

Most of the knowledge I've acquired over the years related to AD/HD has admittedly been through media reports and casual conversations. I've never read about or studied the disorder in any real depth, mainly because I haven't had a chance to teach elementary school pupils or do not have children of my own. I've heard, mainly through second-hand sources, how young children are sometimes subject to overly aggressive, premature diagnoses and placed on medications such as Ritalin when they exhibit the slightest signs of hyperactivity, even when the child's behavior should actually be considered normal in nature. Consequently, I admit to maintaining a certain bias towards this disorder. I was glad to have this dedicated opportunity to read more about it to further my understanding of what I now know is a complex and prevalent condition that affects roughly 5% of children in our schools.¹ In fact, as I read more about AD/HD I realized ALL teachers, regardless of the age or grade level of their student populations, need to be able to recognize patterns and behaviors that could possibly signal a learner is afflicted with AD/HD. This unquestionably includes educators like myself who primarily teach adult learners. This short paper highlights some of the essential notes I've gathered from my reviews including what to look for and what strategies can be employed when teaching both children and adults who are affected with AD/HD.

To start with, I learned that AD/HD symptoms are consistently categorized into three main areas: inattention, impulsivity, and hyperactivity. People can be further described as suffering from three specific types or subtypes, namely the *Inattentive* type, the *Hyperactive-impulsive* type, or the *Combined* type when a person suffers from all three symptoms. I noticed there wasn't a fourth designation along the lines of *Hyperactive-inattentive* type which seemed curious to me; why do children show signs of hyperactivity and impulsivity (and inattentiveness) but not *just* hyperactivity and inattentiveness? This conjecture clarifies to me the complex nature of AD/HD and helps explain why children can easily go un-diagnosed, be misdiagnosed or even "over diagnosed." Apparently the cause of AD/HD is not fully understood but most likely related to an imbalance of brain chemicals or lack of (or "misfiring?") of neurotransmitters, similar to what has been traced to causation in people who suffer from anxiety or depression. Currently, there is no definitive way to test using blood or other bodily fluids to detect whether a person quantifiably has AD/HD. Another interesting side note I discovered about AD/HD is how it is classified for school related services and funding, in that a child can be diagnosed with AD/HD by a trained professional

but not qualify for special 504 special education services as outlined in the IDEA unless his/her educational performance is undeniably affected.ⁱⁱ

There are a variety of strategies a teacher can use with children who show symptoms or are diagnosed with AD/HD. Specifically, teachers should post clear rules and guidelines in the classroom and subscribe to routines that will help children meet expectations and complete assignments. As always, educators should strive to create highly motivating and active lesson activities which include hands-on interaction and physical movement around the classroom, as well as provide opportunities for AD/HD students to self-correct and submit partial work that has not been fully completed. Frequent praise and recognition are essential, especially because children afflicted with AD/HD tend to receive an inordinate amount of negative criticism and feedbackⁱⁱⁱ. In fact, it is recommended that teachers maintain job or “task charts” which display students’ outstanding behavior occurrences and list their assignment submissions with positive affirmations such as stickers or rewards. Students (and adults) who have AD/HD have difficulty focusing on multiple tasks and concepts at time, so teachers should consider “chunking” assignments to simplify learning and allow AD/HD students time to organize their thoughts and internalize instructions.

Those who teach and work with adults might consider additional strategies. Adults who suffer from AD/HD *consistently* exhibit traits such as tardiness, procrastination, argumentativeness, and poor memory. Sadly, many adults have been previously diagnosed with AD/HD in their formative years, but “more times than naught” adults are unaware of their condition and have not been diagnosed or treated. Thus, these people may be unaware of self-coping strategies such as making color-coded lists, using planners and calendars, setting target dates for deliverables, and allowing extra time to get to meetings and appointments^{iv}. Instructors who suspect their adult student(s) has AD/HD could consider employing many of the same strategies mentioned earlier but with the adult learner in mind. These strategies could include breaking down and summarizing learning curriculum into distinct steps, taking advantage of cueing devices and designing learning interventions which include built-in review and summary activities, helping AD/HD students prioritize essential material, providing very clear directions via multiple avenues (written, oral, etc.) which are stripped of superfluous information, recognizing legitimate student achievement while making an effort to provide ongoing positive feedback and reinforcement, and promoting a learning environment that rewards student organization, structure and routine.

In closing, it is now evident to me that AD/HD is a condition which is more prevalent in children and adults than I originally believed. It is due to, rather than socially learned behaviors, a chemical imbalance in the brain which can be treated with medication but never fully cured even into adulthood. As an instructional designer and trainer I will now be more receptive to the idea that a small percentage of my adult learners may be afflicted with AD/HD and that I need to be cognizant of this when designing learning opportunities for future groups and organizations.

ⁱ National Dissemination Center for Children with Disabilities (NICHCY). (January 2004). Attention-Deficit/Hyperactivity Disorder (AD/HD)- NICHCY Disability Fact Sheet- No. 19. Available: <http://www.nichcy.org/pubs/factshe/fs19.pdf>. Last accessed 26 August 2006.

ⁱⁱ Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). (Date of Publication: Unknown). Ask A Question about AD/HD. Available: <http://www.help4adhd.org/faq.cfm?fid=2&tid=14>. Last accessed 27 August 2006.

ⁱⁱⁱ Fowler, M. (April 2002). Attention-Deficit/Hyperactivity Disorder (AD/HD)- NICHCY Briefing Paper-FS14. Available: <http://www.nichcy.org/pubs/factshe/fs14.pdf>. Last accessed 26 August 2006.

^{iv} Jaffe, J Ph.D., Benedictis, T Ph.D., Segal, R M.A., and Segal, J Ph.D. (March 2006). Adult ADD / ADHD: Recognizing the Symptoms and Managing the Effects. Available: http://www.helpguide.org/mental/adhd_add_adult_symptoms.htm. Last accessed 26 August 2006.

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