THE MOST COMMON BEHAVIORS EDUCATORS LOOK FOR WHEN DETERMINING THAT A YOUTH MIGHT BE ADD/ADHD

by

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ABSTRACT

The purpose of this study was to identify the student behaviors educators use to determine when students may have Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD). The need for this study was that some behaviors which youths display in the classroom can be attributed to factors other than ADD/ADHD, thus causing the youth to be misdiagnosed and placed on medication needlessly.

Literature was reviewed on the people typically responsible for referring the youths for evaluation for ADD/ADHD; which youths display ADD/ADHD-like symptoms; what might cause youths to display ADD/ADHD-like behaviors; methods of behavior correction; and why youths are placed on medication.

In this study, a questionnaire was used to gather information from professional educators to establish the most common behaviors they look for in determining whether a student might have ADD/ADHD. The data was gathered from educators in elementary, middle and high schools in Phoenix Metropolitan school districts. The sample of 74 respondents consisted of a librarian, two resource teachers, two counselors, a special education teacher and 68 teachers ranging in grades from Kindergarten through 12th Grade. The most frequently

reported behaviors reported by educators were short attention span, cannot stay seated during class, trouble staying on task, and difficulty concentrating.

Based on the findings from the literature and the responses from the questionnaire, the study seems to support the conclusion that the ADD/ADHD behaviors educators look for are also common in most other youths; that boys are more likely to display ADD/ADHD like behavior; and boys are more likely to be placed on medication than girls.

DEDICATION

I would like to take this time to dedicate this book to my entire family. I would first like to mention my wonderful husband Jim, who has been so supportive of me throughout all of my endeavors. He has been there for me when my health was at its lowest. He stayed up late some nights and got up early every morning to be my nurse and helped me gain back my health so I could continue to see my dreams become a reality. My parents Charlie and Geraldine, all of my family members, particularly my brothers Chuck, Bob and Wayne who have been there for me to always remind me that I have the greatest family in the world. My cousin Gloria, who gave me those words of encouragement. My friend and business partner, Connie, who encouraged me with those long talks on the phone and in the parking lot. My lovely son Wilson, who has been my purpose for living. And most of all, my loving mother Lillie, who gave me life, was my role model, who died before seeing my dreams become a reality. I will forever hold her dear to my heart.

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CHAPTER 1

THE PROBLEM

Introduction

For many school districts across America, providing an education for today's youth is not as simple a task as it once was. Teachers face over-crowded classrooms in which the student/teacher ratio can be up to 30 to 1. Teachers also are asked to report any abuse, from verbal and physical abuse to child neglect, that a student might have been subjected to in their home environment. Teachers are responsible for educating youths to prepare them for the future. Yet these students may be involved, or want to be involved, in gangs. They may come to school with guns and knives in order to protect themselves from others. In this environment, students have difficulty learning. Educators are challenged to assure that learning takes place.

Increasingly, educators are asked to address behavioral problems which further disrupt the classroom learning environment. Educators seem to be getting more and more youths each year who display behavior disorders which make it difficult for learning to take place in the classrooms. Educators may be asked by the parents to screen their child for possible placement on medication

for correction of like behavior. The problem educators face is what behaviors to look for.

Development of the Problem

Ullman & Ullman (1996) note that "Attention deficit hyperactivity disorder (ADD or ADHD) is being diagnosed in epidemic proportions" (p. xv). In a Public Broadcasting System documentary, it was noted that perhaps two million children in the United States currently take stimulant medications (including Ritalin, Dexedrine, and Cylert) for ADD. Ullman & Ullman (1996) state that "in 1988 half a million children were being prescribed stimulants for ADD. The number has quadrupled in only eight years and is doubling very two years" (p. xv).

Breggin (1991) stated that over one million children are being prescribed drugs in order to control their behavior while they are in school and at home. On June 10, 1988, Ted Koppel's ABC News Nightline stated that 800,000 children were taking Ritalin and its production had doubled in recent years.

> The rush to label schoolchildren as suffering from ADD or ADHD has reached nearly epidemic proportions. Currently, between 3% and 5% of U.S. students (1.35 million to 2.25 million children) have been diagnosed as having ADD. (Smelter, et al., 1996, p.430)

Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder is presumed to be a problem of brain chemistry. The symptoms include easy distractibility, impulsivity, poor concentration, inability to focus on one activity for

a normal period of time, acting before thinking, fidgeting or squirming while sitting, daydreaming, disruptive or destructive behavior (Arthurs, 1996).

Most physicians and mental health professionals attribute ADD to an imbalance in transmitters (serotonin) in the brain (Ullman & Ullman, 1996). Ullman & Ullman (1996) noting that there is an indication of neurological differences in children diagnosed with ADD, but there is no mechanism for these differences, feel that a neurotransmitter imbalance is a way to explain ADD but the explanation remains questionable (1996).

Teachers have been the primary referral source of school-age children for evaluation for Attention Deficit Disorder (Brown, 1986). "The amount of trouble that children are causing adults, particularly teachers, appears to be the driving force determining children's referral to mental and medical health services" (Breggin, 1991, p.273).

Armstrong (1995) noted that the National Education Association (NEA), the National Association of School Psychologists (NASP), and the National Association for the Advancement of Colored People (NAACP) opposed Congress giving authorization to consider ADD as a legally handicapping condition. These groups felt that creating a new category based on behavioral characteristics alone, such as overactivity, impulsiveness, and inattentiveness, would increase the likelihood of inappropriate labeling for racial, ethnic, and linguistic minority students and these groups did not feel that a proliferation of labels would be the best way to address the ADD issue (Armstrong, 1995).

Need for the Study

Many youth display ADD/ADHD-like behavior, and these youth may be placed on medication needlessly to correct this behavior when other methods of treatment are available and should be considered first. There are times when parents ask teachers to screen a child for possible placement on medication for correction of ADD/ADHD- like behavior. An increase in the number of youth who receive medication at school raises questions as to whether medication is the answer for all children who display ADD/ADHD behaviors.

