how to focus the distractible child

Annabelle Nelson-Burford
HOW TO FOCUS THE DISTRACTIBLE CHILD

by

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Annabelle Nelson-Burford

To my father, Lee Nelson
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INTRODUCTION

This book came from the integration of a number of disciplines and areas of study in my life and experience that were at first quite separate. It is a synthesis of my formal training in special education, professional experience as a teacher trainer and college teacher, and my personal exploration of imagery, yoga, and relaxation techniques to enrich my life.

Several years ago I decided to put together my experience and knowledge of children with learning problems with my personal development through what we might call right-brain activities. As a result I started working with teachers at first in Oregon and later in Arizona to adapt my experiences to see if they would help children. The success of these adaptations has prompted the writing of this book.

I call the children in question distractible, because I think that is the most descriptive term. In special education the term that would fit most distractible children is learning disabled. However, the approach of this book is designed to meet the needs of all children, those that would be classified learning disabled and those children who seem a bit scattered.

One purpose is to dispel ideas about distractible children, which are not substantiated by current research in special education. There are a number of beliefs in the general populace that children make letters backwards because they have brain damage or that some children cannot pay attention because they missed the crawling stage. Chapter One describes the behavioral characteristics of distractible children and gives a history of labels used by
special educators to categorize these children, what treatments have been developed, and what current research says about the effectiveness of these methods.

Also in Chapter One, one technique from behavior modification, self-instruction or behavior rehearsal, is reviewed and proposed as an effective coping strategy for distractible children. This technique above other procedures from behavior modification is emphasized, because it teaches children a strategy to deal with the inability of focusing and concentrating attention.

Other coping strategies unfold through subsequent chapters in the book, always with the purpose of teaching children how to control and work with their attention. The strategies are imagery, relaxation techniques and yoga. The idea is to empower distractible children so that they can develop self-control. The book also reviews recent theories on the root of distractible children's problems. One theory deals with the lack of selective attention, one deals with the lack of impulse control, and one proposes an underactive neurotransmitter in the brain as the crux of the problem. These theories are tied to the coping strategies proposed.

Some information is also given on styles of processing information by the brain, explaining what is thought of as left brain and right brain styles. Distractible children appear to have a propensity for right-brain processing styles which includes divergent thinking, imagery, movement, and musical abilities. The notion that distractible children have a propensity for right-brain processing but cannot control it is discussed resulting in recommendations for education. A classroom environment which imposes left-brain information processing styles (language, linear thought) on these children is indeed an unfriendly environment and one that promotes failure.

My hope is that this book will prompt educators and parents to consider ways to make these children's nature of divergency a strength instead of a handicap.

Annabelle Nelson-Burford
Prescott, Arizona
April, 1984

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CHAPTER ONE

CHARACTERISTICS, LABELS, AND HISTORY

Distractible children act a certain way which is different from most other children. These actions, or behavioral characteristics, make them unmistakable. The first and foremost characteristic is inattention. Distractible children do not pay attention during group discussions when the teacher is in front of the room asking students questions and responding to students' comments. Instead of paying attention, a distractible child will doodle on paper, gaze out the window, repeatedly drop and pick up a paper, engage a neighbor in conversation, squirm in the chair, or get up to sharpen pencils. Distractible children are also inattentive to teacher direction. Many times in elementary classrooms, teachers will give the class directions as a group, and then expect children to complete work independently. A distractible child does not follow through: instead of completion there is confusion. Because of inattentive behaviors, teachers and parents describe these children as lazy. It appears that the children make no effort to apply themselves to their work.

The second characteristic is that these children may actually look different than other children. They have an unkempt appearance and their desks look messy. They may shy away from having others touch them, and appear uncoordinated.

