Attention Deficit/Hyperactivity Disorder: Perspectives of Participants in the Identification and Treatment Process

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ABSTRACT: There is a need to study possible explanations for the increasing numbers of children being diagnosed as Attention Deficit/Hyperactivity Disorder (AD/HD) within the past decade. The following is a qualitative examination of the perspectives and understandings about AD/HD which are held by individuals who are regularly involved in the process of identifying and/or treating children for this commonly accepted disorder. An examination of the data revealed incongruencies in participants' understanding of the etiology of AD/HD. I suggest that these incongruencies have the potentiality to contribute to the increased numbers of students identified as AD/HD while teachers seek solutions in their struggle to educate these children.

RÉSUMÉ: Il existe un réel besoin d'étudier des causes possibles du nombre croissant d'enfants atteints de Troubles d'Insuffisance d'activité/d'Hyperactivité(TI/H) dans la dernière décennie. Le papier qui suit est un examen qualitatif des perspectives et des opinions communes sur le TI/H. Les individus qui en sont responsables, sont périodiquement impliqués ou, dans le processus d'identification ou, dans le traitement pour enfants atteints communément de troubles. Un examen des données sur l'étiologie des TI/H, a révélé des aberrations dans la compréhension des participants. Je suggère que ces aberrations apportent un plus au nombre accru d'étudiants atteints de TI/H pendant que les enseignants luttent dans leur recherche vers des solutions pour instruire ces enfants.

According to the Drug Enforcement Administration (Drug and Chemical Evaluation Section, 2000), there has been a 600% increase in the production and use of methylphenidate to treat children diagnosed as Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) in the United States since 1990. This increase contrasts sharply with trends seen in the rest of the

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world. In fact, the United Nations International Narcotics Control Board (INCB) has written letters of concern about this increase and has requested data concerning trends in the use of methylphenidate from the United States Department of Justice, Drug Enforcement Administration (DEA). This request was based on a 1993 United Nations Statistical Report on Psychotropics in which the production quota for methylphenidate had increased from 1,361 kg in 1985 to 10,410 kg in 1995. The report produced by this Administration through the Office of Diversion Control in the Drug and Chemical Evaluation Section stated that the largest percentage of that growth occurred in the years between 1990-1995 when a maximum quota was set for production to slow this progression (Drug and Chemical Evaluation Section, 1995). I am concerned about these figures and this continuing growth trend.

Even though cited prevalence figures for individuals treated with medication for AD/HD varies, 3-5% is commonly quoted for the total population of children, and researchers agree that boys account for the majority of that total (DuPaul, Guevrenont, & Barkley, 1991; Walters & Barrett, 1993; Hancock, 1996). Some researchers (Armstrong, 1996; Barkley, 1998; LeFever & Dawson,1999) indicate the figure might be higher. McGuinness (1989) estimated that as many as one-third of American boys are now labeled and treated for AD/HD and are thus considered abnormal because they are fidgety, inattentive, and unalienable to adult control.

Considering the frequent use of stimulants to treat this large number of children and the lack of any conclusive medical test to diagnose AD/HD, it seems reasonable to suspect a problem of over-identification, if not an indication that AD/HD may not exist in anything other than in the realm of socially constructed disorders. In light of this growing phenomenon and of incongruities found in the literature regarding the AD/HD diagnosis and treatment, a closer examination of the circumstances of the diagnosis and use of medication in treatment of ADHD is needed.

To date, the majority of research in this area has been based on empiricist perspectives seeking a biological cause to the phenomenon rather than examining it as a social phenomenon. However, Barone (1992) stated that research by educators which examines social practices is needed, and Rorty (1989) concurred that "social practices taken for granted have made us cruel" (p. 141). This may seem harsh. However, it may be through interpretive rather than empiricist research that we can better view the construction (or understanding) of AD/HD. It is time to stop taking the practice of AD/HD labeling and treatment for granted; it is time to examine

more closely the perspectives of those who are part of this process. Researchers (Bower, 1998; Erdman, 1998; LeFever & Dawson, 1999; Smelter & Rausch, 1996) have expressed a concern that there is an over-diagnosis of children as AD/HD. This work adds to that perspective and provides additional evidence of the inconguencies found in the attitudes and understandings of participants in the identification process.

Purpose of the Study

In this qualitative inquiry, I investigated the viewpoints, perspectives, and understandings about AD/HD and its treatment which are held by parents, physicians, teachers, and other school personnel who are regularly involved in the process of identifying and/or treating students for AD/HD. Through interviews, observations, and archival data, I attempted to understand the meaning and intentions behind the expressions/behaviors/ decisions of the individuals who work or interact with AD/HD children.

Greene (1993) stated that "understandings are not the end of science, but rather the means to achieving a more equitable, just and moral society" (p. 41). Qualitative inquiry recognizes as its underlying assumption that fact is not separate from values. Thus, in this study, I listened to values and perceptions that lead to the AD/HD diagnosis.

