What’s in it for me? New perspectives on motivating students with AD/HD

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Abstract

Despite vast volumes of research into the Attention Deficit/Hyperactivity Disorder (AD/HD) and its impact on students, problems in the classroom which have AD/HD connections continue to be reported. There appears to have been little positive impact on the ability to motivate and moderate the behaviour of students with AD/HD from the plethora of empirical findings and the subsequent increased understanding of the disorder. This paper makes reference to two independently generated, yet complementary sociologically-based theories concerned with the experience of students with AD/HD and their carers respectively. One aspect of the findings of both studies was strikingly similar, that is that students with AD/HD have active agency in relation to their inattentive and hyperactive behaviours, which cause so many issues in the classroom. In essence, these students choose to act in a particular manner based on a number of conditions which were identified by both the students themselves and by their carers. How these theories might translate to improved classroom practices to benefit the educational and social outcomes of students with AD/HD is discussed.

Introduction

Attention Deficit/Hyperactivity Disorder (AD/HD) is currently, arguably one of the most intensely researched phenomena in educational psychology. An indication of the growing level of research interest is evident in the listings of the major databases of research literature, ERIC and PsychINFO. In the 1980s there were 44 listings for

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AD/HD-related articles in the two databases, in the 1990s this had exploded to 3302, a 7500% increase. Already in the 2000s there are 5921 articles listed in the two databases which focus on AD/HD.

The reason for the extensive research focus on AD/HD relates to the wide variety of stakeholders that claim an interest in the disorder. The phenomenon occupies the attention, not only of sufferers and their families, but also of legislators, law enforcement agencies, the medical and scientific professions, and educators. The principle drivers for the vast expenditure of research energy on AD/HD is the prevalence of social problems which have been linked to AD/HD. Recorded long-term effects of the disorder include higher risk of low academic achievement, poor school performance, school suspensions and expulsions, vocational and employment problems, anxiety and depression, aggression, conduct problems and delinquency, early substance experimentation and abuse, driving accidents and speeding violations. Impaired social-emotional development, extending into adulthood, may lead to difficulties in adult social relationships, including peer and family relations and marriage. (Barkley, 1990; Barkley, Fischer, Edelbrock, & Smallish, 1990; Barkley, Guevremont, Anastopoulos, DuPaul, & Shelton, 1993; Biederman, Faraone, & Lapey, 1992; Hinshaw, 1994; Nadeau, 1995; Weiss & Hechtman, 1993). It is perhaps not surprising, then, that there is an over-representation of AD/HD-diagnosed individuals amongst prison populations (Collins & White, 2002).

An awareness of the phenomenon known as Attention Deficit/Hyperactivity Disorder has permeated the wider community moving beyond the academic and professional literature into the popular press. Few would be unfamiliar with the acronyms, AD/HD, or its predecessor, ADD (Attention Deficit Disorder), which have established themselves firmly in the popular lexicon.

Despite the extensive body of research into the disorder, the increased public awareness and advances in understanding of the disorder, the outcomes of sufferers, in particular, the academic and social achievements of students with AD/HD, remain disappointing (Barkley, Fischer, Smallish & Fletcher, 2004). The wealth of research has done little to establish a consensus regarding AD/HD. Debate rages around almost every aspect of the phenomenon, from its prevalence to the validity of the diagnostic process, from arguments relating to the most effective means of treatment and intervention to controversy surrounding the very existence of the condition. There is, in the case of AD/HD, a very apparent disconnect between the empirically-
supported increased understanding of the phenomenon and any resultant substantial and widespread improvement in the lives of individuals diagnosed with the disorder. Far from improving, in the classroom, the problems associated with AD/HD appear to be escalating.

**AD/HD in the Classroom**

In the classroom, AD/HD impacts in a variety of ways. For those with AD/HD the educational and social outcomes often remain unsatisfactory. Beyond the sufferers, negative consequences may occur for other students, and also the teacher, as a result of having one or more students with AD/HD in the classroom. While the general consensus is that the prevalence of AD/HD among school-aged children is 3-5% (American Psychiatric Association, 1994), others (Searight & McLaren, 1998; Whalen, 1989; Zentall, Harper, & Stormont-Spurgin, 1993) have reported much higher incidence. Regardless of the debate surrounding prevalence, there is evidence (Robinson, Sclar, Skaer, & Galin, 1999) and general acknowledgement of an increase in the documented diagnosis of AD/HD. Consequently, there exists an ever-increasing probability that teachers entering classrooms today are likely to have a proportion of students diagnosed with AD/HD in their charge.

