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Counselling for Facilitating Learning for the Attention – Deficit/Hyperactivity Disordered

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Anyamene, Ada - Department of Guidance & Counselling, Nnamdi Azikiwe University, Awka
E-mail: adaanyamene2002@yahoo.com

Anyachebelu, F. E. - Department of Early Childhood & Primary Education, Nnamdi Azikiwe University, Awka
E-mail: anyachebelufaith@yahoo.com

Abstract

The study investigated the extent of counsellor's identification of the symptoms of attention-deficit/hyperactivity disorder and the counselling strategies the counsellors use to facilitate learning for such learners. Two research questions and two hypotheses guided the study. The design of the study was survey. The area of the study is Anambra State. No sampling was done. 703 counsellors constitute the population of the study. The instrument for data collection was a questionnaire developed by the researchers. The instrument with two clusters was validated and reliability co-efficient of 0.86 and 0.92 were calculated using test re-test. Mean scores were used to answer the research questions while t-test was used to test the hypotheses at 0.05 level of significance. The findings revealed that counsellors could not identify some of the symptoms of attention-deficit/hyperactivity disorder and they do not use some counselling strategies for facilitating learning for the attention deficit/hyperactivity disordered. Also there was no significance different between the mean responses of male and female counsellors on the strategies for facilitating learning. Based on the findings, recommendations were made.

Introduction

Attention – Deficit/Hyperactivity (AD/HD) is now recognized as the most prevalent or common neurological disorder of childhood, affecting children from earliest infancy through school and into adult life (Epstein, Shaywitz, Shaywitz & Woolston, 1991; Shaywitz & Shaywitz, 1991; Golstein, 1999). AD/HD is characterized by persistent and developmentally inappropriate problems with attention, impulsivity, and hyperactivity. Barkely (1997) observes that AD/HD should not be considered as just a developmental disorder affecting childhood. Rather, it should be viewed as a disorder that can attack and disrupt developmental stages throughout the individual's life. Longitudinal research studies have found that children, adolescents and adults with AD/HD remain at significantly higher risk for academic, behavioural and social problems across the lifespan (Barkley 1997; & Weyandt, 2001).

Okeke (2004) observes that students with AD/HD exhibit such additional symptoms as fidgetting, squirming, talking excessively, and abnormally high activity levels for their age. Brown (2001) and Guab & Carlson (1997) have consider the major diagnostic features of AD/HD to be inattention, hyperactivity, and impulsivity. There are individuals in whom one symptom pattern is predominant. Learner & Learner, (1991) also noted that children and adolescents with these disorders are eligible for special education services and may be classified either in the learning disabilities category or in the categories of emotional disturbance. Children and adolescents in this group may exhibit one or more of the following: Inability to maintain satisfactory interpersonal relationships, inappropriate behaviours, a pervasive mood of unhappiness or depression and fears from personal or school problems (Patton & Polloway, 1990).

In the light of the above, counsellors should be aware that other prevalence rates exit for the occurrence of AD/HD. Popper (1988) estimates the general prevalence rate of AD/HD to range between 3 and 10% of the total school age population. Shaywitz & Shaywitz (1992) estimate that AD/HD affects perhaps as much as 20% of the school age population, and it might be only the tip of the iceberg for the number of children with some degree of the disorder. According to Barkley (1997a) (1997b) & Learner (1993) the disorder is one of the most common reasons children and adolescents are referred to counsellors and AD/HD remains one of the most prevalent childhood disorders in our society. These children need to be helped in

schools by counsellors using different counselling strategies. Biederman (2002) maintains that counsellors should be cognizant that the "hyperactivity" component of AD/HD is not always readily observable. Counsellors should use one-to-one interaction, focus attention on the child. Sue & Sue (2000) stress that counsellors should have information on some of the more commonly employed methods, techniques, or tests that can be utilized in handling the client. This involves diagnosis and treatment of the disorder.

Early diagnosis and treatment is necessary to enable children to learn effectively (Anyachebelu & Anyamene, 2008). Such support from counsellors would enable affected children build a firm educational foundation for higher order educational tasks in future. The need for counselling these children and adolescents becomes more crucial when one considers that these children have difficulty responding appropriately and working steadily towards goals and they may not be able to control their behaviour even for a brief period (Elliot, Kratochwill, Cook & Travers 2002).

Therefore, due to the numerous problematic behaviours, social dysfunctions, low academic achievement, low self-esteem that children and adolescents with AD/HD often struggle with in the course of their young lives, counselling remains a key intervention that should not be omitted. This paper therefore examines counsellors identification of symptoms and strategies used in counselling the AD/HD in schools.

Research Questions

The following research questions were used for the study.

1. What is the extent of counsellors' identification of the symptoms of attention – deficit / hyperactivity disordered child?