This study provides a different perspective in an area that has been primarily approached from a realist/quantitative methodology (Robin, 1998; Vatz & Weinberg, 2001). Its intended result is thought-provoking dialogue and increased insight among educators concerning the decision to label children as AD/HD and to use medication to control behavior and attention within our schools. Such dialogue can provide an opportunity to re-evaluate procedures used in the AD/HD diagnosis and to consider the number of children placed on stimulant drugs before all other avenues of treatment have been addressed.

Unfortunately, once the assertion has been accepted that AD/HD is an intrinsic biological disorder and millions of children have been medicated as a treatment, it may be very difficult for professionals with academic reputations and years of funding to re-evaluate this realist premise. According to Spindler (1982), the qualitative inquiry process makes the "familiar strange." This study forces us to move out of our familiar comfort zone and to become more aware of the epistemological decision-making that affects our children and society. I have attempted to synthesize the findings of this study into

a more lucid understanding of the common decision to label and treat children for AD/HD.

The Growing Phenomenon in the USA

That the diagnosis of AD/HD has become a national phenomenon can hardly be called an exaggeration. A generally well informed person knows what AD/HD is – whether he/she is an educator or not. It has become a rare week that one has not seen a report on AD/HD on various television news or talk shows such as "Dateline," "Frontline," and "Oprah Winfrey," or in popular newspapers or magazines such as the *Washington Post, U.S.A. Today, Newsweek,* and *Time.*

Academic scholars quote varying percentages of children labeled as ADHD but, in 1987, it was most frequently estimated that 3-5% of children in the United States had been diagnosed as having AD/HD (DuPaul, Guevrenot, & Barkley, 1991; Walters & Barrett, 1993). Since that time, the rate of incidence has doubled every 4-7 years. Barkley (1990) pointed out that:

> The 3%-5% prevalence figure he cites hinges on how one chooses to define ADHD, the population studied, the geographic locale of the survey, and even the degree of agreement required among parents, teachers, and professionals ... estimates vary between 1% and 20%. (p. 61)

Armstrong (1996), on the other hand, suggested that the prevalence rate could even be over 40% in some areas. Alarmingly, I did find classrooms in this study with over 40% of the students on stimulant medication for AD/HD. McGuinness (1989) also indicated that, even with such a dramatic increase in numbers of children diagnosed and medically treated for AD/HD, attempts to confirm neurological and physiological indices of hyperactivity have been elusive. Subsequently, the diagnosis continues to depend exclusively on questionnaire data. Armstrong (1996) suggested that relying on subjective judgments by teachers and parents who have an emotional investment in the outcome might be one contributing factor in this increase. James Carrier (1986) stated that, by attaching labels such as LD (Learning Disability) or AD/HD to students, teachers could justify the student's lack of academic achievement. It is apparent that the perceptions of those individuals completing the questionnaires do have a definitive influence on whether the child in question will be labeled and possibly medicated for having the disorder.

The purpose of this study was to examine the perspectives held by individuals in the lives of children in this growing phenomenon of AD/HD. I examined their views of the disorder and their roles and interactions in the process of identification and subsequent

treatment of these children. As I considered the number of children being labeled as AD/HD, I believed it was imperative that we take a closer look at the ramifications of this issue.

Historical Review

From its inception in the early 1900s, AD/HD (or hyperactivity), as an affliction of children, has been perceived from various perspectives. Some researchers assert that it is a physiological problem of the brain, a malfunction in the central nervous system, or even a reaction due to an allergy. Others claim it exists largely in the eye of the beholder.

Despite no absolute medical/scientific evidence, AD/HD continues to be commonly considered organic in nature and as intrinsic to the child (Pellegrini & Horvat, 1995). According to Mehan, Hertweck, and Meihls (1986):

> From a neurogenic/realist view, handicaps reside in students or in their conduct .... The medical metaphor has been extended from the physical to the mental domain within education. As a consequence, intelligence, aptitude, or mental ability have been medicalized and subject to treatment. It is this medical metaphor that leads to the view that students have a 'problem'. This problem is a disability perceived as residing in students, as their private, personal possession. (p. 159)

It also appears that AD/HD has continued to exist largely because of a unique coming together of the interests of frustrated parents, psycho- pharmacological technology, the cognitive research paradigm, new education products, and professional eagerness to try medications for controlling behavior (Armstrong, 1995). Goodman and Poillion (1992) stated:

> Through the years, the field of ADD has shifted from a very narrow, medically based category to a much broader, more inclusive and more subjective category ... in part, this could be because the characteristics for ADD have been subjectively defined by a committee rather than having been developed on the basis of empirical evidence. (p. 38)

The past 25-30 years have yielded a continual emphasis on therapeutic intervention rather than behavioral ones although the currently suggested treatment is a combination of medication and behavior modification (Barkley, 1998; Silver, 1999). It would appear that Coles (1987) was correct when he stated that "no biological explanation ever dies or fades away" (p. 39).