 Behaviour management is an issue of considerable concern in classrooms today (Arbuckle & Little, 2004). Some of the behaviour management problems have children with AD/HD as the main offenders (Flick, 1998; Giorcelli, 1997; Hewitt, 2002(a); Hewitt, 2002(b); Purdie, Hattie, & Carroll, 2002; Slamet, 2002). The spectrum of behaviours, which can cause problems in the classroom include bullying, harassment, alcohol and drug abuse, violence, stealing, truancy, racism, sexism and prejudice (Krause, Bochner, & Duchesne, 2003).

 Often disruptive behaviour, that is relatively minor in severity, can escalate into more challenging episodes which may endanger the safety of both teacher and students (DuPaul, Eckert, & McGoey, 1997). The actions of students with AD/HD in the classroom can, in extreme cases, raise serious issues of duty of care. The safety of the individual student with AD/HD, other students in the classroom and even the teacher may be at risk. More commonly, though, the actions of students with AD/HD within the classroom cause teachers concern in less physically hazardous ways. For
example, the frequently disruptive behaviour of students diagnosed with AD/HD, which can manifest as inappropriate interruptions, classroom chatter, off-task behaviour or attention-seeking activities, can generate an atmosphere within the classroom that is detrimental to teaching and learning. Thus, not only is the academic progress of the individual with AD/HD impeded, so too is that of his peers.

Teachers struggle to manage these students in an environment that is at odds with the behaviour patterns of individuals with AD/HD (Giorcelli, 1997). Schools require compliance to maintain order and teachers traditionally employ methods designed to enforce this order. Such methods are often anathema to students with AD/HD who are known to have difficulty beginning and completing tasks, following teachers’ instructions, engaging in repetitive activities, planning an apparently logical sequence of actions, dealing with change and transitions, complying with social routines and courtesies and generally conforming to teacher expectations of behaviour (Parker, 1992).

A diversity of complex dilemmas faces the teacher of students with AD/HD since they present in a number of different and demanding ways in the classroom. Whether aggressive, hyperactive, impulsive, passive, distractible or a combination of these, their age-inappropriate behaviour confronts and challenges teachers. The teacher’s attention to these behaviours can be time consuming and generally non-productive. Teachers can spend a disproportionate amount of time attempting to regulate the undesirable behaviour of a few while at the same time endeavouring to teach the class as a whole. This multi-tasking on the part of the teacher is invariably unsuccessful, with little or no lasting improvement in behaviour management being achieved.

Typically, the methods of discipline control employed by the teachers tend to be those generic, routinely-used approaches that are sanctioned by the school as a means of behaviour management. It is not uncommon, in the hectic classroom environment, for sanctions to be administered without due consideration of the circumstances influencing the student’s behaviour. A policy of ‘one size fits all’ frequently prevails when it comes to punishment. In this regard, the teacher is placed in an awkward situation, for if he/she does vary the punishment according to the individual rather than the crime then, feelings of injustice quickly surface amongst the students.
What works for most students, more often than not, does not work for students with AD/HD. The lack of response to the efforts of teachers to moderate the behaviour of students with AD/HD not infrequently leads to extreme frustration for the teachers (Hallowell & Ratey, 1994). Compounding the uncertainty and frustration experienced by teachers is the fact that their attempts to moderate the non-conforming behaviour of students with AD/HD are performed in an atmosphere of conflicting arguments regarding diagnosis, labelling and pharmaceutical interventions (Barkley, Cook, Dulcan, & Campbell, 2002). A number of factors conspire against their best efforts. First, the teachers are not always informed of the diagnostic status of the students in their care. This can happen for a number of reasons, including issues of confidentiality or administrative oversights. Secondly, those students who do have AD/HD can be either diagnosed and on medication; diagnosed and not on medication; or undiagnosed. To further complicate the scenario, there is the potential for there to be students in the classroom who have been incorrectly diagnosed with AD/HD, due to what is sometimes regarded as the subjective nature of the diagnostic process (Goodman & Poillion, 1992; Moss & Sheiffele, 1994). The range of behaviours these students are likely to display, whether diagnosed or not diagnosed with AD/HD, and whether medicated or not medicated, places considerable demands on the teacher’s ability to control or at least moderate their actions. Thirdly, behaviours that mimic those of a student with AD/HD can be exhibited by non-AD/HD students (Cantwell, 1996) who may well respond differently to a teacher’s efforts to maintain appropriate behaviour in the classroom. This causes confusion for teachers about which strategies are useful and which result in little effect. Giorcelli (1997) reasons that teachers’ efforts have been “bedevilled” and “[a] great deal of pedagogical energy has been wasted…obfuscating educators’ vital work of having students learn more effectively (despite their presenting behaviours”).