Purpose of the Study

The purpose of this study was to describe the most common behaviors educators use as criteria to refer students for the diagnosis and treatment of ADD/ADHD.

Research Question

What are the most common behaviors educators use as criteria to refer students for the diagnosis and treatment of ADD/ADHD?

CHAPTER 2

THE LITERATURE REVIEW

Introduction

This chapter discusses the people typically responsible for referring the youths for evaluation for ADD/ADHD; which youths display the ADD/ADHD-like symptoms; what could cause youths to display these behaviors; methods of behavior correction; why youths are being placed on medication; and alternatives to medication.

ADD/ADHD Defined

According to Goldstein and Goldstein (1990), "ADHD is a disorder in which the severity of the presenting problems results from an interaction of the child with the demands made upon the child by the environment. A multitude of environmental variables can influence behavior" (p.18). Many physicians and members of the mental health profession attribute ADD to an imbalance in transmitters, such as serotonin, located within the brain (Ullman & Ullman (1996). However, Ricco, et al. (1993) noted that "although there is evidence of neurological differences in children diagnosed with ADD, no definitive

mechanism has been found for these differences" and recommended a "differential diagnosis of ADD, learning disability, and conduct disorder" (120).

> It may be more accurate to view the syndrome as a cluster of various behavioral deficits, including attention, hyperactivity, and impulsivity, which share a common response to psychostimulants" (Ricco et al., 1993, p. 120)

Barkley (1991) feels attention deficit hyperactivity disorder (ADHD) is a recent term which is being used for both children and adults with a particular developmental disorder that consist of deficits in sustained attention, impulse control, and the regulation of activity level to situational demands. Barkley (1991) feels this disorder has had a number of labels over the past century, including hyperkinetic reaction of childhood, hyperactivity or hyperactive child syndrome, minimal brain dysfunction, and attention deficit disorder (with or without hyperactivity).

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM-IV, 1994) cited 21 characteristics for ADHD and at least six (or more) of these must have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:

Inattention:

1. Often fails to give close attention to details or makes careless mistakes in school work, work, or other activities.

2. Often has difficulty sustaining attention in tasks or play activities.

3. Often does not seem to listen when spoken to directly.

4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).

5. Often has difficulty organizing tasks and activities.

6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).

7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools).

8. Is often easily distracted by extraneous stimuli.

9. Is often forgetful in daily activities.

Six (or more) of the following symptoms of hyperactivity impulsivity have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity:

1. Often fidgets with hands or feet or squirms in seat.

2. Often leaves seat in classroom or in other situations in which remaining seated is expected.

3. Often runs about or climbs excessively in situations in which it is inappropriate(in adolescents or adults, may be limited to subjective feelings of restlessness).

4. Often has difficulty playing or engaging in leisure activities quietly

5. Is often (on the go) or often acts as is driven by a motor.

6. Often talks excessively.

Impulsivity:

7. Often blurts out answers before questions have been completed.

8. Often has difficulty awaiting turn.

9. Often interrupts or intrudes on others (e.g., butts into conversation or games.

Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years. Some impairment from the symptoms is presenting two or more settings (e.g., at school [or work] and at home).

There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder) (DSM-IV, 1994, p. 83-85).

According to Fleisher and colleagues, the ADD syndrome lacks supportive evidence and should be clinically discarded (Breggin, 1991). There is no difference in the attention span between normal children and those with school problems and all children focus their attention better in small classes with more teacher involvement than children in larger classes where there is less teacher involvement (Breggin, 1991). Fleisher and others pointed out that children drifting off can be a sign of post-traumatic stress disorder due to

neglect, beatings, or sexual abuse and that some children come from economically and socially impoverished homes where there is little help in learning how to focus their attention (cited in Breggin, 1991).

Hallahan reported that the children being diagnosed as ADD/ADHD lack a sense of locus of control (Breggin, 1991). These children do not feel they have the ability to control their environment, so they fail to pay attention to it; feeling that positive and negative things happen because of luck, fate, involvement of other persons, or as just one of those things (cited in Breggin, 1991).

Youth Referrals

Traditionally, teachers have been the primary referral source of school-age children for evaluation for ADD/ADHD (Brown, 1986). Teachers have the opportunity to observe the behaviors of children and to compare this behavior to that of their peers. Teachers' knowledge and awareness of ADHD was an important element in the diagnostic process. The results of a study by Brown (1986) depicted the importance of teachers' ratings in the diagnosis of ADD in children and emphasized their place in the psychological evaluation.

> To identify ADD children, it certainly would seem useful for the practicing psychologist to elicit, from teachers, observations of behavioral and conduct disturbance as well as information regarding the child's capacity to sustain attention. (Brown, 1986, p.98)

Henderson (1996) stated there was no psychological tests for ADD, rather diagnosis is based strictly on a subjective evaluation of behaviors. Breggin (1991) stated "the schools have provided the mental health professions with the entering wedge for turning a large proportion of children into involuntary psychiatric consumers" (p.273).

Youths Who Display Symptoms

Pelham reported that "Attention Deficit/Hyperactive Disorder (AD/HD) affects approximately 5% of the elementary school population of North America" and is therefore "one of the most prevalent psychological disorders of childhood and accounts for a very large proportion of referrals to pediatric mental health facilities" (cited in Hawkins, et al., 1991, p. 52). "Attention problems among children are most likely to be displayed in situations which require great amounts of self-application and self-discipline, such as the classroom" (Pelham, cited in Hawkins, et al., 1991, p. 52).

Ullman & Ullman (1996) stated that the group of children who might be included in the diagnostic category of ADD but who may have very individual needs are precocious children with ADD-like symptoms. If a child has an IQ of 150 and a photographic mind, the child may have difficulties placed in a regular classroom and suffer from boredom unless the teacher created special activities and outlets suitable for the child's unusual intellectual capabilities.

