicule not only stifle communication; they are destructive to human relationships. When we speak, we communicate our beliefs and values. If you believe your children are able, worthy, and well intentioned, you will communicate that through the words and gestures you use. Faith in the child will help you avoid the use of labels.

TO SUMMARIZE

Effective communication involves both listening and talking:

1. Purposeful conversation - talking with each other in order to understand what the other means.
2. Reflective listening responses which indicate you understand the child's feelings.
3. I-messages - blame-free messages about your positive feelings and about things that bother you.
4. A nonjudgemental attitude which respects the child.

5. Appropriate timing.
6. Restricting talk to friendly exchanges as much as possible.
7. Avoiding pressure, sarcasm, and ridicule.
8. Showing your faith and confidence in your child.

DECISIONS FOR EFFECTIVE COMMUNICATION

This chart illustrates situations in which the parent determines problem ownership and then decides whether to listen reflectively or to send an I-message.

Situation	Who owns Problem?	Reflective Listening	I-Message
Child weeping about "low" report card.	Child	You're feeling discouraged about your grades, and maybe worried about what I will think of you.	
Child is not helping clean house as agreed.	Parent		When you don't keep agreements, I feel it's unfair because I have to do all the work.
Child unable to sleep the night before a test.	Child	You're pretty worried about that test, and not sure you'll do very well.	
Guests visiting; child interrupting parents and guests.	Parent		We can't talk with each other when you keep interrupting.
Child downcast after losing a race	Child	You're pretty disappointed that you lost.	

POINTS TO REMEMBER

Exploring Alternatives and Expressing Ideas and Feelings

1. Help the child explore alternative solutions:
   a. Use reflective listening to understand and clarify the child's feelings.
   b. Explore alternatives through brainstorming.
   c. Assist the child in choosing a solution
   d. Discuss the probable results of the decision.
   e. Obtain a commitment.
   f. Plan a time for evaluation.
2. Decide who owns the problem. Ask yourself, "Whose purposes or desires are not being met?"
3. Behaviour is a problem for you only when the behaviour interferes with you.
4. Communicate your feelings with "I-messages." I-messages tell children how their behaviour interferes with you and how you feel about this interference. Report your feelings, without assigning blame.
5. Use I-messages to communicate your positive feelings as well as to communicate things which bother you.
6. I-messages delivered in anger become You-messages. You-messages blame children and convey criticism but omit the message that it is the child's responsibility to change. You-messages are sent in disrespectful tones.
7. When there is conflict, limit your talking to perception of feelings and answering questions. As much as possible, restrict talking to friendly conversation in a calm atmosphere.
8. Sarcasm, ridicule, and pressure are destructive to good relationships.
9. Avoid using labels which show a lack of confidence in your child.
10. Communicate faith in your child through words, gestures, and tone of voice.

HOW TO COMMUNICATE WITH CHILDREN

Communication Is a Two Way Street
Many people feel they are communicating but in a sense, they never listen. Therefore, use the technique of, "I'll talk and you listen and then you talk and I'll listen" as a first step in developing communication with your child.

Try Not to Attack When Communicating Your Feelings
When communicating feelings, try using the words "I" "We" or "Me" as often as possible and stay away from the word "You." Even if someone has done something to hurt you, focus on your feelings rather than their behaviour. Inform the individual on how the behaviour affected you.

Teach Children to Label Feelings Properly
Children may have a very difficult time communicating because they lack the experience in labelling their feelings. Therefore, it is crucial for parents to assist their children in correctly labelling a feeling or emotion. You may want to say for example, "While the feeling you are expressing sounds like anger, it is really frustration and frustration is ..... "

Use Connective Discussion Whenever Possible
When faced with a direct question concerning a feeling or a reason for some behaviour, most children will shrug their shoulders in confusion or immediately respond, "I don't know." Instead of this direct communication, try connective discussion. This technique assumes that the parent may be aware of the trigger and connects the feeling and resulting behaviour for the child. For example, parents may say, "It seems to me that you are feeling jealous over the attention your new baby brother is getting and that may be the reason for your behaviour." At this point children may have an easier time responding since the foundation and labels have been presented.

Remember that All Behaviour Has a Trigger
If parents can trace back children's responses to the source or trigger, they will have a very good chance of identifying the real problem. Remember that all behaviour is a message and for many children their behaviour is the only means of communicating their frustrations or feelings. The problem is that such behaviour is frequently misunderstood and misinterpreted, resulting in more problems.

Be Aware of Nonverbal Misinterpretations
Children are very prone to nonverbal misinterpretations. They frequently misread a look on a parent's face and personalize it into something negative. If you are upset, angry or frustrated with something other than your children, let them know that fact in a verbal way. Try, "I am very upset right now about something. But I wanted to tell you that it has nothing to do with you."

Use Written Communication Whenever Possible
The use of writing to communicate feelings is an excellent tool in that it allows parents and children to phrase thoughts as desired. Notes thanking a child for some positive behaviour or telling them how proud you are of them are just some examples. Notes can also be used to register a complaint without nose to nose confrontation.

Try to Use Direct Love as Often as Possible
The need to feel loved and cared for is a primary need for any individual at any age. Direct messages of love require no interpretation or assumptions on the part of the child and should be viewed on the same level of importance as gasoline to a car. Examples of direct love include hugging, kissing, cuddling, holding, stroking, etc.

Make Yourself as Approachable as Possible
The higher the approachability factor on the part of parents, the easier it will be for children to express and show direct love. Parents may want to evaluate just how easily their children feel they can approach them with feelings or problems and make adjustments if necessary. In later life, such individuals may have an easier time using direct forms of love in relationships.

APPENDIX I 4.1

TEN SUGGESTIONS FOR DISCIPLINING YOUR CHILDREN

Taylor (1994:26)

* **Show love and respect to your children**
* **Establish clear expectations**
* **Use NATURAL CONSEQUENCES**
* **Use LOGICAL CONSEQUENCES**
* **Use BEHAVIOUR MODIFICATION**
* **Use TIME OUT**
* **Follow the suggested procedure to change a specific behaviour**
* **Use CONTRACTS**
* **Have FAMILY MEETINGS**
* **Cope with temper tantrums**

APPENDIX I 4.2

TIME-OUT PROCEDURE

Time-out involves isolating the child for a few minutes after he misbehaves. Any boring place can be used. It's not a good idea to use the child's bedroom. Don't think of time-out as a punishment, but rather as a signal to the child that his behaviour is unacceptable, and as providing an opportunity for the child to cool off and pull himself together.

Example:

"Hitting your brother is against the rules. Go into time-out for six minutes and think about what you might have done instead."

Explain the procedure to the child when he is not misbehaving and everyone is calm and rational. Time out should be brief, usually one minute per year of age. The child must be quiet for the whole time. A clock can be set, and the child comes out of time-out when the buzzer rings. If he moves away from time-out or he is not quiet, the clock is turned back to the start. Parents should be calm and matter-of-fact when sending children into time-out, no yelling, lectures, arguing or lengthy explanations and exhortations. Time-out can also be used when you are away from home, e.g., use the car, or a quiet spot somewhere.

A useful variant of time-out - "1-2-3 magic"

This lets you intervene quickly to nip problems in the bud without nagging or arguing. Calmly give a warning at the first sign of trouble by holding up one finger and saying, "That's one." If the behaviour stops, fine, if not, hold up two fingers and say, "That's two." If the behaviour still doesn't stop within ten seconds, hold up three fingers and say, "That's three - take five" and send the child into time-out for five minutes. Example:

CHILD: Can I spend the night at Ricky's house tonight?

PARENT: No, you have to be up early for soccer practice tomorrow.

CHILD: (Whining) Oh, come on. I promise we'll go to bed early.

PARENT: That's one.

CHILD: It's not fair, I never get to spend the night just because of stupid soccer.

PARENT: That's two.

CHILD: You never let me do anything! This place's like a prison. (Kicks couch).

PARENT: That's three - take five.

Penalties usually consist of removing specific privileges. Long-term penalties, or the removal of nearly all privileges, are usually not effective, as the child may feel he has nothing else to lose. Furthermore, parents find it difficult to enforce long-term penalties. Penalties should be in effect for no longer than a day, at most, for every five years of the child's age.

APPENDIX I 4.3

THREE STEPS IN LIMIT SETTING

1. Acknowledge your child's feeling or want. This lets the child know that you do understand.

   I know you would like to watch TV.
   I know you would like to spend a long time eating cereal.
   I can tell you don't want to leave now.
   I can tell you are really angry at Johnny.

2. Communicate the limit. State the rule or tell what needs to be done.

   But the TV time is over.
   But it's time to go to school now.
   But it's time to leave now.
   But Johnny is not for hitting.

3. Target the alternative.

   You can go turn the TV off or you can have me turn it off.
   You can finish the cereal in one minute or you can have me take it away in one minute.
   You can hold my hand and walk out with me or you can walk on your own.
   You can tell him that you are angry.

WHEN "LIMIT SETTING" DOES NOT WORK .....

You have been careful several times to (1) reflect the child's feelings (2) set clear, fair limits and (3) give the child an alternative way to express his/her feelings. Now the child continues to deliberately disobey. What to do?

1. **Look for natural causes for rebellion:** fatigue, sickness, hunger, extreme stress, abuse/neglect, etc. Take care of physical needs and crisis before expecting cooperation.
2. **Remain in control, respecting yourself and the child:** you are not a failure if your child rebels, and your child is not bad. All children need 'practice' rebelling.
3. **Set reasonable consequences for disobedience:** let the child choose to obey or disobey, but set a reasonable consequence for disobedience. E.g. "If you choose to watch TV instead of going to bed, then you choose to give up TV all day tomorrow".
4. **Never tolerate violence:** physically restrain the child who becomes violent, without becoming aggressive yourself. Reflect the child's anger and loneliness; provide compassionate control and alternatives.
5. **If the child refuses to choose, you choose for him:** the child's refusal to choose is also a choice. Set the consequences. E.g. "If you choose not to choose (choice a or B), then you have chosen for me to pick one that is most convenient for me."
6. **Enforce the consequences:** "Don't draw your gun unless you intend to shoot." If you crumble under your child's anger or tears, you have abdicated your role as a parent and lost your power. **Get tough. Try again.**
7. **Recognise signs of depression:** the chronically angry or rebellious child is in emotional trouble and may need professional help. Share your concern with the child. E.g. "John, I've noticed that you seem to be angry and unhappy most of the time. I love you, and I'm worried about you. We're going to get help so we can all be happier."

APPENDIX I 6.1

PARENT INVOLVEMENT CHECKLIST

SELF AWARENESS EXERCISE

Tick the following statements that are entirely true.

I tuck my child into bed every night.	
I participated in toilet training my child.	
I take my child to weekend activities.	
I read to my child at least once a week.	
I play sports with my child at least once a week.	
I participate in a hobby with my child at least once a week.	
I take my child shopping with me.	
I participate in school activities.	
I participate in community-related activities with my child (Sunday school, cubs, etc.)	
I watch TV with my child.	
I help my child with homework (school or therapy)	
I play board games with my child at least once a week.	
I have read a book related to child-rearing in the last month.	
I make myself available to discuss my child's concerns at least once a week.	
I discipline consistently, but reasonably and lovingly	

List 'non-essential' activities that you do with your child on a regular basis.
(Non-essential activities are defined as activities that are not required for the child's basic health and well-being)

_____

_____

_____

_____

APPENDIX I 7.1

RELAXATION EXERCISE

WORD-BY-WORD AUTOGENIC PHRASES AND IMAGES FOLLOWED BY FAVOURITE PLACE

(Roos 1996 Hypnosis Course - Phase 1)

MUSIC: Phil Coulter: Peace and Tranquility

Preparation:

First get into a comfortable position. While you are finding a good position, you will also want to loosen any tight clothing. Become as comfortable as possible.

Let your mouth drop open for a moment and move your jaw gently from side to side. Now close your mouth slowly, keeping your teeth slightly apart. Take a deep breath..... Breathe in so that the air flows into your lungs and feels as though it's filling up your stomach area. Now breathe out slowly..... Feel yourself floating down.

Breathing:

Focus your attention now completely and fully on your breathing. Imagine your breathing is as automatic as the ocean waves, rolling in..... and out..... in..... and out..... Silently say to yourself, "Breathing, smooth and rhythmic....." "My breathing is effortless and calm....." "Breathing smooth and rhythmic....."

And as you breathe, imagine relaxation flowing over your body, one wave after another. Feel the waves of relaxation moving through your chest and shoulders. Down into your arms. Through your back muscles. Down into your hips and legs.

And, with each wave of relaxation, try to feel the heaviness and warmth in your arms and in your legs. And now, I want you to think, still in a passive way, about wave after wave of relaxation. Concentrate on the relaxation moving upward from your lungs in waves, up and across your face and scalp.