Improvement in the management of AD/HD behaviours in the classroom has progressed little despite the vast volume of research dedicated to a better understanding of the disorder. There are many in the classroom who could benefit from improved practice in this regard. As has been noted here, the negative impact of AD/HD in the classroom goes beyond the students whose academic and social achievements may be hampered by their diagnoses; it reaches the other members of the class and the teacher. The current level of understanding of the disorder is
informed by historical developments and recent research resulting in a contemporary conceptualisation of AD/HD.

The Contemporary Conceptualisation of AD/HD

Since the AD/HD phenomenon was first described more than a century ago (Still, 1902) there has been a number of explanatory models and theories developed (Chess, 1960; Douglas, 1972, 1980, 1983, 1988; Glow & Glow, 1979; Gray, 1982; Laufer & Denhoff, 1957; Quay, 1996; Zentall, 1985). Much of the research on AD/HD has focused experimental designs on the deficit perspective, what the child with AD/HD cannot do. Those currently receiving most attention are the cognitive–energetic model of AD/HD (Sergeant, 2000), Barkley’s (1997) unifying theory of AD/HD, the dopamine hypothesis of AD/HD (Swanson et. al., 1998) and the dual biopsychological pathways model of AD/HD (Sonuga-Barke, 2002). All these models have resulted from the positivist-based study of the symptoms and behaviour patterns of individuals with AD/HD, and are located within neurological/psychological frameworks. For instance, Sonuga-Barke (2002) argues that psychological accounts of AD/HD have characterised AD/HD as either a neuro-cognitive disorder that implicates executive dysfunction (Barkley, 1997) or a motivational style, implicating sub-optimal reward processes (Haenlein & Caul, 1987; Sagvolden, Johansen, Aase, & Russell, 2005; Sergeant, 2000; Zentall & Zentall, 1983).

Executive functions are involved in deliberate goal orientated control of behaviour; children with AD/HD have difficulty, for instance, with paying attention in class, waiting their turn and keeping track of homework. These goal-directed behaviours require multiple abilities controlled by executive functions and include the ability to hold information in mind and suppressing irrelevant behaviour (Nigg, 2006).

Conversely, motivation-based dysfunction models shift the focus from core deficits in executive function or elements of executive function to a suboptimal reward processes (Sonuga-Barke, 2003). These sub-optimal reward processes result in a steepened delay-reward gradient, where abnormal weighting of delayed and immediate stimulation leads to overactive inattentive and impulsive behaviour (Nigg, 2006). These models would predict that, in an educational setting, the child would be
constantly trying to perceive and seek out sufficient immediate and concrete stimulation because of the sub-optimal reward processes. However, if they do not perceive enough stimulation from the required task then this would result in them seeking out additional stimulation, possibly resulting in inattentive, hyperactive and impulsive off-task behaviour.

The historical developments, together with the current medical models, have resulted in the contemporary, most common and generally accepted understanding of AD/HD. This conceptualisation identifies the phenomenon as a genetically-based, neurobiological disorder, with primary symptoms of hyperactivity, impulsivity and distractibility, which may exist as individual or combined symptoms. There is a ‘consensus’ (Barkley et al., 2002) that while there is a genetic link, which predisposes individuals to the condition, environmental factors can play a modifying role in the severity of the condition. This accounts for the interventions employed which fall into the broad categories of pharmacological, behavioural and educational. The most frequently employed intervention involves pharmacotherapy, either in isolation or in combination with behaviour modification therapies and educational interventions.