> In the classroom, a gifted child's perceived inability to stay on task might be related to boredom, curriculum, mismatched learning style, or other environmental factors. ... because a gifted child may demonstrate ADD-like behaviors in some settings and not others, one classroom teacher may diagnose the child with ADD while the other teachers do not. (Webb and Latimer cited in Ullman & Ullman, 1996, p.30).

The difficulty in the appraisal of ADHD lies in the fact that all children display the diagnostic criterion behaviors to some extent at various times in their lives (Martin, 1992). Armstrong said "kids need to be themselves, and their hyperactivity may be part of their essential personality" (cited in Rosen, 1996, p.43).

Magazines, television, and other media continually bombard parents with information on ADD (Smelter, et al., 1996). Many of these sources depict the disorder in such a way that any youngster could be so classified. At one time or another, all children exhibit socially unacceptable behaviors; that is part of the maturation process. Often, a child doesn't have ADD but displays ADD behavior such as "difficulty paying attention in the classroom, impulsiveness, failing to finish projects, hyperactivity, restlessness or irritability" (Conde, 1996, p. 1). Out of the 30 to 40 patients evaluated only one was accurately diagnosed with ADD" (Conde, 1996, p. 9). Breggin (1991) emphasized that it is currently fashionable to treat approximately one third of all elementary school boys as an abnormal population because they are fidgety, inattentive, and unamenable to adult control. Two decades of research have not provided any support for the

validity of ADD or hyperactivity (Breggin, 1991). Neither clinical studies nor psychological testing has been able to identify such a group. The problem is how to get professionals to give up a vested interest in the use of the powerful label (Breggin, 1991). Samuels and Miller found no differences in attention span between normal children and those with school problems and found that all children focus their attention better in small classes with more teacher involvement (cited in Breggin, 1991).

Causes of ADD/ADHD-Like Behavior

In an interview, Phoenix licensed psychologist Dr. Michael Bayless stated that sometimes educators are so quick to insist that a child be tested for ADD/ADHD simply because the youth displays ADD/ADHD like behaviors while other causes are being overlooked. Some of these areas are:

1. Did the mother receive proper prenatal care or any prenatal care at all?
2. Is the youth eating a proper diet?
3. Is the youth allergic to certain foods?
4. Is the youth living in a toxic home environment (toxic chemicals)?
5. Is the youth in an over-crowded classroom?

In a telephone interview with licensed Scottsdale Naturopathic Physician Dr. Louise Gutowski concurred with the findings given by Dr. Bayless and that some attention problems can also be attributed to visual difficulties as well.

Arthurs (1996) stated that a large number of ADD cases can be resolved completely by addressing environmental or metabolic causes. Arthurs cited some contributing factors throughout a child's development or an adult's life including: (a) history of stress on the mother during pregnancy; (b) tension at home during the early years of a child's life; (c) maternal use of drugs or alcohol; (d) early infant colic and chronic recurrent infections; (e) repeated antibiotic treatments; (f) allergies; (g) yeast infections; (h) television; (I) high-stimulation activities that can affect normal arousal states and cause restless sleep; (j) use of walkers for infants, which has been shown to affect neurological development and cause learning difficulties; (k) foods which are rendered nutrient-deficient by processing; (l) preservatives, stabilizers, artificial coloring, sugar, sugar substitutes; (m) antibiotics and hormones in meat and dairy products; (n) chemicals and heavy metals in our drinking water (Arthurs, 1996, p. 17).

Greenspan noted a number of attention problems are due to visual, auditory, motor, and special processing difficulties and that children with all of these individual difficulties are often misdiagnosed with ADD" (cited in Ullman & Ullman, 1993, p. 25).

Feingold's 1968 research found a direct correlation between food additives and physical symptoms and a correlation between behavioral disturbances and food additives, concluding that such colors and flavors posed an inherent potential for producing adverse effects (cited in Pescara-Kovach and Alexander, 1994).

In 1973, Conners, Goyette, and Newman tested Feingold's hypotheses when they found a mild improvement in a child's behavior at the beginning of the diet. During the second week on the diet, the mother reported a significant decrease in hyperactive symptoms. When the child was taken off the diet, the symptoms increased. This was followed by a second treatment phase that replicated the initial positive behavioral effects. The team did a second experiment that revealed an increase in negative behavior during both phases of the diet. The mother blamed the negative behavior on the antibiotic medication which the child had been taking (cited in Pescara-Kovach and Alexander, 1994).

Conners, Goyette, and Newman did a controlled double blind clinical study in 1976 where they again tested Feingold's hypotheses. In order to eliminate expectation biases, the parents were led to believe that each diet was equally effective in the control of negative behavior. The findings were that there were no clear behavioral differences between the two groups on the two different diets (Pescara-Kovach and Alexander, 1994).

A study by Prinz, Roberts, and Hartman in 1980 claimed that there are significant correlations between the amount of sugar ingested and aggressiveness, destructiveness, and restlessness in hyperactive children (cited in Pescara-Kovach and Alexander, 1994).

Kinsbourne (1994) referred to the studies by Feingold, Printz and others and then concluded that sugar does not induce psychopathology where there was none before, but it may on occasion aggravate an existing behavior

disorder. Sugar-free diets can be burdensome and socially inhibiting, and should not be endorsed purely on the basis of anecdotal evidence. The potential usefulness of such a diet for a particular child should first be determined by putting the child on a temporary elimination diet and acquiring behavior ratings from several observers.

Thompson (1996), a parent of a child diagnosed with ADD, and an educator, stated "all the carefully conducted, controlled studies in which the family did not know whether or not the child was on an additive-free diet have shown that one type of additive (the artificial food colorings) does not produce significant hyperactivity (though it may produce some minor changes in attention in some children)" (Wender, 1987, p. 77).

Dolby (1997) stated that part of the problem of a child with ADD may be that the child isn't getting enough dietary fat and that omega-3 and omega-6 acids are the two essential fatty acids that must be supplied by the diet, since the body cannot produce them. Children with inadequate levels of these essential fatty acids more frequently experience trouble sleeping, increased thirst, temper tantrums, and learning difficulties, which explains why this deficiency is thought to be correlated with ADD.