Tranquillity:

Your mind is becoming more and more passive and tranquil, and you have a placid, relaxed awareness of the feelings of relaxation throughout your whole body. All of the tensions and worries will slip away from you as you feel waves of relaxation flooding over you. There is a growing feeling of warmth and heaviness in your arms and legs and a passive awareness of your state of relaxation.

Heart Rate Calming:

Now remember how you imagined the waves rolling in and out to help you breathe effortlessly and try to feel that again as you now imagine your heart beating. And silently say to yourself, "My heartbeat is calm and regular....." "My heartbeat is calm and regular....." "My heartbeat is calm and regular....." "I feel very quiet..... and my heartbeat is calm and regular....." "My whole body is deeply relaxed, and my heartbeat is calm and regular....." "My heartbeat is calm and regular."

Right Arm and Hand:

These feelings of relaxation, passivity, and peace will now become more and more profound, as you concentrate on just your right hand and arm. Focus all your attention on your right hand and your right arm. In fact, just to make sure you have made mental contact with your right arm and hand, lightly touch these areas with your left hand.

While you gently stroke your right hand and arm, say to yourself, "My right arm and hand..... are heavy and warm; warmth is flowing into my arm, and down into my hand....." "My right arm and hand are heavy and warm; warmth is flowing into my arm and down into my hand....." Good. And now let your left arm return to a resting position, if you have not already done so.

And continue silently to repeat to yourself, "My arm and hand are heavy and warm....." "Warmth is flowing into my right arm, down into my right hand, and it feels pleasantly warm." Remember, you don't want to force any of these things to happen, just allow them to happen. They will occur naturally and gently, as you passively continue to focus on your right arm and hand, and the feelings of heaviness and warmth. "My right arm is heavy and warm....." "Warmth is flowing into my right arm and down into my right hand."

At this time, carefully study the feelings in your arm and hand, and attend to the feelings of heaviness and warmth. You may use any thoughts you care to in order to imagine your right arm and hand becoming warm. You can imagine that they are in warm water..... or that the warm summer sun is beating down on them..... perhaps you are sitting next to a burning winter fire..... Just let it be pleasant and comfortable for you. And continue repeating to yourself, "My right arm and hand are heavy and warm; warmth is flowing into my right arm, and it feels very pleasantly warm.

Left Arm and Hand:

And now, I would like you to turn your attention to your left hand, your left wrist, and your left arm. Concentrate on this area of your body and focus all of your attention there. Silently repeat, "My left arm is heavy and warm; warmth is flowing into my arm and down into my hand." "My left arm and hand are heavy and warm." "Warmth is flowing down into my left arm and into my wrist and hand." "My left arm and hand feel pleasantly warm."

The feelings of warmth may be deepened by imagining the sun shining on your left hand and arm. Just continue saying these words while focusing on your left arm and hand, "My left arm and hand are heavy and warm." "Warmth is flowing down my left arm and into my wrist and hand." "Warmth is flowing down my left arm and into my wrist and into my hand."

Become fully aware of the feelings in your left arm and hand, and be sure to keep out all other thoughts, as you continue to focus on heaviness and warmth in your left arm and hand. If other thoughts come into your mind, you will find it possible to let them go as quickly as the came. You are passively concentrating on heaviness and warmth. Simply let these things happen; allow these feelings of heaviness and warmth to happen to you. And continue silently to repeat to yourself. "My left arm and hand are heavy and warm; warmth is flowing into my left arm and down into my left hand."

Feel the relaxation. Perhaps your arm feels as if you would need help to lift it..... Maybe the warmth reminds you of the summer sun..... However, you describe it is fine, as long as it is pleasant for you..... Just continue to feel the heaviness and warmth, and feel the relaxation.

Both Arms and Hands:

And now, I want you to focus on both of your arms and hands at the same time, as you say to yourself, "My arms and hands are heavy and warm, warmth is flowing into my arms and down into my hands." "Both my right and my left arm are heavy and warm." "My arms and hands are heavy and warm." "Warmth is flowing into my arms and gently down into my wrists, hands, fingertips, and they feel very pleasant."

That's very good. You are relaxing all over as your arms become very heavy and warm. As the warmth flows into your hands, you will feel your whole body relaxing. You are letting everything go, all cares and worries are far, far away. This is your time to think only of pleasant relaxation and the feelings it brings. It is better for you if you think of nothing but the way your body feels. Let all other thoughts leave your mind.

Once again now, focussing on both of your arms..... and think to yourself, "My arms are heavy and warm." "Warmth is flowing into my hands." Continue passively to concentrate on your arms being heavy and warm. Be sure you gently push out any other thoughts. In our modern society, the mind is not used to being quiet and relaxed and it tends to wander. If yo find this happening, do not become upset or disappointed. Just bring your mind back to the thought, "My arms are heavy and warm; warmth is flowing into my hands."

Take some time now, while you keep your arms very heavy..... and very warm..... and check all around your body to see if there is tension in any muscle. Check all around.... Is your jaw loose and slack, and are your eyelids gently closed? Be sure the muscles in your face are relaxed.

You are becoming very relaxed now..... and you feel loose and limp..... just like an old rag doll. And you really are that relaxed, you know, as you continue to practise to relax.

Legs and Feet:

And now I want you to focus on your legs. Become more aware of your legs. Notice where they are touching the surface on which they are resting..... Notice that pleasant heaviness and warmth is spreading down from your arms to your legs..... and just let it happen.

Passively allow the warmth to spread as you silently say to yourself, "My legs are becoming heavy and warm, warmth is flowing into my feet." "My legs are warm and heavy." "My feet are warm and heavy."

"My legs are heavy and warm, and warmth is pleasantly flowing into my legs and down into my feet - all the way to the very tips of my toes." "My legs and feet are heavy and warm..... heavy and warm..... very, very pleasantly warm."

All Limbs:

Very good. And now, I want you to focus on all your limbs, your arms and your legs together. Become very aware of your arms and your legs..... and repeat silently to yourself..... "My arms and legs are heavy and warm..... warm and heavy....." "My feet and hands are heavy and warm..... warm and heavy."

"Warm and pleasant feelings are sinking into every part of my arms, hands, legs, and feet." "My arms and legs are very limp." "The muscles in my arms and legs are letting go..... and I am becoming more and more relaxed."

I am Calm:

Take a deep breath now..... Breathe in so that the air flows into your lungs..... and feels as though it is flowing way down into your stomach area. Breathe very deeply down into your stomach area..... and..... as you breathe out, say silently to yourself..... "I am calm."

These are very important words that you can use when you are relaxed..... deeply relaxed..... "I am calm....." Take a deep breath and say again, silently to yourself, "I am calm."

Eventually, you will be able to relax yourself by simply thinking the words, "I am calm." When the day is going badly, or when you're caught in a traffic jam, or the children are particularly annoying, or you have to meet new people....., you will remember the feelings of deep relaxation that you are feeling now, and you will be able to relax yourself, just by saying "I am calm."

Favourite Place:

(Naparstek 1994:76-79)

And now, taking a deep, full cleansing breath..... inhaling as fully as you can..... breathing deep into your tummy if you can..... and then breathing all the way out.....

And again..... breathing in..... and this time..... seeing if you can send the warm energy of the breath to any part of your body that's still tense..... or sore..... or tight..... and releasing the tension with the exhale..... and breathing it out.....

So you can feel your breath going to all the tight tense places, loosening and warming and softening them..... and then gathering up all the tension and breathing it out..... so that more and more, you can feel safe and comfortable, relaxed and easy, watching the cleansing action of the breath..... with friendly but detached awareness.....

And any unwelcome thoughts that come to mind, those too can be sent out with the breath..... released with the exhale..... so that for just a moment, the mind is empty..... for just a split second, it is free and clear space, and you are blessed with stillness.....

And any emotions that are still rocking around in there..... those too can be noted..... and acknowledged..... and sent out with the breath..... so your emotional self can be still and quiet..... like a lake with no ripples.....

And now..... imagining a place where you feel safe and peaceful and easy..... a place either make-believe or real..... a place from your past..... or somewhere you've always wanted to go..... it really doesn't matter..... just as long as it's a place that feels good..... and safe..... and peaceful to you.....

And allowing the place to become real to you..... looking around you..... taking the place in with your eyes..... enjoying the colours of the place..... the scenery..... looking over to your right..... and over to your left.....

And listening to the sounds of the place..... whatever they might be..... wind or water..... birds or crickets..... or a whole multi layered texture of sounds..... just so your ears can become familiar with all the beautiful music that your special, safe place offers up to you.....

And feeling whatever you're sitting against..... or lying upon..... or perhaps feeling the texture of the ground beneath your feet..... whether it's sand..... or pine needles..... or grass..... or you might be in a cozy armchair..... or sitting on a nice, warm rock in the sun.....

And feeling the air on your skin..... crisp and dry..... or balmy and wet..... perhaps you're inside.... feeling the warmth of a cozy fire on your face and hands..... or maybe you are outdoors, and there's just the subtlest caress of a fragrant, gentle breeze..... so just enjoying the feel of the place on your skin.....

And smelling its rich fragrance..... whether it's the soft, full scent of flowers..... or sharp, salt sea air..... sweet meadow grass..... or maybe the pungent smell of peat moss in the forest.....

So just taking it all in, all the richness of it..... with all of your senses..... becoming more and more attuned to your safe and beautiful special place..... just feeling thankful and happy to be there...

And letting your body soak in the vibrance of the place..... letting its richness penetrate all the way into you.....

So just letting the beauty of the place nourish you..... taking it with every full, deep breath..... all the way down into your tummy..... all the down to the tips of your toes..... feeling the penetrating warmth and power of the place..... soaking into your skin..... down through muscle and bone..... all the way to each and every cell..... reaching down to the peaceful stillness at your very centre.....

And so, knowing that you can call forth the place.... whenever you wish..... once again, feeling yourself sitting in your chair..... just breathing in and out, very rhythmically and easily, and very gently.... with soft eyes, letting yourself come back into the room..... on the count of three..... knowing that in a deep place, you are feeling better for having completed this exercise..... that you are feeling safe, secure and pleasantly relaxed.... When you open your eyes, you will find yourself back in the place where you started your relaxation. The environment will seem slower and calmer, and you will be more relaxed and peaceful, but if you plan to return to any physical activity, you will be quite capable of doing so.

But before we do that, you should know, that you will never allow yourself to be hypnotised on the stage, or for any purpose of entertainment, or in any situation that may be embarrassing or dangerous to you. You will only allow yourself to be hypnotised by a qualified registered practitioner, or yourself, and you will not allow yourself to be taken advantage of in any way, while in the state of hypnosis. Should an emergency situation arise while you are hypnotised, you will immediately become wide awake, fresh and alert, and be able to deal with that situation capably and efficiently. You will look forward to each experience in trance as a helpful experience.....as you begin to find out more about yourself... so that you can become happier..... more successful in every aspect of your life.

One, relaxed, but more alert..... two.....mentally wide awake..... three, eyes open, alert and refreshed.

MUSIC: Louis Armstrong: What a Beautiful World

APPENDIX J

ATTENTION-FOCUSING EXERCISES

THE STAR PRELUDE
Adapted from Garth (1995:19-21)

I want you to see above your head a beautiful, beautiful star, a star that is filled with white light, lovely white light that shimmers and glows. I want you to see this light streaming down towards you until it reaches the very top of your head. And now, I want you to bring this pure light down through your head and take it right down your body until your whole body is filled with this glorious white light.

And I want you to feel the light going down your arms, right down, until you feel it reaching your hands, and going into each and every finger.

Feel that light going down the trunk of your body, down until it reaches your legs, and when you feel it there, take it right down until it comes to your feet, and then feel the light going through each and every toe.

And now that you have brought this glorious light down, you are like a beacon of light and have become just like a living flame.

Look into your heart and fill your heart with love for all people and for all creatures, great and small. See your heart getting bigger and bigger? It's expanding, because you have so much love in your heart for all people, and for all the animals, and of course, you have so much love for yourself.

In a few moments, I want you to enter your very own, special and safe garden. But before you do so, I want you to look at the large tree outside. This tree is called the "Worry Tree". And I want you to pin on this tree anything that worries you, perhaps it's worries at school, perhaps it's worries about friends, maybe it's worries at home, with brothers or sisters or Mom or Dad. It doesn't matter what kind of worry it is. This tree will take any worries at all, no matter how small or how large. This tree accepts anything that you would care to pin or place there.