The disorder is typically diagnosed by medical practitioners or psychologists. The diagnostic procedure involves comparing the actions of an individual against a checklist of behaviours listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994). A positive diagnosis is delivered when six or more of the identifying behaviours have been present often, for at least six months, and have occurred across two or more settings, including home, school and peer relationships. There should be evidence of “clinically significant impairment” in social, academic or occupational functioning and some symptoms must have been observed before the age of seven. It is most usual for a child with AD/HD to also exhibit the presence of other co-morbid psychosocial disorders such as Obsessive Compulsive Disorder (OCD), Conduct Disorder (CD) and Oppositional Defiant Disorder (ODD), as well as anxiety and mood disorders. Some children with AD/HD experience learning difficulties, while others can be academically gifted. Many, but not all, individuals with AD/HD will continue to suffer the disorder into adulthood.

Notwithstanding the generally accepted understanding of AD/HD outlined above, the level of dissent and disagreement, which surrounds certain aspects of the conceptualisation, is growing substantially. The volumes of ‘how to’ books and the
abundance of AD/HD-dedicated websites offering advice to teachers and parents in their interactions with their AD/HD-diagnosed children are testament to the fact that, despite the level of research, the problem is growing and is, as yet, substantially unresolved.

It is arguable, therefore, that new perspectives are needed to address this problem. Indeed, calls to reconceptualising of the AD/HD phenomenon have begun to be heard (Tannock, 2005; Tannock & Martinussen, 2001). Prosser (2006) argues that “we are encouraged to ask why students fail in school and society, but not to ask how school and society may fail our students” (p.4) and that “past responses to ADHD have been too individual, medical, deficit laden and incomplete (p.6). A review of the extensive body of AD/HD-related literature reveals that, to date, studies have been located predominantly in the medical and neuropsychological paradigms. Little attention has been devoted to the phenomenon from sociological viewpoints. The research described in this paper is one example of this rarely-employed approach to studies into attention deficit disorders.

New Perspectives

This paper describes two independently generated, yet complementary, interpretivist studies. The first is concerned with the perspectives of the child with AD/HD and the second with the perspectives of the primary caregivers, predominantly the parents, of children with AD/HD. The substantive theories developed from this research are explained and incorporated with current theoretical models of AD/HD. How the understanding proposed by this research might translate to improved classroom practices to address motivational aspects of children with AD/HD, thereby enhancing their educational and social outcomes of the child with AD/HD, and reducing the stress of the classroom teacher, is discussed.

The Theories

The theory of self-sufficient reward control
This theory was the major outcome of a doctoral research project (Partridge, 2006) which sought to better understand the AD/HD phenomenon from the perspective of adolescent boys who had been diagnosed with the disorder. The study, employing a symbolic interactionist theoretical framework and grounded theory methodology,
represented a little utilised approach amongst the plethora of quantitative studies that dominate the field of AD/HD research.

The central research question of the study, how do adolescent boys diagnosed with Attention Deficit/Hyperactivity Disorder (AD/HD) respond to the efforts of their teachers to modify their actions? was in response to the experience that, for the most part, the methods that teachers employ to motivate students with AD/HD, are largely ineffectual.

In the tradition of grounded theory methodology, the theory of self-sufficient reward control emerged through “link[ing] subcategories to a category in a set of relationships denoting causal conditions, phenomenon, context, intervening conditions, action/interactional strategies, and consequences” (Strauss & Corbin, 1990). Each cycle from causal conditions to consequences denotes one phase of the theory. The processes that students diagnosed with AD/HD engage in when a teacher attempts to motivate students and manage their actions constitute the basis of the theory.

In essence, the theory states that, students with AD/HD generally are indifferent to the efforts of their teachers to motivate them to behave in a particular way, preferring instead to act in a manner that is most rewarding to them. They make a decision having weighed the consequences of their actions, and often choose the non-conforming behaviour because, notwithstanding potential negative consequences, it is, for them, still the more rewarding. When their chosen, non-conforming action meets with disapproval from others, the students are forced to review their behaviour and, in so doing, have a sense of not fitting in, which subsequently results in the students with AD/HD experiencing tension. As a means of releasing tension, the students often have a chosen activity in which they engage that takes them into a ‘world of their own’. This process can set up a cyclical pattern whereby the consequence of retreating to a ‘world of their own’ exacerbates the feeling of not fitting in and the series of actions/interactions from not fitting in, to retreating into a ‘world of their own’ is repeated.