> Parents often tell us that their child's behavior is considerably worse the morning after Halloween or after any sugar binge. Their perceptions have recently been supported by researchers at the Yale University School of Medicine. They found that within a few hours after substantial sugar intake, children release large amounts of adrenaline, which causes them to experience shakiness, anxiety, excitement, and concentration problems. Their

> brain waves also indicated a decreased ability to focus. (Ullman & Ullman, 1996, p.27)

An article in the February 1997 Consumer Report discussed a second grade girl given Ritalin to correct her inattention and inability to follow directions but the drug didn't help, even after the dosage was increased. She was on the drug for a year and a half before it was discovered that she didn't have ADD; rather she had a severe language-processing problem that required speech therapy, not drugs (When kids can't concentrate: Attention deficit disorder, 1997).

> The parents of many of these children are living life in the fast lane, going for the gusto, constantly worried about the bottom line. We live in a culture where the characteristics of ADD could almost be noticed in anyone. (Arthurs, 1996, p. 19)

Methods of Behavioral Correction

A comprehensive treatment plan for ADD may include behavior modification, cognitive therapy, family therapy, and social skills training. The mainstay of conventional treatment of ADD is medication, usually stimulant medication such as Ritalin or Dexedrine (Ullman & Ullman, 1996).

The two main classes of medication commonly used in the treatment of ADHD are stimulants and antidepressants. The stimulants dextroamphetamine sulfate (Dexedrine) and methylphenidate (Ritalin) are probably the best-known medications. Dexedrine has been used in the treatment of ADHD since the

1930s and Ritalin, since the 1960s. A less common stimulant, pemoline (Cylert) was introduced into the U.S. more recently (Thompson, 1996).

When stimulants are not effective, children may be given tricyclic antidepressants. "Stimulants have a short-term effectiveness of 60 to 80 percent in reducing the hyperactivity, distractibility, and impulsiveness of school-age children" (Ullman & Ullman, 1996, p. 40). Similar rates of success have been found in adults with ADD. "Stimulant medication has also been shown to improve attention span, gross motor coordination, impulsivity, aggressiveness, handwriting, and compliance" (Ullman & Ullman, 1996, p. 40). "Short-term learning benefits have been achieved with these medications, but no lasting improvement in academic success has been shown" (Ullman & Ullman, 1996, p. 40).

Wender, a strong advocate for drugs, stated, "after drug treatment, the children generally become calmer and less active, develop a longer span of attention, become less stubborn, and are easier to manage" (cited in Breggin, 1991, p. 281).

There is a downside to Ritalin, as follows: "(a) derived from the same family as cocaine; (b) lasts only four hours; (c) treats only some of the symptoms of ADD; (d) provides superficial healing, does not treat the root of the problem; (e) can cause side effects such as appetite loss, anxiety, insomnia, tics, headaches, stomach aches; (f) gets children into the habit of taking drugs; (g) may need to be taken over entire life span" (Ullman & Ullman, 1996, p. 42).

Thompson (1996) pointed out that as a child who has been on medication for several years becomes older and grows larger, he (or she) will require an increased dosage. Some children may develop a tolerance to one of the stimulant drugs, and the physician may need to switch to another drug to get results. Some children may experience the aforementioned side effects from stimulant medications as well as"obsessive-compulsive behavior, a proneness to crying, and anxiety (Thompson, 1996).

Linden, Habib, & Radojevic, (1996) published a clinical study demonstrating the use of biofeedback as a treatment for ADD and ADHD. Biofeedback has been known to increase IQ scores, grades and educational test scores.

> Biofeedback is one method to induce deep relaxation by altering brain waves through selective reinforcement. Some have found biofeedback to be helpful for ADD, but the need for frequent treatments may put it economically out of reach for many children and adults. (Ullman & Ullman, 1996, p. 27)

Ullman & Ullman (1996) stated that based on their clinical experience and the reported cases of other homeopathic physicians, homeopathy offers an effective alternative to stimulants and antidepressants in the treatment of ADD. When the match is made well and the prescription is correct, the patient will markedly improve physically, mentally, and emotionally. Homeopathic medicines come from all over the world and the medicines are derived from

animal, plant, and mineral. The homeopathic approach allows metabolic and behavioral changes without side effects.

Adolescent patients may be referred to specialists who recommended detoxing and the use of a supplement program for the youth (Tobias, cited in Conde, 1996).

Gordon condemns the widespread use of Ritalin as part of "an unnecessary medication of the human experience" and recommends the drug as the last resort (Henderson, 1996, p. 27).

> I'm very concerned that we rush to give a drug instead of looking at the social context and what the family and kids can do for themselves. The first and most obvious thing you have to do is look at the whole family and see how the family interacts. (Gordon, cited in Henderson, 1996, p. 27)

Gordon agreed that children do have food allergies, and recommended that certain foods be removed and he prescribes a tremendous amount of physical exercise for these youths (cited in Henderson, 1996, p. 27).

Rosemond, a psychologist, newspaper columnist, and author, suggested the replacement of medication with good old-fashioned parenting, and used his son as an example (cited in Henderson, 1996). Rosemond said firm discipline, an assigned routine of household chores, and most importantly, the removal of the television from the home turned his son into a well-behaved, straight-A student (cited in Henderson, 1996).

Turecki, a child and family psychiatrist, and author, suggested the use of behavior-modification techniques. Turecki claims he is not anti-Ritalin and prescribes Ritalin for about 25 percent of the children who fit somewhere in the ADD spectrum. However, he prescribes it in smaller doses, and over a shorter period of time (cited in Henderson, 1996).