In front of you now, there's a Wise Person, who has been waiting patiently for you to come, a person who will always care for you and protect you. Feel the love coming from this special person towards you. Or perhaps, you have a Guardian Angel who will wrap golden wings of protection around you before taking you into your garden. The Angel's wings are very large and very soft, just like down. Everyone has their own Guardian Angel you know, or Wise Person, who takes care of you and protects you always, so you are never alone. It's important to remember this and to know that you have someone who looks after you with love and care.

Take the hand that is held out to you. Open the gate before you and enter your garden now, closing the gate firmly behind you. And as you do so, the colours spring to life, colours like nothing you have ever seen before. The beauty of the flowers, the colours, the textures, and the perfume - breathe them all in. The grass is a vivid green and the sky a beautiful blue, with white fluffy clouds. It is very peaceful in your garden; it is full of love and happiness.

SPACESHIP

Adapted from Kohen & Botts (1987:228-23) and Hammond (1990:480-481)

Following on discussion of space travel and viewing of books on spaceships, drawn/painted by the children.

Today we're going to talk about ways to teach you and your body to be comfortable, whilst also being in control. We know that your mind can help you to be more comfortable, whilst still being in control, even when we wouldn't normally expect that to be true.

I'm going to ask you to imagine that you are going to your special, favourite and safe place, so that you can sit there comfortably to listen to the story that I'm going to tell you. I wonder if you would like to travel there in a spaceship?

OK then ..... Pretend that you are going to your special, safe place in a spaceship. You may close your eyes,..... if you choose to, ... and pretend that you see yourself climbing up the steel ladder that leads to the door of your spaceship..... See yourself going in the spaceship and sitting down in the seat..... The seat is comfortable for you. Feel the comfort of the seat,..... take note of the texture of the material out of which it is made.....Notice if the material is soft and silky, or hard and wiry..... Perhaps it is fluffy, or maybe it is smooth....Notice how you can adjust the seat to different positions..... It can tilt backwards and forwards..... It can go up or down..... You can adjust it just as you would like to..... See how far away it is from the control panel which is in front of it.....Look at the controls..... Notice the size and shape of them..... Smell the sharp smell of the disinfectant which was used to clean them before your arrival.....

Now..... Take hold of the controls in front of you..... and experience the feeling of power that goes through you as you imagine the work you are going to have to do to keep the spaceship on the path that you have chosen to take it on.....

Take a look now at the control panel in front of you..... See the lights flashing on the screen.....You will have to programme the computer to move the spaceship in the way that you want it to move, so that it keeps on its course.....just as you can control your brain to move the right muscles in your body at the right times.

Listen now to the loud sound of the engine purring, as the spaceship prepares for lift-off..... Hear the noises which come from the control panel, and take note of the important information which is being given to you by the people who are in charge at the space station..... Notice the different feelings in your body as the spaceship leaves the earth..... under your control. Perhaps your heartbeat is faster, maybe the palms of your hands have become sweaty, or maybe you are feeling pleasantly relaxed..... as you imagine yourself heading towards your special destination.

Feel the power of the engine under your control, as you head towards your special place, and experience the pleasure of being in control..... just as you know you are able to control your own strong muscles, because you have a brain which is the boss of your body..... and which you control..... You can decide how fast you want to go, or perhaps you would rather go slowly..... You may choose to take careful note of the important things around ..... The exciting part is that you're able to drive it in a way that is fun, and exciting and relaxing.....and in a way that is good for you.....

You've probably already noticed, since you are in control, that you are more relaxed now. You may have noticed that your neck muscles feel a bit more comfortable..... and loose..... and soft..... and floppy. Some kids like the good feeling of letting their muscles relax a little..... and some like a whole lot of relaxation.....You can choose what part of your body you wish to relax first..... You may choose to relax from your head downwards..... or perhaps you would prefer to relax from your toes upwards..... You can choose how much you want to relax before you decide to land..... And when you are ready to land, you can just let me know by nodding your head.....

Right then..... since you are sufficiently relaxed and ready to listen to the story I'm going to tell you, you can head towards the special place we have spoken about. You can decide which way you would like to go. You could go there quickly..... or slowly..... And when you're there you can let me know by nodding your head again..... and now..... you can land your spaceship in your special, safe place. You feel proud of yourself as you land the ship where you want to land it..... knowing that you were responsible for taking control of such a powerful machine, that you guided it along so expertly, always keeping to the rules that were laid down by the people who are in charge of space travel.....

Good..... Now look around you and enjoy the sight, the sounds and the smells of your special place..... Enjoy the feeling of being in your special place. Take a look at the surroundings..... You may see animals, or flowers, or sky, or sea..... Smell the freshness of the air in your special place..... the fragrance of the place..... Listen to the sounds..... Perhaps you hear sounds of water.....or birds.....or animals..... Maybe you hear your favourite music.....Just enjoy it all now as I read the story.

THE PINK BUBBLE
Adapted from Bennett (1996:64-66)

Following up on the activity of bubble blowing:

You may carry on blowing the bubbles now, if you choose to, and at the same time, you may wish to imagine that you are walking through your favourite garden towards your special, safe place, or you may choose instead, to just sit in the chair with your eyes closed, listening to my words..... Pin all your worries on the worry tree outside your garden before you go in.

Everything around you in your garden is colourful and there is so much of everything..... All the trees are straight and tall..... The grass has just been freshly cut and smells fresh and green..... As you walk, you notice that everything has a moving band of light around it..... This is called an aura.....The trees have a very strong white light surrounding them, protecting them..... You notice that the birds have a blue light, about the length of your finger, surrounding each one.....You can only see the blue light when you are feeling calm and confident..... You feel calm and confident today.....

Walk around your garden and notice that all the living, growing things in your garden have an aura of some sort around them. Some have a strong, clear colour, some a vibrating white light, some just a tiny hint of shadow, but everything has an aura.....Absolutely everything.

Now, find yourself a shady tree to lie under. Look up at the bright sky. It is a very bright blue colour, and it fills your heart..... The sun is shining brightly and you feel full of warmth and happiness.....

Imagine as you are lying there that you surround yourself with a pink bubble. It covers all of your body, front and back..... It is about as wide as your hands..... all around you, enveloping you in a warm glow..... This is the pink bubble of love and you can surround yourself with it whenever you wish.....

If you are going on a long trip and wish to be safe, you can surround yourself and the car with the bubble, and you will feel protected on your journey.

When you leave your house for your trip, you can surround your room, your things and the complete house with a pink bubble of love, protecting it while you are away.

Surrounding the things you love with this bubble helps you to overcome any fear or anxiety you may have about what you are doing and it really works.

Now see your family one by one and put a pink bubble around each one of them.

See your friends with this bubble around them.

Now see a very large bubble around your house so all is safe and happy within your home.

Feel yourself, becoming more and more relaxed, more and more calm and confident, more and more full of warmth and happiness, with this pink bubble of love around you. And now you can listen to the story I have to tell you.

AFTERWARDS

And now..... you can get up from under your tree, and up from the chair you are sitting on, and go out to Mom who is waiting for you..... But know that whenever you feel fear, or hurt, or worry, or just when you want to feel safe, you can put a pink bubble of love around whatever you need to and it will make you feel loved and protected.

COMPUTER SCREEN-SAVER
Adapted from Modlin et al. (1995:39-40)

I'd like you (Name) to pay VERY CLOSE ATTENTION to every word I say.....pay close attention to everything you feel. Look at the TV screen, at the moving shapes on the screen. Watch the movement of the shapes as they bounce across the screen, dancing, jumping, swaying. Look at the colours of the figures, blue colours..... and purple..... yellow..... white..... green..... Take note of the patterns..... See the fine detail of the patterns..... Imagine the sounds of the figures, laughing..... whishing.....whispering.

That's good. Keep looking at the figures on the screen..... without blinking.....don't let your eyes move from the screen for a moment.....and now notice the feeling in your eyes..... the feeling that comes.....all by itself..... as

your eyes become very uncomfortable.....feel that burning feeling... yes.....good..... a gritty burning feeling.....let yourself relax.....as much as possible..... breathe quietly.....in and out..... and gradually you will feel your eyes becoming very, very tired..... your eyelids are feeling heavier and heavier..... so heavy..... that presently they will want to blink.....as soon as they want to blink..... just let them blink as much as they like..... let everything happen..... just as it wants to happen..... don't try to make anything happen.....don't try to stop anything happening..... just let everything please itself.....that's right.....good. You see..... your eyelids are beginning to blink already.....very soon..... those blinks will become slower.... and bigger..... and your eyelids will feel so very, very heavy..... and tired..... that they will want to close.....Already your eyes are becoming a little watery..... you're feeling very, very drowsy..... and your eyes are feeling so very, very heavy and tired..... that they are wanting to close..... as soon as your eyes feel that they want to close..... just let them close.... on their own..... That's good.

BREATHING AWARENESS
Source Unknown

Make sure you are sitting comfortably. Close your eyes..... and become aware of your face, loosen the jaw and mouth.....and let the eyes become softer too.....especially the tiny little muscles around the eyes. Now you are ready to begin the meditation on the breathing.....

First of all, become aware of sounds from outside.... Listen to the different sounds coming from outside.... small sounds.... bigger sounds..... sounds coming and going... Gradually become aware now of the sound of your breathing..... Begin to tune in to the sound of your breathing..... if you can hear that sound, if not, simply focus on the sensation of your breathing..... Feel how your body becomes bigger on the inhale, and smaller on the exhale.....you're feeling that your body is growing bigger on the inhale, and that it gets smaller on the exhale.....The feeling of expansion on the inhale..... and contraction on the exhale.....

Should your mind wander, then gently bring it back again to the focus..... the breathing.....and the feeling of expansion on the inhale and contraction on the exhale..... You don't need to change your breathing. This is not a breathing exercise..... This is an awareness exercise, using the breathing as the focus.....

There is also a feeling of lightness on the inhale..... as if your body becomes lighter on the inhale..... and on the exhale..... there's a letting go of tension..... and worry..... and heaviness..... Feel how your body becomes lighter on the inhale..... also taking in light with the inhale..... and how on the exhale..... there's a letting go of tension..... and worry..... and heaviness.

Becoming lighter and taking in light on the inhale.....letting go on the exhale.....of anything you don't need anymore.....Release it with the exhale.....

Notice how your breathing has become more quiet and softer now..... Another way to feel the breathing is to draw a picture in your mind's eye..... picture a wave in the ocean in your mind's eye..... See this wave building up and breaking at the shore..... Let your breathing follow that wave..... building up and breaking at the shore.....Allow your breathing to become that wave.....

Stay with the breathing a little bit longer, even if you may get restless... or bored.....or impatient..... Stay with the breathing a little bit longer.....

MUSIC

And now you can enjoy the feeling of relaxation, as you listen to the story that I'm going to read to you.

After the story:

Now direct your attention away from your breathing..... back to the external sounds again..... Stretch your ears and listen to different sounds from outside..... Forget about the breathing now and become open to the external sounds..... Close sounds..... far away sounds..... sounds coming and going..... In between the sound of silence.....

Then begin to focus on the room you're sitting in..... First of all..... become aware of the floor..... and your contact with the floor..... feel that..... and feel how there's something solid underneath you..... Something is holding and supporting you..... Then have a sense of the walls around you..... And the ceiling somewhere above your head.....

Also become aware of the atmosphere of the room in which you are sitting..... And finally yourself..... sitting here, quietly with your eyes closed.....

MUSIC

<u>BODY AWARENESS</u>
Source Unknown

Make sure that you are sitting comfortably..... and begin to find a focus in yourself..... which can be the breathing. Begin to contact a quiet space in yourself..... the breathing if you like..... then direct your awareness towards your feet..... become aware of the soles of your feet..... and the many little nerve ends in the soles of your feet. Recall the sensation of walking barefoot somewhere..... on the beach..... on the grass..... on a soft carpet..... anywhere that springs to your mind. Recall that sensation of walking barefoot.

Then feel the toes, each single toe..... the heels..... and the ankles..... focus now on the ankles... Prepare yourself for a journey through your body..... where you are going to meet different parts..... just to find out how they are. Direct your attention towards the lower part of your legs..... sense the bone structure inside your legs..... the skeleton..... the muscles and flesh around that..... the knees..... the different bone structure in the knees.

Now focus on the upper part of the legs. Again try to make contact with the bone structure..... the skeleton inside your legs. You can either see this in your mind's eye or you can have a sensation of it..... Either way is fine..... Around the bone there is muscles and flesh..... Become aware of that. And then feel the whole

leg..... both legs..... Feel the roundness of the legs..... and the strength. Your legs carry you every day. Feel the buttocks..... and sense the contact with the chair..... or the floor..... whatever you're sitting on..... the buttocks.....

Now focus your attention on the lower part of the back and from here move your awareness into the upper part of your back..... the shoulder blades..... the big muscles around the spine..... the whole back..... and the shoulders.