Engaging in behaviors that interfere with learning is the third characteristic of distractible children. Since these
children are not succeeding academically, they create diversionary tactics. One tactic is to act out. Aggression gives a momentary feeling of power and separates a child from the situation of failure. However, in the long run, being rough with other children or resistant to authority compounds the problem of distractibility. Another tactic is to become withdrawn. This is the polar opposite of acting out, but it has the same net effect of removing a student from a learning situation. By becoming withdrawn, and avoiding teachers and other students, distractible children avoid facing situations where they fail. A final avoidance tactic is responding to teacher's questions with random guesses. Distractible children often give wrong answers, and they soon learn that there is no reason to try too hard. They will usually come up with the wrong answer anyway. The children have learned a coping strategy based on their past failure. If they try, they expend effort only to produce the wrong answer. If they guess without trying, they can avoid the situation, since teachers may tell them the correct answers. All three tactics, aggression, withdrawn behavior, and random guessing, set a pattern to create increased academic failure.

Distractible children certainly do have positive features to balance the frustration teachers and adults experience in working with them. They have normal or above normal intelligence. They are characterized by an uneven level of development. For example, a child may excel in reading and fail in math. Or a child may be quite good at comprehending what is heard, but cannot comprehend what is read. These children often seem to “sense” things, or to be very empathetic with others. Many are friendly and affectionate. Some have a gift for the visual arts, dance, or movement.

The behavioral characteristics of any given distractible child are unique. No distractible child would have all the characteristics reviewed above. However, the key to pinpointing such a child rests with the characteristic of being unable to sustain attention to listen or to complete a task.

THREE VIGNETTES

Jill is a distractible child. She is 9 and is in fourth grade. She is attractive and affectionate. She can express herself verbally very well. She will tell a classroom visitor all about her activities the day before. At first, an observer would guess that Jill has no problem in school. Once work begins, that assumption changes. While other children work, Jill fidgets, drops pencils, sharpens pencils, and wanders the room. As long as the teacher is next to Jill and talking to her, things go smoothly. Jill answers the teachers questions correctly and follows instructions. But when the teacher leaves, Jill stops work. She tries to engage other children in conversation, and at times she interrupts the teacher when the teacher is with another student. Jill's desk is disorderly. During group discussions, Jill raises her hand frequently, but her comments do not fit the content of the discussion.

James is in second grade. He is eight. He is a nice looking child and is well groomed. Careful examination shows that his belt is very tight, as if he wants the belt to tell him where his body starts and stops. He shies away from having anyone touch him. James acts tough. He says that failing a test does not bother him; he has more important things to worry about. When the teacher asks him a question, James gives an immediate, but often incorrect, response. When the teacher repeatedly asks James for a response, he becomes belligerent. He often spends long periods of time in the principal's office. He does excel at athletics.

Sonia is five and is in a kindergarten classroom. She is a dainty child, very gentle and very quiet. The teacher calls her withdrawn. Sonia does not seem to have a sense of place, or a sense of herself. She often seems to be looking off into space. When the teacher asks Sonia a question, she may or may not respond. When the teacher gives an instruction to the group, it is as if Sonia does not hear. For example, when it is time for recess, Sonia will still be sitting at her desk while the other children are already lined up at the door. Sonia makes quite beautiful drawings. When one of the class members is hurt, Sonia will comfort her fellow student, and sometimes cry in sympathy.
These three vignettes show the uniqueness of each individual distractible child’s problems. The examples also underscore the frustration teachers experience. Distractible children are a problem because they do not learn like other children. Teachers’ standard practices do not work which creates frustration for teachers and failure for students. The main problem is that the children do not spend enough time interacting with the medium of learning—the teacher’s face and voice, and the book or paper in front of them. Even though these children have normal intelligence, techniques that work with most children are ineffective. It does not work to tell distractible children to try harder, or to encourage them to more productive work by making them stay in for recess.

These children do not have the same skill as others in taking in sensory information. The way they perceive through their eyes, ears and other senses is normal, but they do not integrate the information as others do. It is difficult for them to pick out what is important and ignore what is unimportant. They attend to all the information their senses pick up, instead of ignoring extraneous information. This differs for each distractible child. Some can integrate stimuli they hear, but cannot do this for what they see. Others can integrate what they see, but not what they hear.

Teachers become understandably frustrated with distractible children. After a time of working with them, teachers want an expert to come in and either fix the child, or transfer the child to a classroom with more individualized help. Often teachers form a set of expectations that a child does not learn and this influences how the teacher treats a child. Instead of looking for a child’s positive qualities, the teacher looks for and pays attention to the qualities that interfere with learning. “Oh, Oh, there goes Sonia, James, or Jill, they’re looking out the window again, instead of working.”