Treatment should be aimed at helping youths manage their weak attention or high energy level and deal with any secondary problems that have accumulated over the years through a combination of the following treatments:

1. Behavior Modification: Parents and teachers taught practical techniques for encouraging appropriate actions.

2. Psychological help: Counseling which may help uncover problems that contribute to the expression of ADD. Adults with ADD may benefit from counseling to discuss ways in which ADD affects their lives.

3. Educational help: Assistance in class may be needed.

4. Medication: This is most controversial treatment because its apparent power has led to overuse. Decades of research has indicated that, when used correctly, medication can be very effective for many people with ADD. (When kids, 1997, p. 57)

Armstrong, a special education teacher said,

> Drugs to "calm" such children may create new problems. I'm not necessarily arguing that medication is a bad thing for some kinds. I feel certain that thousands of children have been helped by the use of psychoactive medication used in conjunction with non-drug interventions. However, I wonder whether there aren't hundreds of thousands of kids out there who may be done a disservice by having their uniqueness reduced to a disorder, and by having their creative spirit controlled by a drug. (cited in Rosen, 1996, p. 43)

Armstrong suggested consistency in rules and transitions, giving children choices in their activities, a change in the child's diet, and limiting the child's TV viewing (cited Rosen, 1996).

Arthurs (1996) suggested a nutritional plan. "Begin with a high protein, low carbohydrate, sugar-free diet. Identity and eliminate food sensitivities. Avoid food additives, especially artificial colors" (Arthurs, 1996, p. 18). Arthurs (1996) suggested nutritional supplements:

1. Calcium is important for thyroid function and relaxed muscle tone.
2. Magnesium helps relieve chocolate cravings and is calming to the nervous system.
3. Kelp powder sprinkled on food, tastes good and can provide minerals and iodine for thyroid function.
4. Vitamin C is important for immune and adrenal function.
5. Vitamin B complex contains substances which are important in many body functions, including those which regulate brain chemistry.
6. Zinc is helpful in some children, as is iron.
7. Essential fatty acids are just that, essential! They are anti-inflammatory (p. 18).

Arthurs (1996) further suggested botanical medicine, such as the herbs Hypericum (St. John's Wort), Avena (green oat), Passiflora (passion flower), and Scutellaria (scullcap) which are excellent for strengthening the nervous system, and have a calming effect on the body and mind. Arthurs (1996) notes that Siberian ginseng help protect against the mental and physical effects of stress

by encouraging normal adrenal function. Licorice root nutrifies the adrenals and soothes the mucus membranes.

Dolby (1997) felt the best treatment for ADD/ADHD may be to combine therapy and behavior modification, with supplements of essential fatty acids.

Youths on Medication

Breggin (1991) stated,

> In blaming the child-victim, psychiatry takes the pressure off the parents, the family, the schools, and the society. By diagnosing, drugging, and hospitalizing children, psychiatry enforces the worst attitudes toward children in our culture today and exonerates those adult institutions that need reform. (p.275)

Breggin(1991) added that

> Psychiatry, along with other factions within behavioral and educational psychology in exonerating the schools and blaming the children, find it easier to answer the question "why can't Johnny read?" It's because he has a learning disability. (p. 275).

Henderson quotes Jornlin, a teacher:

> The Ritalin solution may send a harmful message to those children who are taking it. It concerns me that we are giving children the message that they are not responsible for their own behavior. When children use it as a crutch, they blame their aggressive behavior on the fact that they haven't had their pill yet. Other students have said they couldn't concentrate because it was almost time for their medication. (cited in Henderson, 1996, p.29).

Solutions

Smelter, et al. (1996) said "Physicians and psychologists with ADD patients should exercise due caution when counseling the parents of afflicted children (p. 431). While some negative behaviors can be explained or excused by ADD, expectations for children should not be lowered because the child has ADD or the child will meet lowered expectations and do the child great harm (Smelter, et al., 1996). A diagnosis may be "educated guesswork, thus lowering of expectations for a child is not acceptable" (p. 431). Smelter, et al. (1991) suggested that physicians keep in touch with the child's school to monitor the effect that the medication is having on the child and that adult counseling be a component of any ADD treatment. Because children are experts at making excuses, they should not be given the message that their classification as ADD or their being on medication affords them some added excuse whenever they get into trouble (Smelter, et al., 1996).

> Physicians, psychologists, school officials, and teachers have an obligation to the child and the child's parents to explain that the classification of ADD or ADHD is not a license to get away with anything, but rather an explanation that may lead to legitimate help for the child in question. (Smelter, et al., p. 432)

Professions who serve the children in school or a medical setting must exercise due caution when labeling children as suffering from ADD/ADHD. Those who work in the schools should refrain from implying that the diagnosis of ADD/ADHD absolves the child from all responsibility for his or her behavior in

the school setting. In the real workaday world, the individual is expected to cope with society to a greater degree than society is expected to cope with the individual. Children with negative social behaviors get classified and treated; adults get fired or arrested (Smelter, et al., 1996).

Summary

According to the literature review, ADD/ADHD is defined as a disorder in which the behavior that is displayed is severe. Teachers have traditionally been the primary persons who initiate the referral activity on the student. Some educators have disclosed that parents have on occasion been the person to bring the behavior to the attention of the teacher and suggest their child is considered to be placed on medication for behavior correction. Students displaying the ADD/ADHD-like behavior are usually the students who are in situations which require great amounts of self-application and self-discipline. Some are precocious children. Others are gifted children. There are differing opinions as to the cause of ADD/ADHD. Some physicians and mental health professions attribute this disorder to an imbalance in transmitters with the brain. Others suggest lack of proper diet; allergic reaction to certain foods; toxic home environment; lack of proper (or the lack of) prenatal care; over-crowded classrooms; visual, auditory, motor, and spacial processing difficulties; high-stimulation activities; antibiotics and hormones in meat and diary products;

preservatives, stabilizers, artificial coloring, sugar, sugar substitutes; chemicals and heavy metals in the drinking water.

It may be possible that youths are being placed on medication to enforce the worst attitudes toward children in American culture and exonerate adult institutions and schools, and in turn blame the children. It was brought out that medication sends a message to the children taking them that they are not responsible for their own behavior. The children can blame their aggressive behavior on the medication.