Now focus on the upper part of the arms..... and again try to contact the bone structure inside the arms. Get in touch with something very solid and dense inside your arm..... the skeleton. Around the bone there's muscles and flesh..... Become aware of that part of your arm..... the upper part of the arms..... he elbows..... The different kind of bone structure in the elbows..... forearms..... bone..... muscles..... flesh..... the wrists..... and the hands..... the palms of the hands. Sense warmth in the palms of the hands..... the fingers..... and the finger tips..... ten finger tips..... Feel sparkles of energy in each finger tip.

From here, move your focus towards your abdomen..... the abdominal area..... the stomach..... The area around the belly button..... the diaphragm..... the chest. Become aware of the chest and the rib cage..... the lungs..... and the breathing..... the heart..... Focus on the area of the heart..... And become sensitive to the heartbeat..... Maybe you can feel the heart beat as a very subtle pulsation through the body..... A bit like an electric current..... The heart beat. Feel warmth in the heart area. Feel an openness in that part of the body.

And now move your attention to the throat and the neck..... the spine..... Feel the whole spine..... From beginning to end..... And now..... focus on the face.... First feel the jaw and the mouth..... teeth..... tongue..... the lips..... nose..... cheeks.... And the cheekbones..... sense your ears..... and for a short while..... become aware of sounds.....Then feel your eyes..... Soft eyes.... Let the tiny muscles around the eyes become softer and also the eyelids..... the eyelashes and the eyebrows. Sense a point between the eyebrows..... the forehead and the top of the head..... Visualise on the top of the head a flower blossoming..... picture a flower blossoming on top of your head..... Take the first flower that springs to mind..... stay with this flower..... and look at it in detail..... Look at the texture..... How does it grow.....and what is the colour..... Become aware of the colour of this flower or flowers on top of your head..... Then visualise your whole body surrounded by the colour of this flower.....Picture your body completely surrounded by the colour of the flower in whatever way this comes to you.....

And now return again to the breathing.....the starting point..... completely relaxed..... and calm.....

FURRY ANIMAL

The child is given a piece of furry material, requested to close his eyes and imagine the material is his favourite warm, furry animal, which he holds up against his cheek, and with which he gently strokes his cheek.

I want you to close your eyes now, and pretend that you're holding in your hand your favourite, warm furry animal. Keep the animal near your face, and gently stroke your cheek with it.

I wonder what kind of animal you are holding.... Is it a wild animal..... or a tame animal..... Is it a big animal or a small animal..... I wonder what the colour of the fur of your animal is..... Maybe it's black..... or perhaps it's yellow..... perhaps you would prefer another colour..... Maybe it has different colours..... You can decide,..... Because it's your favourite animal..... and you can feel safe with your animal..... Pay attention to the feel of the animal with you,..... Feel the fur..... Maybe it's a thick fur..... or perhaps, it's quite flat..... maybe it's very soft..... or perhaps it's quite wiry.

Notice what it feels like as you gently stroke your animal against your cheek..... Notice how your body feels, as you gently stroke yourself with this warm, furry animal. You're probably already feeling a nice, calm feeling inside..... and this calm feeling can spread through your whole body..... making you feel completely calm..... and relaxed..... and happy..... as you listen to the story I'm going to tell you about the tiger in the cage.

FLYING IN THE CLOUDS
Adapted from Bennett (1996:59-61)

Gently close your eyes, and pretend you are lying in your garden, on a soft green bed of new grass. The smell is sweet and clean as you imagine that it has rained in your garden and the rain has left a superb, complete rainbow. It curves into your garden and looks as if it finishes right there in your back garden. The colours of the rainbow are clear and bright. Look at the brightness of the red. Like a fire engine, so strong in colour. Orange is next. Just like one of the first of the winter oranges, such a bright and happy colour. Now see the yellow which reminds you of the daffodils, strongly supported by the green leaves that protect them from the winds. That green is like the green of new leaves on the trees.

See the lovely blue now, of a summer sky, which fills your heart with love and kindness. Beside the blue is another colour: Indigo. It is a fascinating colour because you don't see it very much. It is like a deep purple, but not as strong. Then imagine a bunch of violets. The last but the most beautiful colour in your rainbow.

Now that you have taken the colours into your mind and heart, you can see yourself lifting off the ground, floating up in mid air. You rise higher and higher into the sky, moving gently above the ground. You're flying, just like a graceful bird. You glide so easily over your garden, seeing everything so neat and full of life. You keep going, all over Africa, until you find a place that you would like to settle down on, to listen to the story.

After the story:

And now that you have heard the story, you can float up again, and make your way back to your garden, notice how everything is in order, just how you left it, and slowly, and softly land. Nestle back into the soft grass and now you can relax, knowing that you can visit anywhere in the world, just by flying there yourself in this way.

APPENDIX K

THERAPEUTIC STORIES

ANNIE STORIES - RELAXATION
Adapted from Brett (1988:169-177)

GOALS:

* To enhance the establishment of rapport

* To provide an opportunity for the children to relax

MESSAGE: We function at a significantly more enjoyable level when we are relaxed.

Brett (1988:171) suggested interweaving two stories to allow the child to become more fully absorbed. This was not done for the four year old, where the story was shortened considerably because of his limited span of attention.

Andrew was a little boy who lived in a brown brick house with his mommy and daddy, his sister and his dog, Thabo.

Usually he woke up each morning feeling happy and sunny, but this day when he woke up, it was with a cross, grumpy feeling.

He stomped into the kitchen. "Where's my breakfast?" he demanded of his mother.

"My goodness," said his mother, "you look as if you got up on the wrong side of the bed this morning."

"A big nasty motorcycle roared by in the street before I was ready to wake up. I didn't want to wake, but it made me wake up," said Andrew. He was very cross about it. He thought all motorcycles ought to be scrunched up and fed to a big motorcycle-eating monster.

"Well, here are your corn flakes darling," said his mom. "I've got them all ready for you."

"I don't want corn flakes - I want Wheatbix," snapped Andrew.

"Well darling, I'm sorry about that but I've already poured the milk, so you really should have them. You can have Wheatbix tomorrow."

"I don't want Wheatbix tomorrow, I want them today. It's not fair!" said Andrew, and he marched into the TV room. "You should have asked me before you served them."

In the TV room he looked at the TV Guide and then he looked at the clock. Darn it! He had missed his favourite TV show. It was just not fair.

"I've missed Extreme Dinosaurs," he wailed to his mother. "You should have reminded me. It's not fair!"

"I'm sorry, darling," said his mom, giving his shoulders a pat, "but I didn't know you wanted to watch Extreme Dinosaurs. Why don't you play with your new computer game instead?"

Andrew looked around. His new game was lying on the coffee table. It was a really exciting game, with pictures of Batman on it. Andrew loved computer games and he wanted another new one with Godzilla on it, but his parents had said, "No!" It wasn't fair, thought Andrew. All he wanted was one little game.

"Why don't you get dressed first," said his mom. "It's a bit cold in here with just your pyjamas on."

Andrew went to his room. He knew just what he wanted to wear today - his favourite red jogging suit. He looked in his cupboard.

"My jogging suit's not here!" he said to his mother.

"It's in the wash," said his mother. "Why don't you pick out something else?"

"I don't want to wear anything else. I want to wear my jogging suit," said Andrew. "It's not fair." And he stomped back into the TV room.

He had just organised his things at the computer table when Thabo, the dog, walked in.

Now Thabo loved three things in life - she loved playing fetch, going for walks, and eating tissues and computer game covers. She came in very quietly so that Andrew didn't hear her. Slowly her black muzzle began to sniff, sniff, sniff at the table where the computer game cover was.

She really loved tissues best, but the computer game cover would do, and so, suddenly, with a quick snatch, she grabbed it and ran off down the hall.

Andrew ran after him yelling, "Bad Dog! Bad Dog! Give me back my computer game cover".

Andrew's mom came around the corner, grabbed Thabo , and took the cover from her mouth. "Here you are," she said to Andrew. "Here is your cover."

"It's all wet!" said Andrew. "Yuck! It's not fair!" And he felt like crying.

"You're really having a rotten morning, aren't you?" said his mom. "And you feel just terrible."

"Yes," said Andrew. "I feel rotten. It's a rotten day."

"Would you like me to show you a way of feeling better?" asked his mom. "That way you might at least be able to enjoy the rest of the day and it wouldn't be such a waste for you."

"Okay," said Andrew. "How would I do it?"

"Well, sit down and let me tell you a special story," said his mom, "and as you listen to the story, you might begin to feel better and better."

"Okay," said Andrew. That sounded good.

Andrew got settled down comfortably and his mom began.

"Once upon a time, there was a little boy named Alan. Normally he was a happy little boy, but today he had been having a horrible, horrible day. Everything he did went wrong. His lunch was a yucky lunch, his drawings didn't work out right, his reading book was missing, and his teacher had complained to his parents about his behaviour.

'I feel yucky,' he said to his mom. 'I'm having a horrible day.'

'Would you like to know how to feel better?' said his mom.

'I certainly would,' said Alan, because he didn't like feeling yucky like this. 'How do I do it?'

'Well,' said Alan's mom, 'why don't you sit down comfortably, and I'll show you how to do some very special breathing that will help you feel better. We can just sit here and take some very quiet, deep breaths. They're very special breaths because it's a very special, magical way of breathing. I'll explain to you why that is in a minute.'"

And then Andrew's mom said to Andrew, "You can breathe along with me, and Alan and his mom too if you like, and then you can be part of the special, magical breathing."

"Oh, great," said Andrew. He had been going to do that anyway, even if his mom hadn't said it.

"Then," Andrew's mom went on, "Alan's mom said, 'Now we can just sit here and breathe quietly for a few minutes, and feel the breath coming in and going all through our bodies, filling us up with air and then coming out again.'

'Yes, I can feel that,' said Alan."

"I can feel that too," said Andrew. He was enjoying breathing and listening to the story. He was waiting to hear what the special, magical part of this breathing was. He liked things that were special and magical.

"'Now the special, magical part of this breathing,' went on Alan's mom, is that if you close your eyes and look very closely, you can actually see the special breaths as they go through your body. When the breath comes in, it's clear and sparkling, like light or glass. Everyone's breath is a different colour. As it goes through your body, it changes colour. It gets grey or muddy, and by the time it goes out of your body, it's very grey or muddy.'

'Oooh, I can see it now,' said Alan. He had his eyes closed and he could really see the breath coming in and going out of his body, very slowly, because he was breathing very slowly and quietly.

'What colour is it?' asked his mom.

'When it comes in, it's a lovely sparkling white, like a diamond. When it goes out, it's a yucky, brown.'"

"I can see mine too," said Andrew. He also had his eyes closed and was breathing quietly. "It's white when it comes in and it's a yucky, muddy colour when it goes out."

"'Why does it change colour?' asked Alan.

'It changes colour,' said his mom, 'because as it travels through your body, it's picking up all the bad feelings and the rotten things that have happened to you during the day and it's taking them away with it, pushing it outside your body.'

'You mean the way a sponge does when you wipe up spills on the table?' said Alan.

'That's exactly right,' said his mom. 'And just like a sponge, the more we wipe up, the less yucky stuff there is left. If you look at your breath coming out now, for instance, you would probably see that it's not quite as brown as it was before.'

'That's right,' said Alan."

"It's happening to me too," said Andrew. "This is great."

"'And as you keep watching your breath,' Alan's mom said, 'you can see that it keeps on getting lighter and clearer as it goes out. That's because there's less and less yucky stuff left in you. All the bad feelings and rotten things that happened to you today are being cleared away by the magic breaths.'

'This is great,' said Alan. 'My breath's nearly completely clear now.'"

"Mine's clear already," said Andrew. "It cleared up even faster than Alan's. It's white all the way through. This is terrific. It feels really good. I like this."

"That's great," said Andrew's mom, and then she went on. "And Alan's mom said, 'Tell me when your breath is completely clear, and then we can do something more that you'll really enjoy.'

'It's clear now,' said Alan.

Alan's mother continued. 'That's great. Now we can go on a very special magic trip in our imagination. And it's something that you can really enjoy.'

'What is it? asked Alan. He was really looking forward to this. He loved magic trips.

'It's a trip on your very own magic carpet,' said his mom.

'Oh wow!' said Alan."

"Oh goodie," said Andrew. He had always wanted to take a trip on a magic carpet, but he just hadn't known that you could do that in your mind.

"'You can do anything in your mind.' said Alan's mom. 'And because it's your mind and your imagination, you can control it. You can make anything happen that you like. You can change anything that you like. And everything that happens can feel just right for you.'

'Oh wow,' said Alan."

"This is going to be great," said Andrew. He was really looking forward to this.

