**Lesson 6: Teaching Adolescents with ADHD or with High Functioning Autism**

Learning Objectives

At the end of the lesson you will be able to:

* Discuss two disabilities: ADHD and High Functioning Autism
* Define the characteristics of both disabilities
* Give examples of both in terms of how it influences learning and the classroom
* Provide some strategies for both disabilities for classroom use

*Introduction*

In this this lesson you will be introduced to two different disabilities: Attention Deficit Hyperactivity Disorder (ADHD) and High Functioning Autism (Asperger Syndrome). In both instances the prevalence within Africa, even with the small amount of documented research, is similar to that of the West. (Chitiyo, 2013, p.21-24)That is for ADHD anywhere from 3 to 10% of children, with boys outnumbering girls.( U.S. Department of Education, 2005)

Before we get to specific details about either one of these disorders we need to introduce a reference manual written by the American Psychiatric Association (APA) which contains descriptions and details for a large number of disorders. This is the *Diagnostic and Statistical Manual of Mental Disorders* V (2013). The definitions include those for categories such as Attention Deficit Hyperactivity Disorders (ADHD) and Autism. This is an important manual to know for referencing when dealing with disorders. In some instances there are disorders which are not in the DSM-V, such as Learning Disorders. This is because there is no consistent characteristic and most of the difficulties are educational, not medical. While ADHD and Autism are included in the DSM-V, because they have a medical basis. It is important to also understand how we can have a disability or exceptionality that needs special help support and not be included in the APA text. Special needs refers to any student who needs some kind of individualized support in order to be a successful learner.



*Attention Deficit Hyperactivity Disorder (ADHD)*

This is a complex condition that presents real challenges for teachers and has been a major concern in public education. Identification requires a physician’s input since it is **Not** primarily an educational diagnosis. It is a problem associated with short attention problems and excessive motor movements. Students with ADHD may qualify for services under other categories (i.e., behavioural disorders, learning disabilities). As this shows, students may have more than one special need that interferes with his or her learning. While it is an invisible, hidden disability it is typically not hard to spot in the classroom. These students may be “always on the move” and can’t sit still, seem to daydream, not know what is going on in the class, show up without materials, and be failing lessons OR have any of those characteristics combined together. Often behaviours may be misinterpreted as a sign of being lazy, disorganized, and disrespectful.

ADHD may have a negative impact on a student’s academic and social success. It occurs across all cultural, racial, and socio-economic groups and affects children to adults with all levels of intelligence. There are a variety of terms been used to describe disorder: E.g., attention deficit, attention deficit/hyperactivity disorder, hyperkinetic disorders depending upon the characteristics exhibited. On the next page you will see a copy of the details from the DSM-V (2013) regarding ADHD. This is for information only – you do NOT needs to memorize this. But you must know the basics of this disorder.

 **DSM-5 Criteria for ADHD**

**People with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development:**

1. **Inattention: Six or more symptoms of inattention for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:**
	* Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
	* Often has trouble holding attention on tasks or 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 (e.g., loses focus, side-tracked).
	* Often has trouble organizing tasks and activities.
	* Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
	* Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
	* Is often easily distracted
	* Is often forgetful in daily activities.
2. **Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16, or five or more for adolescents 17 and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person’s developmental level:**
	* Often fidgets with or taps hands or feet, or squirms in seat.
	* Often leaves seat in situations when remaining seated is expected.
	* Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
	* Often unable to play or take part in leisure activities quietly.
	* Is often "on the go" acting as if "driven by a motor".
	* Often talks excessively.
	* Often blurts out an answer before a question has been completed.
	* Often has trouble waiting his/her turn.
	* Often interrupts or intrudes on others (e.g., butts into conversations or games)

**In addition, the following conditions must be met:**

* Several inattentive or hyperactive-impulsive symptoms were present before age 12 years.
* Several symptoms are present in two or more setting, (e.g., at home, school or work; with friends or relatives; in other activities).
* There is clear evidence that the symptoms interfere with, or reduce the quality of, social, school, or work functioning.
* The symptoms do not happen only during the course of schizophrenia or another psychotic disorder. The symptoms are not better explained by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

There are 4 different types of ADHD:

* AD/HD predominantly inattentive type
* AD/HD predominantly hyperactive-impulsive type
* AD/HD combined type
* AD/HD not otherwise specified

Because symptoms can change over time, the presentation may change over time as well.