There were some suggestions for parents, physicians and psychologist with children who have ADD/ADHD-like behavior. The parents as well as the child need to receive counseling. The physicians and psychologists with ADD/ADHD patients should exercise due caution when counseling the parents. It was suggested that expectations not be lowered for those ADD/ADHD children. If the expectations are lowered, the children will certainly meet those lowered expectations. The physicians need to keep in tough with the child's school in order to monitor the effect the medication is having. The professions who serve the ADD/ADHD children must exercise due caution when labeling children suffering from ADD/ADHD because this implies that the diagnosis absolves the child from all responsibility for his or her behavior in the school setting.

CHAPTER 3

METHODOLOGY

Introduction

The purpose of this study was to describe the most common behaviors educators use as criteria to refer students for the diagnoses and treatment of ADD/ADHD. The study asked for the most common behaviors educators use as criteria to refer students for the diagnosis and treatment of ADD/ADHD?

Research Design

This study utilized a descriptive research design. According to Merriam and Simpson (1987), the purpose of descriptive research is "to systematically describe the facts and characteristics of a given phenomenon, population, or area of interest and to draw attention to the degree two events or phenomena are related" (61).

Population and Sample

The respondents were educators who were selected based on their willingness to volunteer to be a part of this research project. A person from each of the different school districts was asked to circulate questionnaires throughout

their district to get feedback from educators on a set of questions related to ADD/ADHD. A total of 120 questionnaires were given out, and 74 were returned for a response rate of 62%.

The respondents worked in school districts throughout the Phoenix Metropolitan area in grades K-12. The school districts were located within middle to upper class neighborhoods; middle to lower class neighborhoods; and lower class/inner city neighborhoods.

Assumptions and Limitations

It was assumed that the participants in this study answered the questions on the survey honestly and to the best of their ability. Because of the non-random method of sample selection, the findings from this study may not necessarily be generalizable to a larger population of educators. A second limitation was that not all respondents were aware of which students were on medication.

Another limitation of this study was some students have a medication schedule whereby the medication is administered in the morning before going to school, and in the evening before going to bed. These students would not be counted in this study because the school nurses are not the ones administering the medication.

Procedure

The questionnaires were distributed to one hundred twenty educators throughout the Phoenix Metropolitan school districts. One person from each of the school districts was responsible for distributing and collecting the questionnaires. Participation in the study was voluntary.

Instrumentation

The researcher designed an instrument for this study as shown in Appendix A. Questions 1-5 were demographic items that asked about the gender, years of teaching experience, formal level of education, grade level taught, and years the respondents taught that particular grade level. Questions 6-9 were items which gathered information about the behaviors the educators looked for in determining whether a student should be referred for diagnosis and treatment of ADD/ADHD; the number of students in the classroom displaying this behavior; the number who display this behavior and are receiving medication; the number of behavior disorder students which are boys; the number of behavior disorder students which are girls; and the total classroom enrollment. Item 10 asked for additional comments by the respondents.

Method of Analysis

Frequency and percent of response were calculated for all items on the survey. Means and standard deviation were calculated for the following questions:

2. How many years of teaching experience do you have?

5. How long have you taught this grade level?

7. How many students in your classroom display this behavior?

8. Of the students displaying this behavior, how many are receiving medication?

9. How many of these students are boys? How many are girls? What is your total classroom enrollment?

CHAPTER 4

PRESENTATION AND ANALYSIS OF THE DATA

Demographics

Seventy four questionnaires were returned and included in this study. The sample of educators were: a librarian; a special education teacher; two reading resource teachers; two counselors; and 68 classroom teachers from grades K-12. Eighty percent or the respondents were female and twenty percent were male. Educational backgrounds ranged from Bachelor's degree to Ph. D. with the most respondents (58%) having Bachelor degrees.

The respondents taught in grades K-12 with the highest concentration teaching 12th grade. Forty-nine percent of the respondents taught high school, with 37% teaching the 12th grade. Fifty-one percent of the respondents teach grades K-8 with 10% teaching first grade and 10% teaching 8th grade.

Years of teaching experience ranged from less than one year of experience to 27 years of teaching experience. Seven percent of the educators had 5 years of educational experience; seven percent have 7 years of experience; and seven percent have twenty-three years of educational experience. This showed a Mean of 10.18 and a Standard Deviation of 8.042.

Number of years teachers had taught at the present grade level ranged from one year to 26 years with 18% having taught the same grade level for one year. This showed a Mean of 6.23, with a Standard Deviation of 5.86.

Findings and Results

The respondents were asked to list the behaviors which best characterize a youth who is ADD/ADHD. In answering item 6, the responses were subjective and the researcher recorded the following written responses from the respondents:

0 No response

1. Cannot stay seated during class period.
2. Has trouble staying on task for more than several minutes.
3. Cannot control behavior for an extended period of time/sporadic behavior.
4. Loss of patience.
5. Short attention span.
6. Lack of focus.
7. Day dreaming.
8. Difficulty completing projects or complete projects quickly with several missing/wrong answers.
9. Not paying attention in class.
10. Hyperactive

11. Difficulty concentrating
12. Anger quickly/temper.
13. Moody.
14. Easily distracted.
15. Off task.
16. Unable to follow a series of directions.

Twenty percent (15) of the respondents felt that "Short attention span" was one of the behaviors they look for in determining that a youth is ADD/ADHD. Eleven percent (8) felt that both "Cannot stay seated during class period" and "Hyperactive" was the behaviors they look for most often. Nine percent (7) felt that both "has trouble staying on task for more than several minutes" and "Lack of focus" was the behavior they look for most often. Eight percent (8) believed that "Difficulty concentrating" was the behavior displayed by ADD/ADHD.