The most disturbing thing about distractible children is that nothing seems to work.

SPECIAL EDUCATION AND DISTRACTIBILITY: A HISTORY

Special educators have made attempts at diagnosing the distractible children’s problem in order to develop effective intervention strategies. In the late 1960’s it became clear to educators that there was a group of children who did not fit into the groups of learners special educators usually worked with. They were not mentally retarded. (They were not children that when given an intelligence test would score markedly below the norm.) They were not emotionally disturbed. (Emotionally disturbed children are not retarded, but their learning is impaired by serious aggression, profound withdrawal within themselves or other emotional disturbances.) Distractible children were not hearing or vision impaired either. (Distractible children’s eyes and ears take in sensory information accurately.) Neither were distractible children physically handicapped as are children who are born with cerebral palsy.

Even though distractible children did not fit into any of the above categories, they were a problem. They did not learn. It was puzzling because they had at least normal intelligence. These students defied classification. They were mystery children.

Over the years different labels have been tried out in an attempt to define distractible children—brain damaged, minimally brain dysfunctional, hyperactive, and most recently, learning disabled. The following history will trace how these labels came about. Usually the label paralleled what special educators thought caused the learning problem.

MEDICAL MODEL

MYTH ONE: DISTRACTIBLE CHILDREN ARE BRAIN DAMAGED

At first these children were thought to be brain damaged because along with distractibility came some perceptual confusion. For example distractible children would sometimes reverse what they perceived. If they were asked to read the word “was” they might say “saw”, or if they were to
write a "2", they might make it turned around.

After World War II, a physician, working with wounded soldiers noticed that servicemen with brain injury reversed images, just like distractible children. The assumption was made that these children must be brain damaged, too, since they had the same behaviors. It was assumed that because of some brain injury, distractible children's nervous systems were not functioning correctly.

A series of educators and psychologists developed exercises to help children "rewire" their nervous systems so that they would function correctly. There have been a number of instances in which severely brain damaged people have been disabled and later retrained themselves to overcome the disability. This has occurred frequently, for example, when people lose the ability to speak and then later regain it. Physiologically, it is not clear what actually happens with the brain. But there is some evidence that undamaged areas of the brain can take over the functions controlled previously by damaged portions.

Since distractible children's behaviors showed perceptual and motor problems, special educators attempted to give them practice in perceptual and motor skills to correct problems resulting from what was assumed to be brain damage.

Special education was initially influenced by physicians. When children were not developing normally, parents would often take their children to doctors to find out what was wrong. Teachers often sought doctor's counsel as well. Physicians attempted to apply the same strategy of treatment for learning problems as they used for treating diseases and injuries. They looked for a cause and then assumed that a treatment would fall into place, like finding a vaccine or setting a bone. Educators adopted this approach as well. The strategy of diagnosing a cause and then prescribing a treatment is called the medical model. Pinpointing distractible children as brain damaged was attractive since it fit the medical model. The "cause" hypothesized to be a brain injury hopefully would lead to a treatment.

The next development in labeling was that distractible children were given the name of minimal brain dysfunction.

A brain injury could not be found, but since children showed perceptual processing problems, the neurological system must have some subtle impairment that affected perceptual processing. Minimal brain dysfunction meant that it was not clear where a brain injury was located, but it was assumed that there was some impairment since there were perceptual and motor problems. In time the assumption that there was impairment was also rejected, because no physiological evidence was found of the dysfunction.

The attractiveness of classifying these children as brain injured or as having a minimal brain dysfunction soon evaporated. This was primarily because physicians could not find a brain injury or dysfunction in all these children. The medical model did not really fit education. A specific diagnosis which would lead to a treatment suited for that diagnosis did not appear.

As a result these children acquired a new label, learning disabled. In effect, this label was a break from the medical model, since it did not imply a cause of the disability. It just meant that children were not learning, and that children did not fit into special education classifications such as mentally retarded, emotionally disturbed, visual or hearing impaired, or physically handicapped. Learning disabled children did not learn and the medical profession did not know why. The term specific learning disability was used since most learning disabled children performed in some areas very well, but failed in other areas. It was assumed that there was some very specific perceptual processing deficit that interfered with learning.