2. What strategies do counsellors use in facilitating learning for the attention-deficit/hyperactivity disordered child?

Null Hypothesis

The following null hypotheses guided the study:

H_{o1} There is no significant difference between the mean responses of male and female counsellors on the extent of identification of the symptoms of AD/HD disorder.

H_{o2} Gender will not have significant influence on the strategies counsellors use to promote learning for the attention - deficit/hyperactivity disordered child.

Method

The survey design was used to elicit appropriate data for the study. The population of the study consists of 703 professional counsellors from the secondary and primary schools in Anambra State. (Source: ASUBEB and PPSSC, Awka) Because the population for the study was small and manageable, no sampling was made. All the female and male counsellors were used.

Instrument used for data collection was a questionnaire. The questionnaire had two parts – A and B. Part A sought information on personal data while part B sought responses on counsellors' identification of the symptoms and strategies for facilitating learning for attention -deficit/hyperactivity disordered. The items were structured on a five point Likert scale of Always 5 points, Almost Always 4 points, Occasionally 3 points, Rarely 2 points and Never 1 point. The instrument was validated by two experts in guidance and counselling and an expert in measurement and evaluation from Nnamdi Azikiwe University, Awka. For the reliability test, the researchers used test – retest method. Pearson Product Moment Correlation Coefficient was used to calculate the reliability test, it yielded coefficient values of 0.86 and 0.92.

Data were collected through direct approach with the help of five research assistants. Statistical mean scores and standard deviation were used in answering the research questions while t – test was used in testing the null hypothesis. Any item that had a mean score ranging from 3.00 and above was considered as being accepted and items that score below 3.00 were rejected.

Results and Discussion

Table one revealed that counsellors in public primary and secondary schools in Anambra State could identify 11 out of 19 symptoms of attention – deficit/hyperactivity disorder; (8) out of (19) of them are rarely identified by counsellors. This goes to show that counsellors should endeavour to have

more clear diagnostic picture and understanding of individuals with AD/HD. This, Goodman and Poillion (1992) stressed the need for counsellors to be able to identify the symptoms of the AD/HD in children. The disorder is one of the most common reasons children and adolescents are referred to counsellors. Therefore, proper identification of the symptoms is very important which according to Woolf (1999) posits that counselors should use direct observation, interview, one to one interaction and focuses attention to identify children with AD/HD disorder.

It table 2, it was revealed that male counsellors use 9 strategies while female counsellors use 10 strategies in facilitating learning for the attention – deficit/hyperactivity disordered. This showed that male counsellors do not use 11 strategies and female counsellors also do not use 10 strategies out of the 20 items. Counsellors should be ready to devise ways and assist the AD/HD with better management as was stressed by Resnick (2000) that counsellors must be cognizant with strategies to help the AD/HD. Counsellors should be ready to devise ways and assist the client with these strategies. These strategies are very important and necessary because children with such disorder cannot organize themselves and therefore need assistance from counsellors. Learner (1993) opined that counsellors should take charge of their AD/HD problems and also help instill optimism and encouragement that they can have better, and more productive lives.

Table 3 shows that there is no significant difference between the mean responses of male and female counsellors in the extent of identification of the symptoms of AD/HD disorder. It indicates that at 0.05 significant level and 701 df the calculated –t 0.87 is less than the crit-t 1.96. Therefore, the first null hypothesis is accepted. Hence counsellors identification of the symptoms of AD/HD disorder is consistent across gender. This findings indicate a universal identification of the symptoms of AD/HD disorder. Both sexes agree with Okeke (2004) that students with AD/HD exhibit such symptoms as fidgetting, squirming, talking excessively and abnormally high activity levels for their age.

Table 4 above shows that there is no significant difference between the mean responses of male and female counsellors on the strategies for facilitating learning. This is because the calculated value of 0.92 is lower than the critical-value of 1.96, at 0.05 level of significance. This inference was drawn because the t-cal 0.96 is less than the t-crit 1.96. The hypothesis is therefore

accepted. In the finding is expected that male and female counsellors should use these strategies in counselling AD/HD children in school. According to Anyachebelu and Anyamene (2008), early diagnosis and treatment is necessary to enable children to learn effectively. The need for counselling these children using these strategies becomes crucial when one considers that these children have difficulty responding appropriately and working steadily towards goals. (Elliot, Kratochwill, Cook & Travers (2002).

Conclusion

Counselling remains a key intervention that should not be omitted. It is important for counsellors to use these strategies in schools during their individual/group counselling to help the children with AD/HD to facilitate their learning. Counsellors must be sufficiently competent to identify the symptoms of AD/HD in children, providing the kind of support, assistance and information that can enhance the individual's attempts to move ahead.

Recommendations

Based on the findings the following recommendations were made.

- Counsellors should devise ways and assist the client with different strategies, these strategies are very important and necessary to enable the child to be organized.

- Counsellor should establish a good relationship with the child by showing love, trying to help him establish relationship with his peers.

- Seminars, workshops and enlightenment programme should be organized for counsellors.