"'First of all,' said Alan's mom, 'you have to choose what colour your magic carpet will be. Will it be pink or red or yellow or blue? Will it be green or purple or black or white? Will it be just one colour or a few different colours?' Alan thought for a few moments."

Andrew thought too. It was funny how it was easier to think of these things when you had your eyes closed. He began to see lovely colours floating across his mind. Which of them would he choose, I wonder? .....

"'I'll have green and orange,' announced Alan, and he imagined a beautiful green and orange carpet to himself. Green is for peace, and I like that.'"

"My carpet will be orange and green," said Andrew, and he imagined a wonderful orange and green carpet to himself. "Orange is refreshing and I like that."

"'What sort of patterns does your carpet have?' asked Alan's mom. 'Are they swirly, circle patterns or are they straight, square patterns? Are they simple, separate patterns or are they all tangled-up patterns? Or are they not patterns at all?.....'

Alan looked closely at his carpet. It was lovely. 'It has a beautiful pattern of green stars on it.'

'That sounds beautiful,' said Alan's mom."

"That sounds beautiful," said Andrew's mom, and she continued on. "And Alan's mom said, 'What does your carpet feel like, I wonder..... Is it smooth and silky or is it soft and furry? Is it cool like sheets,..... or warm like blankets?.....'

'I wonder what nice feelings your carpet has for you?.....'

'Mine's warm and woolly,' said Alan. 'I can snuggle up in it.'"

"Mine's comfortable and cozy," said Andrew. "I can cuddle up in it."

"'That sounds nice,' said Alan's mom. 'Now where do you think you'd like to fly in it? Would you like to fly somewhere special, or would you just like to fly around in the sky over the rooftops for a while?'

Alan thought for a moment. 'I think I just feel like floating around, slowly and calmly, in the sky for a while,' he said.

'That sounds nice,' said his mom."

"I might just enjoy flying around and seeing what I can see," said Andrew.

"I think you'll enjoy that," said his mom.

"'I wonder how fast your magic carpet can fly?' said Alan's mom. 'Will it whoosh along like a jet plane, or will it just ease along gently, drifting here and there? Will it fly in a straight line or will it curve around in circles?'

'I'm not sure,' said Alan. 'I might just fly around wherever I feel like.'"

"Me too," said Andrew. He was enjoying this. It was nice flying around on a magic carpet.

"'What might you hear, I wonder, on your magic carpet?' said Alan's mom.

'Some magic carpets sing songs, you know. Some sing music without words and some sing words without music. Some talk to you when you want to, as you whoosh through the sky, and some are peacefully quiet .....'

'Mine's singing nursery rhymes,' said Alan. He was surprised."

"Mine's singing my favourite music," said Andrew. "I don't know what its name is, but I like it."

"'It's nice to fly on a magic carpet,' said Alan's mom. 'You can fly over beaches and cities and fields. You can fly over mountains and meadows and trees. You can fly over deserts and lakes and snowfields. Where will you fly, I wonder.....'

Alan didn't bother answering right away. He was too busy seeing all there was to see. 'I'm flying over meadows and grass and trees,' he said. 'There are rabbits and squirrels. I can see them frolicking in the leaves.'"

"I'm flying over everything," said Andrew. He wanted to see it all.

"'It feels nice, doesn't it, on your magic carpet,' said Alan's mom. 'Magic carpets are happy carpets, and anyone who sits on them feels happy. It's part of their magic.'

'I feel happy,' said Alan."

"I feel very happy," said Andrew. He was enjoying this. It was a bit like being on a ship at sea. The wind was like the waves, and there was a happy breeze.

"After a while, Alan's mom said, 'Now you might want to look around and find a lovely place to land and rest for a while. You can find a place that looks just right for you. A place that's smiling and peaceful and just what you like .....'

Alan looked around himself, and then he found just the right spot. 'I've found it,' he said. 'It's so wonderful.'"

"I've found my place too," said Andrew. "It's lovely. It's green and peaceful, and there are orange flowers in the meadow. And," and he gave a gasp of surprise, "there's children playing swing ball in the meadow too. They're running up to me now. They want me to play. Oh wow, this is great!"

"That's terrific," said his mom. "You can play with them as much as you like, and then you can all rest. You and the other children."

"It's lovely," said Andrew, after a while. "I'm going to rest now."

"You can have a lovely rest," said his mom. "You don't have to sleep, but you can sit there and look around you. There are such lovely things to see, and you can feel that everything's just right. It's such a lovely feeling, to know that everything's just right. It's fine and just the way you'd like it to be....."

"'Now,' said Alan's mom, 'soon you can get ready to say goodbye for now to your carpet. You're not saying goodbye forever, because you can come back for another trip whenever you like.'

'Now, though, you are getting ready to be back here with me. But you can take with you that happy, peaceful feeling the carpet gave you. It can stay with you whatever you're doing and whatever you're doing can feel extra nice.'

'You might imagine yourself now, getting up and doing whatever it is you're going to be doing after this.'

'And whatever it is that you're going to be doing you can imagine yourself feeling really good doing it. It feels really nice. And it feels nice to know that it will feel so nice .....'

'I'm going to be doing some drawing after this,' said Alan dreamily. 'It will feel really good.'"

"I'm going to be playing my computer game," said Andrew. "I'm going to feel really good. I can see myself doing it now. I feel really good."

"'Good,' said Alan's mom. 'Now you can see yourself opening your eyes with a happy smile and feeling just so nice.....'

Alan opened his eyes. 'Gee, that was nice,' he said."

Andrew opened his eyes. "Boy, that was nice," he said, and he gave his mom a hug. "I feel really good. I think I'm going to have a great, great day."

THE CAR THAT WOULDN'T STAY ON THE ROAD
Adapted from Davis (1990:543-546)

GOALS:

* To reduce levels of hyperactivity

* To increase levels of focussed attention

* To improve poor problem-solving skills

MESSAGE: We can learn techniques to help us pay attention, to slow down and to problem-solve.

Davis (1996:543) suggests that even though there are physical causes of hyperactive behaviour, the unconscious mind can figure out ways to normalize functioning.

Once upon a time there was a car whose dream was to be a police cruiser. He wanted to have flashy lights and a loud siren. He wanted to be painted in blue and white and race by cars that had pulled over to let him pass.

The family who owned the car had no idea that he wanted to be a police car. They just wanted a car that drove them safely to work, to school and to do their shopping. But this car was a big problem. When the family drove the car, he often went so fast that he ran off the road. The car didn't seem to pay attention to where he was going and always seemed to be bumping into things. The more he ran off the road and ran into things, the more dented and rusty his body became. He seemed to always be in trouble, because he did not seem able to pay attention to where he was going and what he was doing.

After the car had scared the owners one too many times, they decided to buy another car. "You're not good for anything," they told the car. So they covered him with a big piece of canvas and parked him in a field.

As he sat alone in the field, the dream of being a police car seemed to fade further and further into the distance. He was lonely and couldn't see what was happening because the canvas covered his body from back to front.

One day a thief was running from a policeman and spotted the car. Thinking the car would be a great hiding place, the thief pulled up the canvas and jumped inside. The policeman soon followed with his dog who smelled the trail of the thief even though he was hidden from view.

When the dog began to bark at the car, the police officer threw the canvas off and quickly arrested the thief. After putting the thief in his car, the police officer began admiring the car that he had uncovered and wondered why such a nice car was not being used. Just then the owners of the car ran over to see why the police were running through their field. After telling the owners about the thief, the police officer asked them about the car.

"Oh, that old thing," they said with disgust. "He won't stay on the road, he only has one speed - fast - and he doesn't pay attention."

"Well, the car sure looks good to me,' the policeman responded.

"You can have that car if you want it, it's just taking up space in our yard," they told the policeman. The policeman asked his partner to drive the police car with the thief back to the police station so he could drive the car home.

Sitting quietly had not taught the car a thing. In fact, being still had pushed the car to be more out of control. Even with the expert driving of the policeman, the car went on and off the road, and ran into a parked car, denting the bumper.

Because the policeman also was a car mechanic, he looked at the car in a far different way than the previous owners had. When they had looked at the car, they saw it in terms of problems. When the policeman looked at the car, he saw it in terms of solutions. "I can fix you so you pay attention," he told the car, "And I can repair you so you stay on the road."

He put the car in his garage and found his tool kit. First he opened the hood and slowed down the carburetor. Then he changed the fuel mixture. He tightened the steering and fixed the accelerator pedal so the driver controlled the speed of the car. After that, he washed the car, and polished it until it shone.

When he drove it again, the car stayed on the road. It seemed to pay attention to what was happening around it and to slow down. Each time the policeman drove the car, it seemed to gain more and more control. Soon it was acting like every other car on the road. When the policeman was sure that the car was safe, he began taking his family for outings in the car. The car loved being a family car and realized that being a police car might have advantages, but so did having a family who cares about you.

As the car sat in the driveway in front of the police officer's home, he realized how lucky he was to be owned by a man who looked for solutions as a way to deal with problems.

And when you're ready, you can bring these pleasant feelings back with you into the room in which we started this story, and take the feelings with you as you go home.

THE RED TOW TRUCK
Adapted from Davis (1990: 497-501)

GOALS:

* To increase focus of attention

* To improve problem-solving skills

MESSAGE: We can change our ways and develop techniques to help us with forgetfulness so we can succeed, once we are aware of the problem.

Once upon a time there was a Red Tow Truck with "Mike's Garage" painted brightly on each door. The Red Tow Truck had to do many jobs that helped the garage run smoothly. He would drive to cars that were wrecked or stalled, and bring them back to the garage to be fixed. When a car ran out of petrol, the Red Tow Truck carried petrol to the owner so they could get on their way.

Working at a garage meant that the Red Tow Truck had to remember many different things to do. This was a big problem because he would often start a job and forget what he was doing. The Red Tow Truck would get a call on his radio from Mike, the owner of the garage, to pick up a wrecked car. He would start in the right direction, but after driving by a park or a nursery school, the Red Tow Truck would forget what he was supposed to do as he stopped to watch the kids playing. The wrecked car and its owner would wait and wait and wait, for the Red Tow Truck who never came. Then Mike would yell through the radio of the Red Tow Truck, "Where are you, Red Tow Truck? Why haven't you done what you were told to do?"

When this happened, the Red Tow Truck would feel very sad and embarrassed. He didn't like the boss shouting at him. So he would start off again to get the wrecked car, but soon he forgot what he was supposed to be doing again. Sometimes the Red Tow Truck would get angry at other cars and crash into them on purpose, causing accidents. When this happened, a traffic jam formed, causing even more problems. Then Mike, the boss, would shout at the Red Tow Truck again through the radio and the Red Tow Truck would try very hard to find the wrecked car as he was supposed to. Sometimes when the Red Tow Truck went on a trip that should have taken ten minutes, he would be gone five hours. When he eventually came back to Mike's Garage, everyone would be very cross with him.

At night, when Mike's Garage was closed, the Red Tow Truck would ask himself, "Why is everybody so mad at me?" He didn't understand what he was doing to make them all so cross. Mike tried to tell the Red Tow Truck what he needed to do, and so did the mechanics who worked there. Everybody tried to talk to him. Even though the Red Tow Truck listened, he really didn't hear what they had to say.

Although Mike was a kind man, after many weeks of shouting at the Red Tow Truck with no improvement in his behaviour, Mike said, "I'm going to get another tow truck if you won't do your job properly. We are losing business because you take so long to bring back the wrecked and stalled cars, and to take petrol to customers who run out. The customers are always shouting at me and they are starting to use another garage with a much better tow truck.

The Red Tow Truck was very, very sad when Mike said he would get another tow truck. "Please give me another chance," he pleaded, "I promise I'll try really, really hard."

Mike liked the Red Tow Truck and he was a nice man, so he said, "I'll give you one more chance."

So that night, when the tow truck was in the garage, he began to think about his problem. He knew that he had promised to try harder, but he didn't know what he had done to make everyone so unhappy. Then one of the mechanics who had worked on the Red Tow Truck when it had to be fixed once came into the garage. "I'm going to

show you why you are always in trouble," the mechanic told him. "It's important to see what you do wrong, so that you can change your behaviour, if you want to."

There was a TV and video player in the garage that the mechanics watched when there was no work. "I followed you today," the mechanic told him, "I took a videotape of everything you did and I'm going to show you why people are always cross with you." At that, the mechanic put on the videotape and a picture appeared on the TV. As the Red Tow Truck watched the videotape, he noticed how he had forgotten what he was supposed to do. He saw that he was doing many things that he wasn't supposed to do. Then he noticed how he was sent to get a wrecked car and did everything else, but never went to the car. The Red Tow Truck was surprised. "I never knew I acted like that," he said.

"I knew that," the mechanic said. "That's why I decided to show it to you. I hope seeing yourself in this way helps you." Then the mechanic went home for the night, leaving the Red Tow Truck to think about what he had learned. He decided that if he forgot what he was supposed to do, that he would find ways to help himself remember.