TREATMENT HISTORY
MYTH TWO: MOTOR AND PERCEPTUAL REMEDIATION WILL "FIX" DISTRACTIBLE CHILDREN

The treatment of distractible children paralleled the label that was used to define their problem. When they were thought to be brain damaged, the treatment focused on motor and perceptual retraining. The following section reviews treatments developed by four educators who worked during the 1960's to accomplish retraining. These educators
assumed that children’s learning problems were the result of brain damage or a minimal brain dysfunction.

One of the first educators to develop a treatment for children assumed to be brain damaged was Newell Kephart. He worked at Purdue University and developed a test to tell the exact motor or perceptual problems of distractible children. During the test children were asked to perform a number of motor tasks including skipping, jumping, and copying figures at a chalkboard. After children’s problems were pinpointed by analyzing the test results, physical exercises were prescribed for children. Much of Kephart’s work focused on teaching children to integrate both sides of their bodies. Many children Kephart worked with had what he called midline problems, meaning they could not work with their right hand or arm on the left side of the body.

Working at the same time as Kephart was C. H. Delacato. Delacato believed that all children grow through normal stages of motor development. By motor development, Delacato meant actions children do with their hands, legs, and body. Young infants learn to reach out and grab objects, and then to pull themselves up to a standing position. They learn to balance, walk, run and jump. Delacato hypothesized that children with perceptual and motor problems had not progressed through all the normal stages. He devised a program to help children regress to the stage they missed, practice it and then hopefully go on to the next stage. Delacato is most famous for patterning exercises which simulated crawling. A child would lie on a table with five people holding the legs, arms, and face. The child’s limbs were then moved as if the child were crawling.

Both Kephart and Delacato worked with children by giving them practice in motor skills. Kephart clearly saw the children he worked with as brain damaged. His aim was to give practice in motor skills in areas of deficiency to reintegrate the brain network. Delacato believed that children’s brains were not developed because they had missed important stages of motor development. His aim was to re-patter the brain network so that it functioned correctly. Both Kephart and Delacato felt that if the parts of the brain that controlled motor performance were remapped, then children’s academic performance would improve.

In a slightly different approach, Marianne Frostig attempted to give children practice on perceptual skills. She devised a test to see if children could complete skills that she called visual-perceptual skills. These included copying forms and organizing shapes in space. After a child was tested, the perceptual skills at risk for that child were pinpointed. Then the child would be asked to complete exercises in a curriculum that Frostig had devised.

Samuel Kirk developed a test that combined perceptual skills with language skills. It was called the Illinois Test of Psycholinguistic Abilities (ITPA). It had a number of subtests and tested things like auditory sequential memory (“Repeat for me what you hear: 6-4-3-2.”) and visual association (“What goes with this picture?”). After this test was administered, testers created a profile of what perceptual and language skills were strengths or deficits for children. Special education teachers would then create practice for the deficient skills. For example, if a child had poor visual sequential memory, then a teacher might present the child with a series of color chips in a specific order, asking the child to study the order carefully. Then the chips would be taken away, and the child would be asked to replicate the order. One skill most distractible children have difficulty with is auditory sequential memory. This was documented in the 1970’s by educators using the ITPA, and has been supported recently with evidence that learning disabled children have selective auditory attention deficits. This supports the assumption of this book, that focusing on incoming stimuli, in this case auditory stimuli, is the basic problem with distractibility.

There were other educators and psychologists who developed tests and remedial activities for distractible children, but the treatments outlined above are representative of the philosophy for dealing with distractible children in the 1960’s and 1970’s. At first treatment was designed to rewire children’s brains by giving them motor practice. This progressed to rewiring children’s visual and language skills by giving them practice in those areas which were pinpointed as a deficit.
Some of Kephart, Delacato, Frostig, and Kirk's tests and treatments are still used. But more than the specific treatment, the basic philosophy that these educators proposed is still accepted by teachers. Many teachers believe that children cannot learn because they missed the crawling stage or that practice in perceptual or motor skills is necessary.