In answering question 7, "How many students in your classroom display this behavior?," 19% (12) of the respondents said they had two students who display this behavior. Seventeen percent (11) of the respondents reported that 3 of their students display ADD/ADHD like behavior. Thirteen percent (8) respondents reported that none of their students display ADD/ADHD like behavior. This showed a mean of 4.6, with a standard deviation of 5.4.

For question 8, "Of the students displaying this behavior, how many are receiving medication?," 50% reported that either none of their students were taking medication; they did not know if the students were taking medication, or

they were not made aware of this information. Thirty percent reported that one of their students was receiving medication for their behavior disorder. This question showed a mean of .86, with a standard deviation of 1.3.

The responses to question 9, "How many of these students are boys?," twenty-seven percent of the respondents reported that two of their students were boys. Thirteen percent reported zero percent of their students were boys, while thirteen percent reported one was a boy, and thirteen percent reported three of their students were boys. This question had a mean of 3.4, and a standard deviation of 3.1.

For question 10, "How many are girls?", 60% reported zero girls received medication for this behavior disorder, while 22% reported one of their students was a girl. This seems to hold true to the research done in this area. The boys are placed on medication at a higher rate than the girls. The mean was .87, while the standard deviation was 1.7.

For question 11, "What is your total classroom enrollment?," 8% responded they have a classroom enrollment of twenty-five students in their classroom. Seven percent of the respondents reported having twenty-six students in their classroom. Five percent reported having twenty-two students, while four percent reported having both twenty-three students, and the other reported having twenty-four students in their classrooms. This showed a mean of 81.1, with a standard deviation of 54.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this study was to describe the most common behavior educators use as criteria to refer students for the diagnosis and treatment of ADD/ADHD. The research question addressed in this study was what are the most common behaviors educators use as criteria to refer students for the diagnosis and treatment of ADD/ADHD?

According to the literature review, ADD/ADHD is defined as a disorder in which the behavior that is displayed is severe. Teachers have traditionally been the primary persons who initiate the referral activity on the student though on occasion the parents have brought the behavior to the attention of the teacher. Students displaying the ADD/ADHD-like behavior are usually in situations which require great amounts of self-application and self-discipline and may be gifted or precocious. There are differing opinions as to the cause of ADD/ADHD. Some physicians and mental health professions attribute this disorder to an imbalance in transmitters with the brain. Others suggest lack of proper diet; allergic reaction to certain foods; toxic home environment; lack of proper (or the lack of) prenatal care; over-crowded classrooms; visual, auditory, motor, and spacial

processing difficulties; high-stimulation activities; antibiotics and hormones in meat and diary products; preservatives, stabilizers, artificial coloring, sugar, sugar substitutes; chemicals and heavy metals in the drinking water.

There were some suggestions for parents, physicians and psychologist with children who have ADD/ADHD-like behavior. The parents as well as the child need to receive counseling. The physicians and psychologists with ADD/ADHD patients should exercise due caution when counseling the parents. It was suggested that expectations not be lowered for those ADD/ADHD children. If the expectations are lowered, the children will certainly meet those lowered expectations. The physicians need to keep in tough with the child's school in order to monitor the effect the medication is having. The professions who serve the ADD/ADHD children must exercise due caution when labeling children suffering from ADD/ADHD because this implies that the diagnosis absolves the child from all responsibility for his or her behavior in the school setting.

In this study, respondents were 74 educators who taught in the Phoenix Metropolitan school districts. The results of the study showed short attention span to be one of the most common behaviors educators use as a criteria when considering ADD/ADHD students. Trouble staying on task for more than several minutes and hyperactive were the next most frequently reported behaviors .

The study did show that even though students were displaying these behaviors, 50% (or 25) of the educators reported having no students receiving

medication for behavior correction, while 2% (or 1) educator reported having as many as seven students receiving medication for ADD/ADHD-like behavior.

This study seems to support the literature which stated that more boys than girls were receiving medication for ADD/ADHD-like behavior. Of the boys receiving medication, 27% (or 17) of the educators reported having two boys in their room who was receiving medication. As many as 60% (or 38) of the educators reported that none of their girls who displayed ADD/ADHD-like behavior were receiving medication for behavior correction. However, 22% (or 14) educators reported that one girl in their classroom was receiving medication for ADD/ADHD-like behavior.

The review of literature also pointed out that class size can make a difference in student behavior. This study showed that 8% (or 6) educators reported having 25 students in their classrooms. This can be a factor in student behavior.

Conclusions

The findings of this study seem to support in part the diagnostic criteria for ADD/ADHD discussed by the American Psychiatric Association's (1994). Most of the time, the child doesn't have ADD but displays an ADD-like behavior such as difficulty paying attention in the classroom, impulsiveness, failing to finish the projects, hyperactivity, restlessness or irritability.

The findings also seem to support Fisher and Greenberg (1989) who reported that more boys than girls are placed on medication due to their being fidgety, inattentive, and unamenable to adult control.

The information also showed that all educators, whether new to the profession or seasoned educators, they all seem to hold the same ideas about ADD/ADHD. The behaviors they qualify as ADD/ADHD are the same. However, the more experienced educators seem to feel that the school system is too quick to recommend that a child be evaluated for placement on medication to correct this behavior disorder when other means should be considered.

The study and review of literature seem to support the following generalization:

1. The ADD/ADHD behaviors educators look for are also common in most other youths as well.
2. Boys are more likely to display ADD/ADHD like behavior.
3. Boys are more likely to be placed on medication than girls.

Recommendations

The review of literature gave some recommendations that parents and those in the helping profession should consider as interventions before a youth is placed on medication for behavior correction. Some of the recommendations are Biofeedback, behavior modification/counseling, diet monitoring (for food allergies), testing for lead poisoning (and other environmental toxins), firm

discipline and assigned routine of household chores and responsibilities, vitamin/nutrition deficiency, eyes examined, test for language-processing (speech therapy), monitor time watching television, teach the youths to recognize and self-monitor their symptoms. Appendix C, suggested readings for parents and educators, contains additional material which may help youth.