The next day, the Red Tow Truck asked Mike to write down what he was supposed to do each time he went on a run to get wrecked or stalled cars. Then he also asked Mike to put the instructions on a tape recorder so that he could play it again and again, to remind himself what he was supposed to do. The Red Tow Truck talked to himself as he was out on a run, reminding himself again and again what he was sent to do. He also asked the mechanics and Mike if they could tell him other ways that would help him to remember, and he tried each new idea until the Red Tow Truck found what worked for him.

It wasn't long before the Red Tow Truck would go straight to a wrecked or stalled car and quickly come back to Mike's Garage. Then he would take petrol to drivers who had forgotten to fill up and they would quickly be on their way again. The Red Tow Truck soon was driving to cars who had flat batteries and he recharged them in what seemed like no time at all. Not only was Mike very happy with the Red Tow Truck, but all the customers phoned Mike to tell how pleased they were with the Red Tow Truck, and the garage got more and more business.

Every day the Red Tow Truck found more and more ways to remember where he was going and what he had been sent to do. He liked it when people said he did his job so well and, he liked doing his job well. When he had a problem, the Red Tow Truck worked out what he had done to cause the problem..... then he worked on how to sort out the problem. One day the Red Tow Truck heard Mike tell a customer that he was the best and most hard-working tow truck in town. If tow trucks could smile, the Red Tow Truck would have smiled at hearing this, because he loved getting his job done right.

And now, I want you to see yourself on a TV screen in your imagination. See yourself discovering ways to overcome forgetfulness. See yourself talking to yourself, about the things that you have to do, at home and at school. See yourself working out how you can solve problems, and then see the smiles of the people around you when you manage to do your chores so well, without having to be reminded. And then, when you're ready, I want you to bring those smiles and feelings of pride in your success back into the room with you, knowing that you are able to learn new ways to remind yourself of your duties.

THE ADVENTURES OF BLUE SPARKLE
Adapted from Mills and Crowley (1986:79-80) and Davis (1990:507-511)

GOALS:

* To reduce levels of hyperactivity

* To improve focussed attention and listening

* To create an awareness of the needs of others

* To improve relations with parents, teachers, peers and self

MESSAGE: Our behaviour is under our control. We have the ability to use our skills to be better-behaved, so that we are more successful, and more acceptable to others, rather than trying to be a problem child. At the same time, we can heal the tears in our own hearts.

Sit still now, and relaxed, with your eyes closed, so that you can imagine that you're watching KTV, pretend that you're watching a show called "The Adventures of Blue Sparkle".

Blue Sparkle was a wonderful little fish who wiggled his tail so quickly that no-one could ever catch him. Now you know, that's a very fine ability for a little fish to have when he needs to race.....or when he has to protect himself, but Blue Sparkle was hardly ever still. As a result, everybody would get really mad at Blue Sparkle. His parents got cross with him, and so did his teacher. Even his friends got cross with him, because often ..... although he didn't mean it, he would crash into their things, breaking them, or he would knock into them and hurt them. That would make them very, very angry and so they didn't really want to play with him anymore.

Eventually, Blue Sparkle came to see himself as a huge big problem. He started to believe that he was ugly and stupid and that he could do nothing right. He began to feel that he was just a huge, big failure.

Blue Sparkle didn't really want to be a failure at everything, so he decided he was going to become a problem fish. "I can succeed at being the best problem fish that anybody around here has ever come across..... I can be really good at that..... I wouldn't have to be smart..... or quiet..... or calm to be a problem fish..... I wouldn't have to be good-looking..... and I wouldn't even have to be nice and friendly..... I know I can succeed at being a problem fish."

So Blue Sparkle immediately began to work towards his goal of being a problem fish and, do you know what, he succeeded very well at it. He swam so fast and wriggled so much that he caused a huge amount of damage. He refused to do his chores at home. He didn't listen to his parents and would never answer when he was called to have dinner. He was rude to his teachers and to his school friends and he got into all sorts of fights with the other little fish. Then, he heard all the bigger fish calling him a 'problem fish'..... and he smiled to himself.....because that was exactly what he wanted to be.

One day, after everyone had shouted at him all day long, Blue Sparkle thought for a moment about things. "I have succeeded ..... I am the worst problem fish that anybody has ever come across..... So, why am I so sad," he wondered? I thought being a problem fish would make me happy, but it hasn't. I just don't understand what's wrong. As he continued to think about things, it dawned on him as well that..... because he never stopped long enough to enjoy the treasures in the ocean..... he was not learning very much either..... He heard all the other fish telling amazing stories of slowing down to see all the fascinating things in the ocean, and he felt quite jealous.

Then Blue Sparkle found himself thinking about a time when the current of the water was slow..... and calm ..... and peaceful..... He really enjoyed the slow..... floating..... feeling of the slow..... current and he found himself resting quietly, and as he did so, he found himself thinking relaxing thoughts. And as he thought the relaxing thoughts, he noticed that his fin had slowed down too. He was delighted with this discovery and he was very eager to see if it would work again.
Blue Sparkle tried it out over and over again. He swam by a school of fish who had gathered around a shimmering treasure chest. He remembered the slowness of the water's current and he slowed down. Then he joined the group of fish, staying calm and in control, so that he was able to look ..... and listen ..... and learn about the treasure chest. He slowed down at home..... and so his family became happy with him. He slowed down at school so that his teachers were happy with him. He even slowed down on the playground, and so his classmates weren't so angry with him.

Every day, he became less and less of a problem, and he slowed down more and more, keeping more and more calm, and more and more in control. And Blue Sparkle began to feel that his heart was somehow changing. As his heart grew bigger and bigger, his body didn't seem like such a problem any more. One day..... Blue Sparkle even got a hug from his teacher. As the days went on, Blue Sparkle changed the way he acted with friends, with his teachers and with his family, and ..... he changed the way he talked to himself..... about himself. Blue Sparkle began to see himself in a different way altogether. "I don't want to be a problem fish any more," he thought. "I want to be someone special." And then he smiled to himself, because he realised that he already was someone special.

In no time at all, Blue Sparkle had so many friends. His teacher was happy to see him in the mornings and she stopped complaining about him. He tidied up his things at home and always got ready for school on time so that his parents were so happy with him..... And as he slowed down so much, and he changed his behaviour so much, he began to learn so much..... And best of all, all of the other fish were so surprised at the difference in Blue Sparkle that they were happy to have him swim near them..... and play with them..... and learn with them.

When you're ready, you can open your eyes and come back into the room that we were sitting in when we started this exercise, feeling calm and pleasantly relaxed.

RAINBOW THE PUPPY
Adapted from Mills and Crowley (1986:130-136)

GOALS:

* To improve focus of attention

* To reduce levels of hyperactivity and impulsivity

* To improve the control of aggressive outbursts

* To improve skills of socialisation

MESSAGE: We can become aware of our personal boundaries and reduce levels of uncontrolled and unacceptable behaviour, so that we learn new skills and become more accepted by those around us.

Rainbow was a little puppy with many colours on him, a very special little dog. He belonged to a family who loved him very much. They got him when he was a puppy, and, like most puppies, Rainbow was mischievous and needed to be taught many things. He chewed old shoes, got into the food in the pantry, and knocked things over with his tail.

Rainbow's family didn't quite know how to teach him, so first they had to learn all about Rainbow and his special qualities. They tried all kinds of things month after month, but Rainbow kept doing what he wanted to do. He kept chewing shoes, knocking things over, and sometimes he was even confused about where he was. For example, sometimes he would think he was in the bedroom when he was in the family room, or in the kitchen when he was in the bedroom. It was so confusing at times. Lots of things are confusing at times.

Keep focussed on your breathing now, taking in nice deep breaths and getting that sense of feeling so good inside, as you continue to listen to the story with your eyes closed, or you can listen with them open, if you choose.

Rainbow liked to do many things. He liked to play, to bury bones, and to look for other friends to play with. But it was hard for him to find friends. He used to look out the window and watch the other dogs playing, and he thought that he could just run out and play with them. But he had forgotten something very important, he had forgotten that it takes time to make friends.

Well, at first he sat on his step on the top of the porch and watched the other little dogs playing together. He watched them as they ran around the grassy fields, across the lawn in the garden, and over the pavement. He watched and waited, watched and waited, until one day, one of the other dogs came bounding up to him playfully, nudging him to come join him and his friends. Rainbow was so happy! At last he had learned how to make friends.

Now the children who owned Rainbow loved him very much. They petted him at night and tried to get him to be still. But, as with most other puppies, Rainbow had a difficult time being trained in the beginning. He was so active and busy all day that it was difficult for him to just lie down at the end of the day.

One day, as he was running about, his owners called him in and said it was time to go to dog training school. The next thing he knew, Rainbow found himself in the park on a very long chain. Every time he broke into a run, he felt a stop. He didn't know what that stop was, except that it was like a yank or a pull. A definite stop. Well, he tried to run again. He tried to run here and there, and wham-o, every time he tried, he was stopped.

Interested, he looked around to see where the STOP was coming from. Somehow he knew that something was stopping him from dashing about. Well, the class lasted about an hour, maybe two. It seemed like forever to Rainbow. It's hard when you're a puppy. After all, he was (seven) months old. And at (seven) months old, there is a lot of running around to do. Well, he watched the other dogs as they learned, and little by little, they learned how to sit. That's right, little by little, they learned how to lie down and roll over. And they learned how to walk closely to their owners. Then, of course, there was the time when the leashes were taken off and the dogs could play freely - freely and comfortably - flopping their ears and tails in the park and barking with laughter.

Day after day, this class took place with the instructions. And this little dog, Rainbow, would run about. And then suddenly, surprisingly, without anyone being aware of when or how, Rainbow surprised himself! And it's nice to be surprised. Rainbow experienced something different. All he did was hear those words that got his attention easily - Heel, Stop, - and he stopped right then and there! When he did, he got a delicious reward of a dog biscuit. Like a special cookie, a favourite cookie. It's nice to hear the crunchy sound of a favourite cookie or a biscuit - something Rainbow enjoyed so deeply.

And Rainbow, in his own special way, was able to do all kinds of wonderful things with that biscuit. He chewed it, he threw it around, he tossed it in the air. He did all kinds of things. But most of all, he learned that you may get a reward for simply paying attention. And, it's nice to have rewards.

We can look at Rainbow and think of how enjoyable it is to see all his colours blend together, each one separately and together. That's right. You might be wondering about many, many things right now. A part of you knows that it is nice to imagine that little dog, Rainbow, and to hear about his adventures: about how he learned to do many things; how he learned to sit; how he learned to stay; how he learned to roll over and laugh at himself again; how he enjoyed playing totally.

Now this story may have many, many meanings for you, and you might enjoy one part particularly. A favourite part. That's right. And as you look back, you can just begin to get a sense of how special it would be to be able to see that little dog, Rainbow, to remind you how easy it is to STOP, to take a look about, and to enjoy what you're doing. That's right.

Now in a moment, you can allow yourself to have a special dream. And enjoy totally whatever part of that story you want to.....

And when you're finished, you can just take a nice big stretch, take a nice deep breath, feeling really good for the rest of the day. Knowing that there is lots for you to learn and enjoy and have fun with, while you continue to play. That's right. Giggles of laughter and rainbows of colour that make you aware of feeling so very good inside.

THE LITTLE ELEPHANT
Adapted from Mills and Crowley (1986:146-158)

GOALS:

* To improve enuresis

* To enhance awareness of skills mastery

* To enhance self-concept

MESSAGE: The child has the resources to resolve his dilemma of bed wetting. The important thing is that he must take responsibility himself.

Now..... as you begin to get very comfortable..... that's right, taking all the time you need to just breathe easily and comfortably. And as you're sitting there, take a nice, deep, satisfying breath in through your nose, and out through your mouth, as if you were blowing a feather in front of you..... That's right. Just slowly and comfortably.

And since you mentioned, that you like to hear stories about animals, I'm going to tell you a story about a favourite animal of mine..... a little elephant. A little elephant that actually lived in a circus. And as I'm talking, I'd like you to begin to see the story unfold, just like when you're watching television, and you can imagine your favourite cartoon show, or see your favourite characters.

The story takes place at Brian's Circus, out in the middle of an unknown place..... a small town with fields big enough to hold the big tents and all the circus equipment. Imagine hearing the excitement of the people and the animals as you watch everyone doing their job, putting everything exactly where it needs to be placed in order to pull up the big tent that's going to hold everything within it..... all the people, the animals, the acts, the trainers, the jugglers, the tightrope walkers, and much, much more. And as you already know, the animals help put it all together.