Over the years a number of authors have carefully reviewed research that has been done to test the effectiveness of Kephart, Delacato, Frostig, and Kirk's work in helping distractible children. These authors found that sometimes teachers could be effective in teaching the skills that would be diagnosed as deficient. For example, if a teacher used Kephart's test and found that a child had midline problems, then if the teacher gave the child practice in working with the left arm on the right side of the body, when the test was administered again, the child would improve. However, this improvement was not always the case. Sometimes practice in the skills did not improve the student's performance on the motor and perceptual motor tests. Another more significant finding was that, in general, the motor and perceptual remediation did not improve children's performance on academic tasks in school. The authors conclude that it is high time to lay Kephart, Delacato, and others to rest. Further, it is time to reject the assumption that the brain can be rewired through motor and perceptual practice.

The medical model does not work in helping distractible children. The approaches devised to rewire children's nervous systems, which were aimed at fixing the cause of the distractible child's problems did not remedy the problem and then allow students to improve in school. The child's nervous system was not made whole again. Distractible children did not become like other children as a result of the motor and perceptual remediation. Children may improve on the perceptual-motor skills in which a teacher is providing training, but this does not translate into "cured" patients who can then function well in the classroom. Giving a student practice in remembering a sequence of color chips, or practice crawling will not help the child in the classroom or at home. The practice does not create increased ability to use attention to learn letter names, to watch the board when a teacher is presenting a math problem, or to find the correct problem on a piece of seatwork.

**MYTH THREE: DRUGS AND BEHAVIOR MODIFICATION ARE LONG TERM SOLUTIONS FOR DISTRACTIBLE CHILDREN**

A common treatment for distractibility which began in the late 1960's and continues today is drug therapy. The Association of Children with Learning Disabilities reports that 65% of learning disabled children are, or have been, on drugs prescribed by physicians. These drugs are usually reserved for distractible children who are very active and sometimes called "hyperactive".

Ritalin or amphetamines are prescribed. Even though these drugs act as stimulants for most people, they have a calming effect on distractible children. Children's ability to stay seated and remain quiet significantly increases as a result of the use of the drugs. However, there is little evidence that children's schoolwork actually improves. Children's capability to sit still while under the effect of drugs increases, but this does not mean that they learn more, nor does it mean that the children have learned skills to cope with their attentional problems once the drug influence wears off. Drug therapy suppresses distractibility but does not increase student's learning capacity or teach concentration.

Unlike drug therapy, behavior modification is designed to teach skills and not to suppress distractibility. The approach of behavior modification is to provide rewards for correct classroom behavior both for completing academic work and paying attention. The underlying assumption of behavior modification is that behavior is influenced by the events that immediately follow the behavior. For example, if you smile at someone, often that person will smile in return. This will increase the likelihood that the next time you see someone you would smile. Thousands of such events happen to each of us, markedly affecting behavior and teaching us how to behave.

For the distractible child, many times the teacher will
respond each time the child wanders around the classroom or does not pay attention. This teaches the child that the more "off-the-wall" a behavior is, the more teacher attention that will follow. A behavior modifier would look at a distractible child and examine what happens in the child's environment right after the distractible behavior. If the child gets up and starts moving around the classroom, what happens? The teacher reminds the child to sit down. After the distractible behavior, the child is rewarded by the teacher's attention. When a student cannot find his or her place on a sheet of paper, the teacher comes and points to the place. Again the student gets teacher attention for distractible behavior. A behaviorist would say that this sequence is actually teaching the child to be distractible. In setting up a behavior modification system, the purpose would be to remove rewards for distractibility and instead deliver rewards for correct classroom behavior.

This can be done in a number of different ways. One example is derived from a tutoring program in reading. The reading book used during the tutoring sessions was designed for the student to fill in answers to questions and missing parts of words. To create rewards for correct behavior, the student was given a point for each sentence completed correctly. The student colored in earned points on a racetrack marked off into spaces. When all the spaces were filled, the student earned a model to be put together.