The review of literature supports the view that even though some youths have been successful using medication for behavior correction, medication should be considered as a last resort once other avenues have been considered.

Based upon the findings, educators and school counselors need to look at the total picture in the life of the child before referring them for diagnosis and treatment for ADD/ADHD-like behavior. It is also recommended that teachers and counselors read a book by Hallowell and Ratey (1995), entitled Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood to Adulthood which lists 50 tips on classroom management, along with offering specific strategies to use. They suggest that teachers break down large tasks into small tasks; try to use daily progress reports; make directions clear and concise; be consistent with daily instructions; monitor student frequently; use a supportive attitude; maintain eye contact with the student during verbal instruction; develop an individualized educational program; seat the student near the teacher's desk, but include as part of regular class seating; place student up front with his back to the rest of the class to keep other

students out of view; surround the student with good role models; reward more than punish in order to build self-esteem; teach the child to reward himself/herself.

It is very important to have the parents involved with the child and the school. Therefore, the school personnel need to work closely with the parents and ask parents for help in answering any questions they might have about the child which might contribute to the ADD/ADHD-like behavior.

Based on the findings and the review of literature, future research could be conducted using two groups of educators. One group could be trained to work with ADD/ADHD students and knowledgeable about all facets of the behavior disorder such as other variables that could contribute to this behavior, while the second group receive little to no formal training nor any additional information about the disorder. A tool could be developed to measure the level of frustration on the part of the educator. It is the frustration level of the educator as well as the parents, that seems to initiate the referring of the student for further testing.

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APPENDIX A

TEACHER'S QUESTIONNAIRE

Teacher's Questionnaire

1. What is your sex? (Male Female)
2. How many years of teaching experience do you have?
3. What is your level of formal education?

   Bachelor's degree

   Master's degree

   Ph.D. degree
4. What grade level do you teach?
5. How long have you taught this grade level?
6. Based on your educational experience, what are some behaviors you look for in determining whether a student is ADD/ADHD?

7. How many students in your classroom display this behavior?

8. Of the students displaying this behavior, how may are receiving medication?

9. How many of these students are boys? How many are girls?

   What is your total classroom enrollment?
10. Additional comments:

APPENDIX B

RESPONDENTS COMMENTS

RESPONDENTS COMMENTS

The following are some comments made by the respondents in the study:

"Taking a pill does not fix the problem. Medication must be used as one tool to fix the ADD/ADHD problem. Rules, boundaries, contracts, parental involvement and follow-up are a must."

"Too many professionals use this label to describe immaturity."

"District does not provide enough help."

"ADHD students need to have a private signal for when they are displaying inappropriate behavior to privately 'show' them what is OK/not OK." They need LOVE and positive (lots of) reinforcement."

"Though I have some students who display one or more of these behaviors, none are so consistent or extreme that I would classify the student ADD/ADHD."

"I am teaching advanced placement, and therefore do not encounter a lot of these types of students."

"Most of the time I am not informed unless the student displays inappropriate behavior. Then the parents let me know".

"I see this condition becoming more prevalent in the incoming classes. What kind of care did mothers and fathers take before deciding to have children? Not to indulge in substance abuse. Did mothers have good pre-natal care to insure their child developed into a healthy baby?"

"ADD/ADHD is difficult to deal with for teachers, parents and students. If a child has ADD/ADHD, the teacher usually notices early on where as the parents are not as willing to acknowledge the problem. I think teachers need better training as to how to counsel parents with children that exhibit ADD/ADHD behaviors."

"Last year I had a class with 6 students that were ADD/ADHD. It was the hardest class to teach. The other students were greatly affected by the amount of ADD/ADHD students."

"I feel that we often tag students as 'ADD/ADHD' as a way to compensate for the break down of the American family. Parents are frustrated and rather than look at what is wrong at home, lets blame it on something or someone."

"ADD/ADHD is covered up by medication. Children have to be taught to deal with their emotions and behaviors. It is not fair to them to put them on drugs and make them mummies."

"There are many factors that play into ADD/ADHD. There are also many different levels. Every child with ADD/ADHD is unique and needs to be dealt with individually, not just give medication."

"Why do schools think that medication is the answer for young children? Couldn't it be just a need for individual attention?"

"My experience has shown that ADD/ADHD medications (Ritalin) are over-prescribed and under-monitored. Many students receive this medication for

behavior medication purposes when a behavior-modification program (not medication) should be the prescription, both at home and at school."

"I believe this condition is over-diagnosed, over-medicated, poorly understood, and a catch all for behavior problems of all kinds."

"I have two students on medication, although they do not exhibit uncontrollable symptoms. They are very much aided by their medication. The girl does better, certainly, her brother might do better, still, if his dosage were decreased (he's too withdrawn & disinterested in his medication). Currently, though, they've both been off their medication for about a month (parental neglect) and their problem behaviors (the girl's) are steadily increasing! Another student (a boy) is able to sustain focus on most subject matter, and he is not particularly hyperactive; however, he does display impulsive behaviors which have not responded well to modification techniques, medication may be the solution for him."

APPENDIX C

SUGGESTED READINGS FOR PARENTS AND EDUCATORS

SUGGESTED READINGS FOR PARENTS AND EDUCATORS

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BIOGRAPHICAL SKETCH

Brenda Hemphill Nelson was born in Tempe, Arizona, on July 7, 1949. She attended all Mesa public schools and graduated from Westwood High School in 1967. She attended Mesa Community College where she was active and Captain on the Cheerleading Squad; participated on the Drama Team; and served as Senate Secretary. In January of 1972, she graduated from Arizona State University where she received her B. A. Degree in Elementary Education. In May 1977, she received her Masters of Arts in Education Specializing in Guidance and Counseling from Arizona State University. She later obtained her English as a Second Language endorsement in 1982. In January 1994, she entered the Graduate Program at Ottawa University. In April 1996, she was granted a Charter by the State Board of Education, and she will open her charter school during the 1998 - 1999 school year.