The animals are a very important part of the circus. The elephants are often used to carry the heavy buckets of water and the great big heavy beams that hold up all the tents and the different displays. The elephants move these beams and buckets around by carrying them in their trunk. And it's amazing when you look at a large elephant and watch him carry a large beam..... He does it with such ease. Imagine hearing that elephant. Imagine the sound that an elephant makes as he's reaching over to see the next beam he's going to carry comfortably.

All of the elephants are doing their work so well.....except for one little elephant named Sammy. Little Sammy went over just like everyone else and took his trunk, wrapped it around the handle of a large bucket of water, and began to lift it and hold it. Within a short period of time.....BOOM.... you heard it land and saw it begin to roll. Sammy hoped that nobody had noticed what he had done..... but the others started yelling..... "What did you do that for - it almost rolled over my paw!" roared the lion. "Can't you grab hold of it; can't you hold onto it longer like everyone else does?" the older elephant bellowed.

Sammy got scared. He decided that maybe he hadn't paid enough attention, so he began to watch the other elephants carry the water and the beams. He watched them closely, and then he went back and tried again.

Using all those muscles within that trunk of his, he wrapped it around the handle of the bucket of water, saw himself picking it up, and felt really good inside as he walked along, swaying from side to side, just about bringing it over to where they needed it..... and BOOM.....down again! This time the beam rolled and rolled so far that it knocked over the cold drink machine, and the cold drink spilled everywhere.

Everyone was very angry and upset with Sammy now. "Can't you control that water yet!" they yelled. "You can learn to control that water..... all the elephants do. They control it very well..... Just watch what they do to control their trunk carrying whatever they carry within their trunk."

Well, Sammy was quite frustrated at this point. He tried and tried, day after day, but BOOM.....down went the buckets of water every time he tried. All he felt was the animals and circus people looking at him so meanly. He could tell by the look in their eyes that they were very upset with him. Sammy didn't know what to do to please them. He felt really ashamed of himself, and sad. At times, he would even go off by himself and cry. "No one understands," he mumbled, "no one really cares."

Time passed..... One day, when Sammy was very sad, the circus camel heard him crying and said: "You don't look very happy. Is there anything I can do to help you feel better now?" Sammy answered: "I don't know. I keep trying and trying to hold onto that bucket, to do my part, but I keep spilling it. I keep letting it go too soon."

The camel thought for a moment and then began reminding Sammy of all the things that Sammy had learned to do since he'd been in the circus. The camel said: "When you were born, you couldn't even walk right away. You had a time when your legs were shaky. You had to learn to take each step, one after the other. At first, you had a difficult time, yet you continued to practice and learn. After a while, you learned to walk successfully. You also learned how to pick up grass and eat it with your trunk. You learned how to eat all by yourself. Now your trunk can carry just the right amount of food to totally satisfy you, so that you can feel good. You learned to recognise when you are full and comfortable. You feel so good inside, and you can be surprised at how long you can hold onto that good feeling for a long, long time, Sammy".

Sammy thought for a few minutes and then answered, "Yes, I do remember that."

The camel continued: "It's just like the cyclist here at the big top. I remember years ago when he couldn't even ride the bicycle. He would get up on his bike and fall down. As a matter of fact, someone had to teach him how to hold on to the handle bars correctly. He had to practice holding on for a long time. And after he learned to hold on, he was able to relax and enjoy the feeling of letting go. When you watch him later today, Sammy, pay attention to that look on his face and the fun he is having being in control of that bike. Telling you about the cyclist," mused the camel, "also reminds me of the juggler here at the circus. I remember when he first came here, all he could juggle were two little bowling pins. Now he can juggle big bowling pins and dishes, and he can mix all those things together..... He can juggle balls, pins, and dishes all at the same time while riding a bicycle. His balance is perfect. He knows exactly when to let go and hold on to each of those items. You just have to trust you can do it..... Some things take a little more time to learn than others and you have all the time in the world you need to learn that now."....

Suddenly, Sammy and the camel heard sirens. They looked up and saw flames in the distance. "It looks like there's a fire at the farmhouse way over there," the camel said. "But those fire engines won't be able to get through the pass, because the bridge was washed out. The only other way to put out that fire is for the other elephants to carry water in their trunks and spray it on the fire. But they are busy with the trainer way across town getting ready for the parade later today."

Little Sammy looked at the camel rather curiously and said, "Well, what are we to do?" The camel replied, "It's up to you now." "What do you mean?" asked Sammy. The camel said, "I'm going to teach you something important. As you know, camels carry water for a long, long time. I'm going to teach you how to do that, so you can carry water for a long period of time too. And once you can learn to do that, you will be able to go over to the lake, put your trunk in, see yourself hearing all that water going in past your trunk, and hold on to it for a long period of time, successfully. Then you can see yourself walking along over there to where the fire is and putting out that fire by letting go of the water just at the right time. Not a kilometre before, not a half kilometre before, not even twenty metres before - but only when you are at exactly the right spot. Then you can aim your trunk and let go of all the water....."

"Simply remember, when you held onto a special happy feeling for a long time..... Or maybe you carried the excitement for a long time of wondering what gift you'd be getting on your birthday. Since everyone knows elephants have good memories and always remember everything that is important..... remember something important you learned a long time ago and still carry happily with you now....."

"After listening to you Mr Camel," said Sammy, "I feel I can see myself doing all of that..... I feel I can do it now.....So the camel and Sammy went over to the lake and Sammy took in as much water as he could hold comfortably..... Then he began the long walk over to the fire and just like the camel had told him, Sammy let go of all the water at exactly the right time and place. Just the sound of that water hitting the fire at the right time gave him such a happy, joyful feeling inside. His face lit up as he heard everybody clapping and cheering. "Hurray, Sammy, you did it!", they all exclaimed. Sammy felt very special for the first time in a very long time. He was written up in the local newspaper for his special ability and talent - ..... being able to hold on to the water for such a long time and knowing exactly when and where it was time to let go of it all successfully.

As the days went by, Sammy was able to discover other abilities that he had forgotten about. He thought to himself, "Once you know how to hold onto the water..... you can hold onto anything successfully." Just at that moment, the camel was walking by. Sammy saw him and shouted, "Watch this!". He went over to the main tent, picked up a heavy wooden beam, and brought the beam all the way over to the centre of the tent, where it belonged. As he gently let it down, Sammy felt so good inside. He saw himself letting go of the beam so securely and hearing it land so gently. The camel smiled at Sammy and said, "You have learned that and much, much more. And as you continue to be part of this circus, an important part, you will continue to learn much, much more each day."

Weeks later, as Sammy was playing, he saw the camel again. The camel reminded Sammy, "Anytime you want to see yourself doing anything in the future, just remember all the important things you've learned..... You can learn anything else you need, just by taking your time and holding on to those happy memories." Sammy looked at the camel, nodded his head and said, "Thank you, Mr Camel, for reminding me of something I knew all along."

Now you can just sit quietly for a moments and think about the story that has been read to you. And, when you're ready, you can come back into the room, with quiet eyes, feeling peaceful and calm and relaxed, knowing that you have learned so many things since you were a little baby, and that as you go through life, you will manage to learn more and more.

THE BROWN LEAVES
Adapted from Davis (1990:183-185)

GOALS:

* To improve encopresis

MESSAGE: You can safely 'let go' when you go to the bathroom.

Once upon a time there was a little tree who was trying very hard to be a grown-up tree. In spring his leaves began to grow, and by summer he was covered all over with leaves. He thought he was handsome and very smart to have so many beautiful leaves all over him. Then autumn came and all of his leaves started to turn beautiful colours. He noticed that the leaves on the big tress turned pretty colours, too. Then all the leaves on every tree turned to brown, and he watched as the big trees let go of their brown leaves, letting them fall to the earth. The little tree didn't want to let go of his leaves even though he saw the big trees do it. He felt that the brown leaves were his very own that he had made himself. It made him mad and a little scared and maybe even a tiny bit sad to watch the wind and rain take the leaves away.

He thought, "What would I do with no leaves? The big trees can make lots of things - big shade to sit under, homes for little birds and squirrels. But I don't do all that - all I have is my leaves. I won't LET THEM GO, OH YES!"

Well, the wind came and tugged gently but he didn't LET GO, OH YES! And the rain came, plop, plop, plop, and he didn't LET GO, OH YES! My goodness, he was so tired with all that work. Pretty soon, when he was so tired that he almost fell asleep, a furry kitten came by.

Hello," said the little tree.

"Hello," replied the kitten. "My, you look so tired."

"I am," said the little tree. "I'm working very hard to not LET GO, OH YES of my leaves."

The little kitten started to giggle. Then she started to laugh and she rolled all over the ground. This made the little tree mad! "Why are you laughing?" he asked.

"Because when you get more leaves in the spring, where are you going to put them? There won't be any room," she giggled.

"Is that really true?" the little tree asked quietly.

"Of course," said the kitten. "Trees always grow new leaves in the spring and as they grow taller in the summer, the leaves get bigger and greener. Then fall comes and the leaves turn colours and drop to the ground. Then the trees sleep through the winter so that they can get ready to make new leaves in the spring."

"Gosh," remarked the little tree. "No one ever explained about leaves to me before." And all of a sudden, in just the right way, and in just the right place, plop, plop, plop, the little brown leaves came down.

"OH, YES," he said. And the little kitten smiled.

Take a deep breath in now, fully relaxed. And when you're ready, you can open your eyes, and come back into the room in which we started this exercise, bringing with you those lovely feelings of relaxation and peacefulness.

THE TIGER IN THE CAGE
Adapted from Davis (1996:291 - 294)

GOALS:

* To alleviate feelings of anger

* To enhance positive relationships with others

MESSAGE: Anger covers up sadness; sadness is the result of not connecting with people. Dropping your rage will open you to finding and sharing love.

Once upon a time, there was a very handsome tiger that lived caged in a zoo. Now this tiger was in a very small cage because all of the zoo officials were afraid of him. They were afraid because this tiger was constantly angry. He would roar and scratch and try to attack, so people stayed more and more away from the tiger. There were animal trainers within the zoo who wanted to make friends with the tiger, but each time they got close, even if they were offering him food, the tiger roared and charged at them. Soon, no one came near the tiger at all, because they were afraid of his anger. Instead, they threw his food through the door and closed it quickly. The tiger was angry because he didn't get the kind of food he wanted, and since his cage was small, he would roar and pace up and down, and growl. When people came to view the tiger they stayed far back from the cage, because the tiger made it very clear that he wanted no one around him.

Now what the tiger acted like, and what was going on inside him, were two very different things. The tiger was actually very, very, very sad. He didn't like the small, tight cage and he didn't like being away from the jungle, and he didn't like having no other tigers around. He found the cage boring and lonely. All of these things made the tiger feel like there was a big, dark hole in his chest. But rather than let the world see his sadness, he showed anger. He really didn't know any other way to act. What he did not realize was that he was keeping himself from getting the things that would make him feel better.

The zoo officials would have been happy to put him in a large, airy jungle area with other big cats, but because of his rage and bad temper, they were afraid that he would hurt the other animals, or the people who came to look at them. So life for the tiger got more and more difficult and he acted more and more angry.

Now it happened that the zookeeper who was in charge of tigers was at that time having problems with his own family, and he gave up on the tiger who was always charging at the bars in his cage. He decided to put the tiger's cage in a back area where no one would ever view him. The tiger became more and more lonely.

One day, since the number of animals in the zoo was growing, the officials hired a new caretaker - a woman who was an expert at understanding animals. After several days of exploring the zoo, the woman came upon the tiger. She watched him carefully as he roared at her and pretended to sleep, refusing to eat the food that she offered him.

Now this caretaker was different from the others who had fed the tiger, cleaned his cage, and left as soon as they could. She saw through his anger and his attempts to attack her, and she knew what lay under this. She began to talk to him on a regular basis, letting him know that she recognised his sadness and that she would help him. Although the tiger put up quite a show of rage - snarling and roaring - he began to understand that this caretaker could indeed help him to get rid of his sadness, and he found himself listening, and learning.

As time passed, a change came over the tiger, and the day came when he was put in the open jungle area of the zoo with the other big cats. He was free to roam with the others, crawl through the underbrush, or lay in the sun. At first, he had a little trouble making friends with the other animals, but the special caretaker, who knew he was a quick learner, worked with him, until he was a welcome member of the group. All of the other caretakers were amazed at the changes in the tiger, and predicted that before

long he would become his old miserable self again. But the caretaker knew differently, because she had helped the tiger find a special understanding of life and sadness and anger. The tiger soon found that the hole in his chest was healed. After that, every time the tiger saw the caretaker, he purred. It was the loudest purr that anyone at the zoo had ever heard before.