Behavior modification can be used directly on schoolwork, as described in the example above, or a system can be set up to reward paying attention in class. For example, a teacher can set a timer to ring at variable times, averaging every five minutes. This means the teacher would set it to ring after one minute, then after six minutes, and then after four minutes. Students can never exactly pinpoint when the timer will ring. The teacher looks up at the students when the timer rings. If a given student is paying attention, looking at the work, or looking at the teacher during a presentation, the teacher marks a point on a card on the student's desk. If the student has earned a certain number of points, he or she can go to recess early.

The strength of a behavior modification program is that it deals directly with distractibility instead of attempting to "fix" the child. Behavior modification breaks from the medical model mold. A behavior modification program in effect ignores the cause and tackles, head on, behaviors that are creating problems. The usual strategy, described above, is to give rewards for correct behavior and ignore those behaviors which distract from learning.

Behavior modification can be a positive source of encouragement for distractible children. We have said earlier that teachers form a set of negative expectations for distractible children. Teachers start looking for what will fulfill their expectations instead of noticing the correct things a student is doing. The longer a teacher works with a child, the less patient a teacher will be. An effective behavior modification program can turn this situation around, since the teacher must notice the correct things the child is doing to deliver rewards. This can work to remove the negative stigma from the student.

Some object to behavior modification programs, pointing out that they are mechanistic or non-humanistic. The criticism is that such programs reduce a student to a thoughtless, spiritless organism responding only to external rewards. The counter argument is that it is very humane to use an approach, when no other approach is working, to teach a distractible child to be successful in a setting where he or she was previously failing.

From a practical standpoint, the main question with behavior modification is what happens when the rewards are removed? Once the rewards are no longer available, will the student maintain accurate academic performance or increased attention to group presentations and seatwork? As with drug therapy, behavior modification affects may disappear once withdrawn. Drug therapy and behavior modification programs can help a distractible child as long as they are in force, but when they are removed, what happens to the distractible child?

Behaviorists do deal with this problem, and there are a number of procedures that can be used to teach a child to carry on the correct behaviors once the rewards are removed. For example, a program may fade away. Remember the
race car track. The student colored in a square for each reading problem read correctly. To teach a child to do correct reading without rewards, more and more reading would be required for the reward. At first the child would have to read four or five sentences to color in a square, and then the entire page of reading would be required. Eventually, there would be no reward other than the teacher’s praise, or maybe a sticker, or possibly a certificate for a job well done.

One technique from behavior modification designed to teach new behaviors which does not always use rewards is called behavior rehearsal or self instruction. An example is a distractible child who has problems finding materials needed for a reading activity, and then finding where the reading group is being held. A behavior rehearsal procedure would have an adult take the student through the steps necessary to find materials and the reading group, one by one, actually “rehearsal” the student as you might rehearse someone for a play. The rehearsal would continue until the student could complete the steps independently.

Behavior modification definitely has strengths in coping with distractible children’s problems. It does not fall into the trap of trying to fix the nervous system with motor and perceptual skill practice, nor does it merely suppress distractible behaviors like drug therapy. Behavior modification directly teaches distractible children skills that will help with their distractibility. It also makes attempts at helping a student maintain these skills after rewards are removed.

The weakness of behavior modification with distractible children is that it uses external rewards to teach behavior, and often does not leave children with a strategy for dealing with their basic problem—how to focus their attention.

SELECTIVE ATTENTION THROUGH SELF-INSTRUCTION


. . . youngsters are apparently unable to keep their own impulses under control in order to cope with situations in which care, concentrated attention, or organized planning are required. They tend to react with the first idea that occurs to them. . . I have come to think of (the deficiency) as the inability to ‘stop, look, listen’.9

According to Ross, this problem of impulsivity is another way of saying that the child cannot selectively attend. A student has not developed the ability to pay attention to the necessary and relevant features in the environment to respond appropriately.