- Counselling sessions should be better planned, made more timely and designed round many of the issues that are currently revolving round the lives of these children.

- Counsellors should devise ways and assist the client with better time management.

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Table 1: Mean responses of counsellors identification of the symptoms of AD/HD disorder.

S/N	Items	$\overline{x}$	SD	Remark
1	Often fails to give close attention to details.	3.01	0.9	Occasionally
2	Often makes careless mistakes in school work or other activities.	3.62	0.4	Occasionally
3	Often has difficulty sustaining attention in tasks or play activities.	2.60	1.2	Rarely
4	Often does not seem to listen when spoken directly.	3.46	0.6	Occasionally
5	Often does not follow through on instructions and finish school work.	3.21	2.8	Occasionally
6	Often has difficulty organizing tasks or activities.	3.96	0.8	Occasionally
7	Often avoids, dislikes or reluctant to engage in tasks that require sustained mental effort.	3.76	0.6	Occasionally
8	Often loses things necessary for tasks.	2.52	2.0	Rarely
9	Is often easily distracted byextraneous stimuli.	2.62	1.4	Rarely
10	Is often forgetful in daily activities.	2.06	0.5	Rarely
11	Often fidgets with hands or feet or squirms in seat.	3.58	2.9	Occasionally
12	Often leaves seat in classroom or in other situations in which remaining seated in expected.	3.42	1.2	Occasionally
13	Often runs about or climbs excessively in situations in which it is in appropriate.	2.68	2.8	Rarely
14	Often has difficulty playing or engaging in leisure activities quietly.	3.88	1.4	Occasionally
15	Often talks excessively.	3.61	0.7	Occasionally
16	Is often “on the go” or often acts as if “driven by a motor”	2.40	2.9	Rarely
17	Often blurts out answers to questions before the questions have been	3.14	1.6	Occasionally

	completed.			
18	Often has difficulty waiting turn.	2.54	1.7	Rarely
19	Often interrupts or intrudes on others.	2.34	1.8	Rarely

Table 2: Mean responses of male and female counsellors on the strategies they use in facilitating learning for the attention – deficit/hyperactivity disordered children.

S/N	Items	Male			Female		
		$\bar{x}$	SD	Remark	$\bar{x}$	SD	Remark
1	Reinforcers or rewards for success	3.24	0.7	Occasionally	3.36	0.9	Occasionally
2	Use close communication in school	3.56	0.6	Occasionally	3.61	1.8	Occasionally
3	Encourage excursions and field trips	2.37	1.1	Rarely	2.42	0.8	Rarely
4	Give out appropriate information	3.96	0.4	Occasionally	3.81	0.6	Occasionally
5	Give individual attention	3.42	1.2	Occasionally	3.56	0.6	Occasionally
6	Give accurate empathy	3.06	0.5	Occasionally	3.24	0.7	Occasionally
7	Use time management	2.63	1.8	Rarely	2.88	1.4	Rarely
8	Give appropriate homework assignments	2.42	2.2	Rarely	2.34	1.6	Rarely
9	Help instill optimism and encouragement	2.63	1.8	Rarely	3.00	0.7	Occasionally
10	Being proactive in meeting the client	2.24	1.8	Rarely	2.50	2.0	Rarely

11	Use losts of pictures to help them learn	2.88	1.4	Rarely	2.52	0.6	Rarely
12	Review the clients note books	2.50	2.0	Rarely	2.63	1.8	Rarely
13	Make explicit the positive qualities and tracts the child possess.	2.78	0.6	Rarely	2.54	1.7	Rarely
14	Use feedback to improve children's behaviour	3.34	0.7	Occasionally	3.62	0.4	Occasionally
15	Use role – playing	3.24	0.8	Occasionally	3.37	1.1	Occasionally
16	Self-talk	2.32	0.9	Rarely	2.71	0.8	Rarely
17	Give self-esteem building exercises	2.63	1.8	Rarely	2.88	1.2	Rarely
18	Encourage active participation of the children in school work.	3.04	1.6	Occasionally	3.96	0.4	Occasionally
19	Plan home visit	2.36	0.8	Rarely	2.21	1.1	Rarely
20	Build rapport with the child	3.21	1.0	Occasionally	3.81	0.6	Occasionally

Table 3: t-test on male and female counsellors in the extent of identification of the symptoms of AD/HD disorder

Respondent	N	$\bar{X}$	Sd	Df	Cal-t	Crit-t	Decision
Male	64	2.82	0.67				
				701	0.87	1.96	Accepted
Female	639	3.07	0.71				

Table 4: t – test on male and female counsellors on the strategies use in facilitating learning for the attention – deficit/hyperactivity disordered children

Respondent	N	$\bar{x}$	Sd	Df	t-cal	t-crit	Prob	Decision
Male	64	2.89	0.53					
				701	0.92	1.96	0.05	Accepted
Female	639	3.04	0.68					