And now, I want you to feel those pleasant feelings that the tiger is feeling. And then, when you're ready, you can bring those feelings back with you into this room, leaving behind all the feelings of sadness and anger, just feeling a peacefulness, and calmness and a whole lot of love.

LITTLE BUNNY RUNS AWAY
Adapted from Davis (1996:441-442)

GOALS:

* To enhance self-image

* To improve the parent-child relationship

MESSAGE: It is not necessary to prove love; you have the understanding to know when you are loved.

Once there was a little bunny who lived with his mommy and daddy in a snug, warm rabbit hole at the edge of the Dark Forest. Most of the time, they were a happy bunny family, but as happens in all families, there were times when they disagreed. At one time, after a family argument, all of the family had felt unloved. But this was changed by the magic yellow bird who gave them the secret of happiness.

One day, the little boy bunny was in a nasty mood and he thought to himself, "I don't believe there is a magic yellow bird, and I don't believe my family really loves me! I'll give them a test to see if they really do. I'll pretend to get lost in the Dark Forest." Now, all the bunnies feared the dangers of the Dark Forest, but he was determined to test their love. So that evening the bunny took an extra shirt, put some tomato sauce on it, and went to the edge of the woods where he tore it into strips and made a trail leading into the Dark Forest.

The little bunny settled into his hiding place at the edge of the forest to watch and see what would happen when his family found the torn shirt. He waited and waited, and then got so tired that he fell asleep. When he awoke he couldn't tell how long he had slept ------- a few minutes or a few days, and all around him were strange and frightening noises. The bunny felt sad and was so scared that he cried to himself, "Why, oh why, did I doubt that my family loved me? Why did I say there was no magic yellow bird who had shared the secret of happiness? I wouldn't be here right now if I had kept believing!"

Suddenly, close to him there was a flicker of yellow. It grew brighter and brighter; it was the magic yellow bird. The bird hopped close and said, "If you are ready, I will light your way back to your family. It has been a long time since you have seen them." Following the bright magic bird, the bunny made his way back to his rabbit hole.

Suddenly he stopped and cried, "Something strange has happened! All the grass and flowers around the hole where we live have died, even the plants in our vegetable garden! What has happened?"

The magic yellow bird replied, "Your family found your torn shirt and thought you had been killed by a beast of the Dark Forest. The salt from their tears has killed the flowers, and the grass, and even the vegetable garden. They have forgotten the secret of happiness."

"Oh, no!" cried the little bunny. "I just wanted to test them to see if they loved me. I didn't want to hurt them and make them so sad! What can I do now?"

"I will give you the secret of happiness to take back with you to your family," said the bird, "and you will find you no longer need to test their love in this way again."

After listening to the secret, the little bunny eagerly rushed down the rabbit hole to his family, carrying with him the secret of happiness and understanding that he would never need to test their love that way again.

The next morning the grass and flowers and vegetables were again growing around the snug, warm rabbit hole. The bunnies were again a happy family. Little boy bunny became wiser with each passing day. He finally understood that love is not a test, it is a feeling.

And now that you have heard the story, you can float up again, and make your way back to your garden, notice how everything is in order, just how you left it, and slowly, and softly land. Nestle back into the soft grass and now you can relax, knowing that you can visit anywhere in the world, just by flying there yourself in this way.

THE RED CAR

Adapted from Davis (1990:177-181)

GOALS:

* To reduce oppositional behaviour

* To encourage appropriate assertiveness and cooperation

MESSAGE: You can find a way to use your oppositional tendencies to be assertive and to be cooperative and follow rules when either is appropriate.

Once upon a time a bright shiny red car sat on a sales lot with other cars. These cars were all waiting for someone to buy them. But the red car was unlike the other cars on the lot because when a customer tried to unlock the door, it locked. And when the customer tried to start the car, it stopped. When the gear was put in forward, the car went in reverse. It would even honk the horn when everyone wanted quiet. It was such an unusual car.

Even though customers were not happy with the red car, the red car was happy with itself. "This is the way to be in control," the red car said to himself. "I will do the opposite of whatever anybody tells me to do."

Many people came to the sales lot to buy cars, and the other cars on the lot quickly sold. Some customers liked the red car and he even liked some of them. Sometimes customers would try to take the red car for a test drive. However, when they put the gear shift into forward, the car went in reverse. This scared many people away. "I don't want this car," they told the salesman. "Show me something else."

The red car saw that no-one wanted to buy him, but he didn't understand the connection between how he acted and their rejection. "I'm such an independent car," he muttered after driving away yet another buyer. "I think for myself. It shouldn't matter that I do the opposite of what everybody wants me to do." And he said to himself, "I don't care if nobody ever buys me." But in his heart he knew that wasn't true.

One day a boy was riding his bike near the sales lot where the red car was parked. The boy darted into traffic and was hit by a truck. The driver of the truck immediately picked up the injured boy and put him in the back seat of the red car. He then jumped into the red car exclaiming, "I have to get this boy to the hospital as quickly as possible."

The red car decided that this might be a time to stop being so stubborn. When the man put the key in the ignition, the car started. And when he put the gear shift into forward, it went forward. Then the driver pushed hard on the gas pedal to make the car go fast and the red car drove very fast. Soon they arrived at the hospital where the boy's life was saved because the red car had helped the driver get him quickly to the hospital.

When the boy's parents arrived to see him they thanked the man who had driven the red car with their son to the hospital. The driver in turn thanked the red car. "I am so glad I found you," he told the red car. "Without you, I don't know if we could have got the boy to the hospital in time to save him."

If cars could smile, this red car would have smiled. A picture of the car was on the front page of the newspaper and the salesman even gave it a wax job. Because of the publicity, many people wanted to buy the red car. The red car decided he was tired of being the only car in the sales lot that couldn't find an owner. The car had discovered the excitement of the world beyond the sales lot. He did, however, make a decision that he would have some say in who bought him. So he would go backwards when he was supposed to go forward only if he did not want the driver to become his owner.

One day a fire chief arrived at the lot to buy a car to use at the fire station. He had seen the red car on television, "I would very much like to use this car as my personal fire car," the fire chief told the salesman. "It would lead the fire engines to all the big fires. This car has to be a leader and be in perfect condition or I will have to pick another car."

The salesman remembered how the red car often did the opposite of what it was asked to do as he handed the chief the car keys. The chief jumped into the car for a test drive

before the salesman could warn him. The red car had listened to the kind of car the chief wanted and decided being a fire car would be exciting. The red car thought about getting his own siren and racing down streets with regular cars having to stop when he was going to fires. He thought about leading big fire trucks and being around exciting events. "Wow," he told himself, "this would be even better than doing the opposite of what people want me to do."

When the chief put the gear in forward, he went forward; when the chief put the gear in reverse, the red car went in reverse. And he did not honk his horn until the chief pushed the button on the steering wheel. He performed in every way like a car that deserved to lead fire trucks. The fire chief agreed and soon drove the red car back to the fire station.

Soon the red car had sirens and special emblems and red and blue flashing lights on the top. From that time on, when there was a big fire, the red car ran through the streets making sure that the other cars stopped and the fire engines got quickly to the fire. People stopped and looked with admiration at the red fire car, and the red car was proud of himself too. He had realized there are all kinds of ways to be in control, and making a decision to cooperate can be one of them.

And, when you're ready, just coming back into the room, feeling a glow of pride, and calmness, and control.

THE MONSTER IN THE MIRROR
Adapted from Davis (1990:191-195)

GOALS:

* To improve aggressive and destructive behaviour

* To enhance a positive self-image

MESSAGE: You can find a way to see that you are a valuable and worthwhile person, to say positive and optimistic things to yourself, and to behave appropriately.

Once upon a time there lived a very special boy named Kevin who was getting taller every day. Many people told Kevin, "You are so handsome and smart." But, whenever Kevin looked in the mirror, he saw an alligator or a shark or an ugly monster.

"I'm not handsome at all. They must be saying that just to make me feel good. Why can't they see the way I really look?" Kevin whispered to himself. A voice within him constantly told Kevin that he was worthless and was a failure. This caused him to feel very bad about himself. He felt like being an alligator and biting people. He felt like being a monster and scaring people. He had a lot of anger in him just like a shark.

Kevin tried to get people around him to see the world the way he did. "I am not a handsome, smart person, I'm a monster," he said. Because no one would believe he

was a monster, Kevin started acting like a monster. He growled, he hit, and he acted angry all the time. He attacked people and he did very mean or weird things.

Pretty soon, people were saying, "Why is such a smart, handsome boy acting like he has a monster inside him?" Then Kevin would smile because he was finally getting his point across - he was a monster. He just had to convince more people. So, Kevin did everything he could to make people think he was an ugly monster. It wasn't long before people said, "Kevin is really a monster!"

One day Kevin was sitting alone on the basketball court because no one would play with him. A little boy named John came up to him and said, "Hey, why do you want everyone to think you're a monster?"

Kevin growled, "Grrrr, because I am a monster, that's why. Get away."

But John was very special, and he saw through all this growling and meanness, "Isn't it lonely trying to be a monster?" John asked.

Kevin had to admit, if he was honest with himself, that it was very lonely being a monster. It was also very lonely feeling like a monster and having everybody treat him like a monster. Kevin also had to admit to himself that the worst thing about being a monster was the mean things he said to himself.

"Are you ready to give up trying to be a monster?" John asked.

"I don't know how to give it up," replied Kevin.

"Let me take you to my mirror," John said. "It's a mirror that shows the truth."

"Okay, I'll go," said Kevin, feeling a little hopeful that maybe his life could be different. To his surprise, when he looked in this new mirror, that reflected truth, there wasn't a monster there at all. There was a very intelligent, handsome and well-built guy. "So what if I don't look like a monster on the outside," Kevin sputtered. "I'm still a monster inside."

"You don't have to feel you are a monster inside much longer," John stated. "Why don't you ask for a special dream that can help you understand how to stop being a monster"

So that night when Kevin was going to sleep, he decided to try it. "I need a very special dream to show me that I am not a monster," Kevin whispered to himself. Because he had decided that he wanted to change, a very wise person came in his sleep and talked to him for a long time. This wise person let Kevin know how special he was, how smart he was and how he was not a monster at all; it was only a trick his heart was playing on him. Then the part of Kevin that knew he was not a monster, a shark or an alligator became very strong and found a voice that talked to him all night. This voice said, "You are getting smarter every day. You are finding a way to make many good friends. You are doing better and better in school. You are remembering everything that you study and you are doing better and better on tests. You are liking yourself more and more each day. You are trying new things and discovering who you really are."

When Kevin thought he was a monster, the voice inside him had said mean and ugly things. This voice kept Kevin believing that things would always turn out wrong in his life and he would continue to feel like a monster for ever. Now Kevin knew that voice would never be strong again. The part of Kevin that said nice things had gained control and was directing Kevin in new and rewarding directions.

When Kevin woke up, the dream seemed so real; the positive voice was still talking to him. Then Kevin looked in the mirror and realized that he was different. In the days that followed, Kevin stopped acting like a monster. He stopped growling and hitting. He stopped hating himself and being angry like a monster.

It wasn't long before his life changed in many ways. He found ways to make friends and be a friend. The positive voice kept talking to him so that even when he made mistakes, he realized that was normal-it had nothing to do with being a monster. The more the voice told him that he could handle his anger, the better Kevin got at expressing anger appropriately.

One day when Kevin was walking down the hall at school, a first grader ran from the bathroom yelling, "There's a monster in there." Kevin smiled and hugged the shaking little boy. "There's no such thing as monsters," Kevin told him and when this happened, Kevin felt his heart smile.

And in a few moments, when you feel ready, you can open your eyes, and come back into this room, bringing with you a smile in your heart and thoughts of all the nice things you know about yourself.

APPENDIX L

PARENT QUESTIONNAIRE - REVIEW OF THE PARENT SUPPORT GROUP PROGRAMME

Please answer the questions below honestly:

Name _____

What were your goals in participating in the programme? _____

How were your goals met? _____

How were your goals not met? _____

Comment as specifically as possible, on the usefulness, or otherwise, of the parent group sessions:

Videos:

_____
_____
_____

Information:

_____
_____
_____

How would you rate the benefit of the parent group sessions on your child, on a scale of 1 - 10, with 1 being little benefit, and 10 being a great deal of benefit? _____

How would you rate the benefit of the therapeutic stories on your child, on a scale of 1 - 10, with 1 being little benefit, and 10 being a great deal of benefit? _____

What specific changes, either positive or negative, in your child's behaviour have you noted since the start of the programme?

_____

What specific changes, either positive or negative, have you noted in the family dynamics, since the start of the programme?

_____
_____

What feedback, either positive or negative, have you had from your child's teacher since the start of the programme?

_____
_____

What suggestions can you make for improving the programme?

_____
_____

Thank you for your cooperation and your tremendous support.

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