Since externally administered ‘rewards’ offered by teachers to motivate students were found to be met with indifference, the study explored in detail the chosen or preferred activities of the boys with AD/HD, in order to gain a better understanding of what the students found rewarding and motivating, and consequently what influenced their actions. The theory of self-sufficient reward
control elaborates on the chosen actions of boys with AD/HD stating that they possess a number of common properties. Typically, the chosen or preferred activities of adolescent boys diagnosed with AD/HD provide them with intrinsic motivation, including a sense of accomplishment and self-achievement. In addition, the activities are often solitary, creative and challenging. Importantly, the activities provide the boys with a degree of escapism.

The theory of gaining control

This theory was the major outcome of a doctoral research project that is nearing completion (Williams, 2007). The research examined the perspectives of 20 parents of children with AD/HD (combined subtype), who had decided not to have their child medicated for AD/HD, regarding their education. This study employed a interpretivist paradigm and data were analysed using a grounded theory approach (Strauss & Corbin, 1998). The substantive theory that emerged describes the processes that parents engage in between the presentation of a challenging situation associated with the behaviour of their child with AD/HD, and the distress that parents experience associated with those behaviours.

The theory states that when parents are presented with a challenging situation associated with their child’s inattentive, hyperactive and impulsive and often non-compliant behaviour, parents used one of two broad coping processes; either cognitive or emotional. The key factor that was associated with which process was employed was the interpretation of the challenging situation and this could be either as manageable or as a threat. If the challenging situation is perceived as manageable then this was dealt with using a cognitive process in a non-emotive way. The parent and child then operated within a parent created environment, this allowed parents to create the conditions under which there could be a controlled resolution of the problem situation and relatively little distress. Conversely, if the challenging situation is interpreted as a threat then this was dealt with using an emotional process, reacting to the child’s behaviours. The parent and child then operated within a child created environment, that is, they reacted to the child’s behaviours with little cognition and this was associated with uncontrolled resolutions of the challenging situation and significant distress.

One of the key components of the cognitive process is sharing control which involved genuinely listening to the child, respecting their opinions, negotiating with
them and enforcing reasonable boundaries and consequences; this was associated with more controlled resolutions, where there were voluntary agreements, and this was associated with only mild to moderate distress. In this way both the parent and the children achieved a measure of control by choosing a particular path of their own volition. Conversely, a key component of the emotional process was forcing control which involved more coercive means of achieving control, for example, threatening, shouting, pleading and using physical measures. This was associated with high degrees of oppositional and emotional behaviour from the child, uncontrolled resolutions, no voluntary agreement and was associated with severe distress. Thus, there seemed to be a paradoxical effect where as parents tried to exert more overt coercive controlling measures they actually achieved less actual control than those parents who were attempting to use more cooperative measures.

One of the key elements within sharing control appears to be the choice that is given to the child; they enter into a reasoned negotiation with the parent and negotiate a resolution. However, the data suggest that only a few of the parents interviewed were consistently able to share control and this appeared to be mediated by the degree of stress and the resources that they had at the time of the problem situation. This suggests that sharing control is a process that requires extensive skills and emotional resources. However, it does not mean that parents employing forcing control are deliberately choosing an emotional process but it does suggest that they may be simply reacting to a situation that they felt they have insufficient resources to deal with.

Discussion

The substantive theories described in this paper do not claim generalisability beyond the confines and context of the respective studies from which they were generated. Rather, they indicate ‘possibilities’ by providing a new perspective and a revised understanding of the phenomenon of AD/HD, which may assist those working with with AD/HD, to develop their own strategies. While the first study had an educational context, the second study focused primarily on the interaction between caregiver and child. For the teacher, ‘in locus parentis’, these findings may offer valuable and relevant insight into their relationship with their students.
The two studies, though independent, resulted in complementary findings of surprising synergy. *Choice* and *decision-making* appear to be central to both theories. The theories help to disentangle the processes that are involved in the *decision-making* of the child and his or her caregiver; they offer a basis on which more cooperation can be built. The *theory of self-sufficient reward control* suggests that the child is *choosing* a particular behaviour in a conscious *planned* manner, trying to gain control over his environment, to maximise the opportunities for sufficient stimulation and that this is weighed against possible consequences. The ‘*theory of gaining control*’ suggests that the parents who *share control* with their child, actively engage their child in the *decision-making* process resulting in the child *choosing* a negotiated set of behaviours.