![C:\Users\ejordan\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\EY3GZOZ0\disegno_adhd[1].jpg]()

It is important to note that many of these characteristics are ones we have all had in our life; forgetting things, disorganization, difficulty sitting still, etc. Because of so many of these are such common characteristics the APA has put conditions on identifying characteristics. These are: must be present for at least 6 months, six or more of the symptoms listed and are inappropriate for the developmental level of the person.

In Canada, identification of AD/HD ultimately requires involvement of a physician or psychiatrist

* + Identification frequently begins in school through teacher or parent referral to a school psychologist or school team
	+ Teachers should be familiar with specific behaviours and commonly used assessment techniques associated with attention-deficit disorders
	+ As soon as school suspects a child is experiencing attention problems, parents should be notified and invited to meet with the school team
	+ A variety of methods and assessment procedures will be needed to gather information to evaluate the presence of AD/HD in a child
	+ Many students with AD/HD are prescribed medications by physicians

Since medication is sometimes involved teachers need to understand:

* + Types of medications used
		- **Psychostimulants** (E.g., Ritalin, Adderall, Cylert)
		- **Antidepressants** (E.g., Tofranil and Norpramin)
		- **Antipsychotics** (E.g., Mellaril and Thorazine)
	+ Commonly prescribed medication dosages
	+ Intended effects of medication
		- E.g., increased attention, more on task behaviour
	+ Potential side effects of medication
		- E.g., loss of appetite, stomachaches, headaches

However, for many parents medication is not the choice. Some of arguments medication include: the change in behavior is coming from the medication not the student learning how to manage the disability, and in other instances, the student is sleepy and not energetic. No matter whether the parents agree to medication or not a teacher can find ways to organize his or her classroom so itis **beneficial for all students.**

* + Techniques include:
		- Group Management
		- Physical Management
		- Behavioural Support
	+ Group Management
		- Techniques are critical in managing the behaviour of individual students with AD/HD
			* E.g., establishing classroom rules and consequences for breaking rules, time management
	+ Physical Management
		- Physical environment of classroom can also impact on behaviours of students with AD/HD
			* E.g., arrangement of the room

1. Behavioural support techniques can enhance the education of students with AD/HD. In particular are those that reward desired behviour;

* positive reinforcement to increase appropriate behavior
* cueing or signaling students when on the verge of inappropriate behaviour

Modifying Teacher Behaviour:

* + - Students need challenging, novel activities to keep them focused and learning
		- Vary activities; give frequent breaks
		- Allow and encourage movement that is purposeful and not disruptive
		- Let students stand as they listen, take notes, or perform other academic tasks (Weyandt, 2001)

Modifying the Curriculum

* + - Students need a curriculum:
			* Adapted to focusing on “doing”
			* That avoids long periods of sitting and listening
				+ E.g., experience-based learning, Problem-Based Learning, etc.

**These adaptations can benefit all students**

Students all need to be taught Study Skills, such as note taking and taking tests. These are considered student-regulaed strategies. It is hoped over time all students will be able to utilize these skills when taught in an organized way over time by the teacher. We want students to be aware of their thinking processes, task approach strategies, and be responsible for their own reinforcement.

Student-Regulated Strategies or Learning Strategies

* + - * Approaches that combine what is going on in individual’s head (cognition) with what a person actually does (behaviour) to guide the performance and evaluation of a specific task
			* E.g., HOMEWORK strategy (Babkie & Provost, 2002)
				+ **H**ave a place to work
				+ **O**rganize assignments according to difficulty
				+ **M**ake sure to follow directions
				+ **E**xamine the examples
				+ **W**eave my way through the assignments
				+ **O**bserve work for errors and omissions
				+ **R**eturn work to school
				+ **K**eep up the effort!

Sometimes students with AD/HD often do not exhibit good problem-solving skills or are unable to predict consequences for their inappropriate behavior. For these students there may need to be some social skills training; such as, practice, modelling, and reinforcement of appropriate behaviour during real-life situations

*Activity*

Answer these questions in a group of 4.

* 1. What is the DSM-V? How is it used in education?
	2. Give 3 characteristics of a student who has:
* Inattention
* Impulsive-hyperactivity
* A combination
1. What are the conditions necessary for an identification when so many of the characteristics are common to everyone?
2. What are two self-regulating strategies?