Think for a minute what might be happening in an elementary classroom. A child is sitting at a desk by a window. It’s warm outside so the window is up. Noises and fragrances come drifting in the window. The janitor is in the hall washing the floor. Mopping and movement noises accompany the work. The child’s view of the classroom also includes a lot of visual stimulation. Think about all of the things there are to see: the bulletin board, children and teachers’ faces, marks on the chalkboard, papers on the student’s own desk, and erasures on the floor. If a student has difficulty picking and choosing from all the incoming stimuli to pay attention to only a small portion of them that are necessary to complete a task, then this student has difficulty with what Ross calls selective attention.

Selective attention is the ability to screen incoming stimuli, sights, noises, feelings, and movement, and focus on only what is necessary. For those who can use selective attention, it is not a conscious choice, it is automatic. When we are small infants, we react on impulse. When it is cold, we cry. When we are fed something sweet, we smile. When someone takes something away from a two-year-old, the child has a fit, screaming, “Mine, mine, mine.” The environment presents stimulation and we react impulsively. But as we grow we normally and naturally develop the ability to think before we respond, and to not be at the beck and call of instincts and impulses. At first it probably results from
someone telling us, like our parents, to stop before we respond. Adults remind children of the consequences of their actions and alert children to those things that are important to warrant attention. After awhile, it is not a conscious decision to weigh incoming stimuli before we respond, we do so automatically. We develop the natural and automatic ability to hone in on only what we need or want to perceive. We can screen out distractions.

Tanner and several other special educators\textsuperscript{10} report evidence that distractible children do not naturally develop this ability to screen out distracters. They do not have as high an ability to use selective attention as other children.

If distractible children are deficient in selective attention, then the best way to help them is to teach them coping strategies. A coping strategy could help the distractible child sift the incoming stimulation into relevant and irrelevant piles, and think, “Aha, I’m going to pay attention to this.” By teaching a coping strategy, educators would be saying to distractible children, “Your attention works differently than others, here are some ideas to make it work better for you.”

For the most part the procedures we have reviewed from special education did not teach a coping strategy for selective attention. Kephart had children walking on balance beams. Delacato had children crawling. Frostig had children copying shapes. Kirk had them repeating numbers. None of these procedures taught children a strategy for how to focus their attention while they engaged in these activities. No one said, “This is what you can do while you are copying this form to help you figure out what to pay attention to.” It is possible that through repeated practice, or trial and error, some children figured out their own strategy. But this could not be counted on to happen in every case.

Drug therapy does not teach a coping strategy to those with attentional problems. A Ritalin capsule does not wink at a child and divulge secrets for attending to relevant features of a reading lesson. In the last analysis, behavior modification does not either. Children are prompted to correct behavior with the strength of rewards. Because children want the reward, they may be more motivated to figure out their own coping strategies. But strategies are not taught directly.

The one procedure from behavior modification that is a coping strategy for how to focus attention is behavior rehearsal. With this procedure the adult actually tells the student what to pay attention to while going through the steps in the procedure. In behavior rehearsal, students are often taught to talk aloud to themselves as they practice the steps. This enhances the value as a coping strategy, and it then can be called a self-instruction strategy.

A normal thing to do when one is rattled is to talk aloud to oneself. Talking aloud increases the sensory input. We hear ourselves talking as we are trying to focus attention. Talking aloud blocks out extraneous noises that may distract us. Most people find that they talk aloud to themselves when they are having difficulty figuring something out. It works. A large number of educators\textsuperscript{11} tried this technique to help distractible children pay attention. Self-instruction, as it is called, works well. Children can be taught to make letters better, approach learning tasks more carefully, and improve their performance on tests and multiple choice questions through self-instruction.

The best gift for a distractible child is to be taught control of impulses and attention. Think what it must be like to be barded by sensory events that cannot be integrated. In a sense, a distractible child is awash in a sea of noises, sights, and sensations without a method for steering. The job of teachers and parents is to help these children work with their attention so that they can use it for their benefit. This can happen by teaching them coping strategies to focus attention. Talking aloud is one way. Several other strategies will unfold in subsequent chapters.

A FEW WORDS ABOUT LABELS

Some of the labels in special education that have been used in reference to distractible children are brain damaged, minimal brain dysfunction, learning disabled, hyperactive, and dyslexic. All of these are overlapping circles and the distractible child may fit in one of these categories or may not. Brain damaged is for the most part