Both child and caregiver might ask: “What’s in it for me?” The importance of the child’s personal agency is apparent in both theories. The *theory of self-sufficient reward control* suggests that the child is *indifferent* to classroom rewards and punishments and chooses their behaviour based on balancing what they think they are going to get out of it against the possible negative consequences of that action. The ‘*theory of using gaining control*’ suggests that gaining the child’s cooperation is associated with allowing him or her to negotiate and exert personal agency over their actions. This, in turn, is associated with better outcomes for both child and adult. In essence, it appears that having personal agency may allow the child to internalise and accept decisions based on joint negotiations. The personal agency that is given to the child and the personal control attained by the caregiver could be regarded as both the child and the caregiver achieving *autonomy*, such that they both have considerable volition over their own actions.

The positive link between autonomy and motivation has previously been established. Autonomy is seen as one of the central tenants of self-determination theory (Ryan & Deci, 2000) and an essential component in facilitating intrinsic motivation. Moreover, anything that undermines personal autonomy leaves the individual feeling controlled and is likely to decrease intrinsic motivation (Deci & Ryan, 1995). It has also been found that parents who facilitate autonomy in their child positively predicted children’s self-regulation and an inverse relationship with poor behaviour such as acting out (Grolnick & Ryan, 1989). In relation to the classroom setting, Reeve (2002) concluded that the findings of two decades of empirical studies indicated that, “autonomously-motivated students thrive in educational settings [and]
students benefit when teachers support their autonomy” (p.183) The concept of seeking and facilitating personal agency, that is implicit in both theories, contrasts with the generic routinely-used methods of behaviour management employed by teachers in the classroom. Frequently, operant conditioning principles are employed in the administering of rewards and punishments which is contingent on student behaviour. In this situation the control is with the teacher and the child either complies or does not. In these situations, genuine choice, which the theories argue is central to the positive and productive behaviour of the child, is absent.

The theory of gaining control suggests that sharing control is associated with the caretaker’s interpretation of the challenging situation. If the challenging situation overwhelms the caretaker’s skills and resources then this is associated with a threat interpretation and is associated with forcing control over the child. Conversely, if the challenging situation is within the caregiver’s skills and resources then this is interpreted as manageable and associated with sharing control with the child. This suggests that building the specific skills and resources of the caregiver to enable a productive interpretation of the problem may be the key to moving from a negative reactive environment to a positive proactive environment. Further, this is consistent with the theory of self-sufficient reward control and the findings of self-determination research that suggest that a child is likely to respond positively to an environment that encourages choice and autonomy. Together, the theory of self-sufficient reward control and the theory of gaining control suggest that it may be possible to have to have a better working relationship with the child with AD/HD. It offers a means of understanding how to work with the child in a more cooperative manner with the likelihood of achieving a better outcome for both the child and the teacher.

Just as the two theories described here work well together and at the same time reflect previously established theories of motivational psychology, they also complement the existing models and theories which currently inform the understanding of AD/HD. For instance, the theory of self-sufficient reward control proposes that the child engages in planned, decision-making processes, choosing to pursue the most stimulating or rewarding option open to them. This is consistent with many of the motivational accounts of AD/HD that implicate sub-optimal reinforcement processes. (Haenlin & Caul, 1987, Sagvolden, Johansen, Aase, & Russell, 2005, Sagvolden & Sergeant, 1998, Sergeant, 2000, Zentall & Zentall,
1983), Both the established psychological view and the new sociological perspectives would predict that the child with AD/HD decides on the most stimulating choice and acts accordingly. Unfortunately, in many cases this may not be their schoolwork.