You will now view a video which provides some classroom strategies for students who have ADHD. Then answer the following question:

1. Describe at least 3 strategies you can use when dealing with a student who has some variation of ADHD (whether identified or not)?

*High Functioning Autism or Asperger’s Syndrome*

Autism, in general, is often referred to as a *spectrum disorder* meaning that its symptoms and characteristics can present themselves in a variety of combinations, ranging from mild to quite severe. This is a pervasive developmental disorder that primary affect social interactions, language, and behavior. We are going to look very briefly at the overall category of Autism. This is a major field within Special Education and if you are interested in more information you can go to the CEC website mentioned in Lesson 5 or google, “Autism”.

No single definition has been universally accepted. In the newest version of the Diagnostic and Statistical Manual of Mental Disorder (DSM-5; APA, 2013), there are two main changes associated with the diagnostic criteria for autism spectrum disorders. These changes include:

* + Diagnosis called Autism Spectrum Disorder (ASD) (no longer any sub-diagnoses – I will discuss this later in the lesson; Hyman, 2013)
	+ New diagnostic criteria have been rearranged into two areas:
		- social communication/interaction, and
		- restricted and repetitive behaviors (Hyman, 2013).

Historically this has been considered a low incidence exceptionality; however, the number of children identified has increased dramatically over past few years. In the U.S., some form of autism in approximately 1 in 166 births. In Canada, approximately 1 in 200 children have an ASD. And in Africa the numbers are similar. (Chitiyo, 2013) Plus, males are four times more likely than girls to have ASD. Just as autism is hard to define, children with autism are often difficult to identify, especially when they have only mild symptoms. Early identification has been highlighted with the changes in the DSM-5 (APA, 2013) indicating “individuals with ASD must show symptoms from early childhood, even if those symptoms are not recognized until later” (APA, 2013b, p. 1). Key characteristics for earliest detection have been identified in the literature (e.g., lack of eye contact- will not look at a mother or father, limited social skills- do not respond when spoken to, differences in motoric characteristics – like rocking back and forth or banging their head for long periods of time).

There is no single specific cause for Autism. It may be an organic disorder (e.g., may be caused by brain damage, genetic links, and complications during pregnancy). However, most accepted models suggest a combination of a genetic base influenced by environmental events (i.e., toxins). Either way there are a large number of student with ASD in our schools. No single method is effective with all children. Intensive intervention programs have been somewhat effective with this group of students. We do know that appropriate role models appear to be very important.

For our purposes we are going to look at those students with Autism who are high functioning. Up until the 2013 version of the DSM there has been a separate category for this group called Asperger’s Syndrome. This is considered by many to be the mildest form of ASD. Individuals with this form are the most highly functioning people with ASD. Its prevalence not well established and it is not usually recognized before age 5 or 6 due to normal language development. (Remember: language development and delay is one of the characteristics of autism).

The characteristics are:

* + Trouble maintaining relationships
	+ Lack of the normal back and forth conversation
	+ Lack of typical:
		- * Eye contact
			* Body language (non-verbal communication skills)
			* Facial expression

Often people with Asperger’s display:

* Fixated interests
* Repetitive behaviours
* Excessive attachment to routines, objects or interests
* Some develop additional psychiatric symptoms and disorders in adolescence and adulthood
* Often physically awkward

However, these individuals often have high intelligence, great abilities and are sometimes even considered gifted. You are going to see 2 videos with someone with autism and a person who has Asperger’s syndrome. Dr. Temple Grandin has Asperger’s Syndrome. She has a Doctorate dealing with animal care and behavior. We are fortunate she is so well spoken and can discuss how she thinks. In this video she is explaining how her mind works. It is very different from how the average mind works.

*Activity*

Watch the video and answer these questions in your group.

1. Give 3 specific examples of autism that you saw Dr. Grandin display.
2. How is her thinking different than ours?
3. Why do you think she is so successful in her field?

In this next video you will see part of a movie. In this clip from the movie called The Rain Man, the actor displays characteristics of autism. Since everyone is not exactly the same this is an example of how a person with one type of autism would behave. When one person seems to have an outstanding ability, like this one with counting, it is called a “splinter skill”. You will notice the lack of social skill and awareness of surroundings.

Watch the video and answer these questions in your group.

1. How is the character different from Dr. Grandin?
2. What kinds of skills does Dr. Grandin have that the movie character does not have?
3. How does the splinter skill surprise everyone?