While the theories, emerging from this novel perspective, do not contradict existing models of AD/HD, by providing alternative and new views on the disorder, they do challenge some aspects of the accepted understanding. The most prominent of these is the common public perception supported by theoretically reasoning (Barkley, 1997) that individuals with AD/HD are impulsive and unable to inhibit inappropriate behaviours. The two theories described in this paper offer an alternative explanation, consistent with the motivational accounts of AD/HD. That is that children with AD/HD may appear impulsive because of the child’s pursuit of a higher stimulating/more rewarding environment but that this pursuit is largely under cognitive control. It follows then, that there is an opportunity for the teacher to facilitate autonomy and thus self-determined behaviour, to help the child choose more productive behaviours in the classroom. This is consistent with many anecdotal accounts from parents and teachers where these children appear to be able to be engaged in productive behaviours with many activities that they find interesting. It can be reasoned, that this is because the children find the pastimes sufficiently stimulating and that they have chosen to be involved in the activities. Thus, these two theories offer support to the contention that AD/HD may be more a performance deficit, that can be moderated by certain conditions, as opposed to an ability deficit.

How the altered insight into the understanding of AD/HD might better inform classroom practice to improve the outcomes of students with AD/HD becomes the next big challenge. Interestingly, in terms of suggested practice, much of what the two theories propose is already acknowledged as best pedagogical practice. For instance, the imperatives of ensuring that learning activities are personally motivating to the students, are challenging and creative, all resonate with the properties of the preferred activities of the students with AD/HD as identified in the theory of self-sufficient reward control. Likewise, the trend towards negotiated curricula also echoes the propositions of the theory of gaining control.

Translating theoretical findings and empirically-based evidence into altered and improved practice is traditionally an uneasy transition. Several writers and researchers have lamented the reality that research generally (Hadley, 1987), and qualitative social research specifically, infrequently informs policy and practice.
Notwithstanding, these hurdles, Silverman (2005 p.366) recently observed that “there is some evidence that public bodies are starting to take qualitative research more seriously”.

Apart from the handicap that qualitative research faces in informing classroom practice, there are also daunting systemic obstacles which present themselves. In an ideal world, all students would have their individual learning needs addressed, recognising that they are not all the same and that they sometimes require different and diverse strategies to motivate and inspire them. In reality, teachers who are required to be all-things-to-all-students, often find themselves over-worked in under-resourced and over-crowded environments, where whole of class teaching rather than attention to individuals’ learning styles becomes the only feasible strategy.

It is not the intention or purpose of this paper to add to the litany of ‘how to’ sources of specific teaching strategies, but rather to act as a guide for educators to use in the construction of their own approaches. Tannock and Martinussen (2001) have called for a new way of conceptualising the AD/HD ‘disorder’. In this paper, a call is made for teachers to review the way in which they perceive their students diagnosed with AD/HD. This is important since it is the teachers, as practitioners, who are at the pedagogical ‘coalface’ and who have greatest involvement with the development and maintenance of classroom strategies. Effective classroom procedures then require a sympathetic vision from these guardians.

The theories outlined in this paper move away from the established medical and psychological models to a social perspective. As such, the reader is obliged to adopt an unfamiliar standpoint. This, in turn, requires alternative views on a number of issues. Predominantly, the findings of these studies discourage the labelling of AD/HD-diagnosed students in favour of seeing them as individuals with recognisable strengths and attributes that can be utilised in the classroom. Data collected suggested that they are strongly independent which has customarily been interpreted as ‘non-conforming’ and hence ‘deviant’. The advantages of this altered view are obvious and include negating any self-fulfilling prophecy of labelling (Klasen, 2000). For example, learned helplessness and using the diagnosis as an excuse (Milich & Okazaki, 1991) for what might be deemed the inappropriate actions of AD/HD students may be eliminated or substantially reduced if a renewed vision informs renewed practice.
Once the focus shifts from ‘deficits’ to ‘attributes’ it is clear that many of the observed qualities of the AD/HD-diagnosed boys are commendable and represent those that teachers and education systems generally advocate as desirable outcomes for their students. These qualities include being intrinsically motivated, independent learners who strive to achieve in their chosen activities. Collectively, these qualities might be described as self-determination or self-sufficiency. In the currently prevailing view of AD/HD, this quality is mostly labelled ‘non-conforming’ and is judged as inappropriate since it often results in actions that do not meet outsiders’ expectations. Taking the insider’s perspective, that is the view of the individual with AD/HD, sheds a more positive light on this characteristic.

In summary, it is hoped that teachers might start to see the world from the viewpoint of their AD/HD students. In so doing they may come to appreciate that the qualities intrinsic to their students with AD/HD represent essential components for the successful production of positive outcomes for these students.

References


motivation social development and well being. *American Psychologist, 55*, 68-78.