Methodology

Qualitative inquiry, unlike empiricist quantitative research, does not have a goal to derive lawlike generalizations (Giddens, 1977; MacIntyre, 1984). The purpose of this inquiry was to deepen insight and understanding about a given phenomenon. There was no effort to gain prediction or contradiction. Therefore, it was not my goal to build a random sample but rather to select persons or settings that I thought represented the range of experience of the phenomenon in which I was interested. In accordance with Maykut and Morehouse (1994), it is my working knowledge of the contexts of the individuals and settings that lead me to select them for initial inclusion in the study.

This study was conducted in a mid-western metropolitan area with a population of 112,000. Of the total 35 participants in this study, 19 were elementary school personnel, six were parents, and ten were associated with the medical community. The school personnel group included ten teachers, three counselors, and six principals. Those participants associated with the medical community were two physicians, two private practice nurses, five school nurses, and one pharmacist. It is worth noting that four of the professionals spoke from dual roles (professional and parental). Even though the sample was relatively small, the interviews (including follow-up interviews) lasted $1^1/_2$ - $3^1/_2$ hours in addition to the classroom observations of each interviewed teacher's classroom or the classroom of a parent's child in question.

In this study, I used what is referred to as a triangulation of data sources. Berg (1995) defined triangulation as a process of using "multiple lines of sight ... as a means of mutual confirmation of findings" (p. 5). This usually involves gathering three sources of data to investigate the same phenomenon. In this study, the sources were (a) taped and transcribed interviews, (b) classroom observations, and (c) archival documents which were student records and data from the school districts. Non-participant observation and extensive field notes were added to the process and reaffirmed comments and reoccurring patterns emerging in the data. Archival data such as statistical documents from governmental sources, AD/HD testing instruments, and inservice materials also reaffirmed the emerging patterns. These patterns showed consistency of views or perceptions of participants and also reinforced inconsistencies in those perceptions.

Findings

Incongruencies of Etiological Understandings

The findings revealed that most participants in the identification process hold incongruent, if not contradictory, perspectives about the nature of AD/HD. It appears that the inconsistencies in perspectives about the etiology of AD/HD contribute to their continuing decision to identify children as AD/HD and subsequently use or prescribe medication as a treatment as they struggle between the biological and sociological views of AD/HD

Despite the common practice to label for AD/HD, the picture that emerged from this study depicted a situation in which those involved in the identification process offered two different (and competing) understandings of its nature. The first belief expressed by participants was that AD/HD exists as a biological disorder. Within this view was the guiding assumption that the etiology of AD/HD is based on problems with brain chemistry, neurological functioning, or glucose absorption in the brain.

In diametric opposition to the biological determinist perspective, participants also conveyed at least some adherence to the social constructivist perspective, that is, the expressed belief that AD/HD is a product of social consensus: that AD/HD is caused or influenced by sociological situations. The social constructivist perspective is one in which an idea (in this case AD/HD) becomes reified, not through biological testing but through social consensus. The biological determinist view suggests that we discover AD/HD in children, whereas the constructivist view is that AD/HD only becomes real through the construction by individuals who interact with these children.

Murphy (1992) discussed how most labels reflective of a "learning disability" are actually "more societal than individual" (p. 14). He noted that many otherwise capable children might respond to a lack of academic success or personal/family problems by withdrawing or behaving aggressively. In accordance with this belief, participants in this study suggested that recent changes in the American family structure, societal mores, and child-rearing practices have contributed to the development of ADHD.

What is of crucial interest in this study is that the participants did not seem to recognize (or if they did, they did not acknowledge and deal with) the internal inconsistencies of their account of AD/HD as a condition. Within the same interview they would explain AD/HD in biological terms but later explain the increased numbers of children diagnosed in sociological terms.

Biological Etiology

Most participants in this study, including professional practitioners and parents assumed that the AD/HD diagnosis is based on objective, scientific information and that such definitions/diagnosis operate in the best interests of children. As stated previously, most participants in this study expressed the belief that AD/HD is a biological disorder diagnosed by medical personnel and that children benefit from being diagnosed and treated for AD/HD.

This biological determinist view was cited in the initial responses from most participants to a question about the etiology of AD/HD. Almost every respondent noted the cause as being related to an anatomical problem with brain chemistry, nerve functioning, or glucose metabolism. What follows are the voices of these participants as they shared their perspectives with me.

Nurses' Voices

I found the interviewed school nurses responded quickly and assuredly to my questions regarding the etiology of AD/HD. They appeared comfortable with my questions and open in their responses.

The most typical answer to my question about etiology was, "It's in the central nervous system: it's a disorder." Another school nurse answered the question by sharing information she and other nurses had received at a workshop. She stated, "the speaker [a physician] indicated that it's an actual physical problem. He compared it to when you have asthma they take medicine, when you have diabetes they [patients] take medicine." Because AD/HD is considered a physical disorder, it follows that the use of medication is viewed as an appropriate treatment. Later in the interview, she added, "all medical journals have proven that it is safe and effective. In fact, they don't even study it any more." To probe a bit deeper into this issue I asked, "How do you tell the difference between the child who has AD/HD and one who just has no self control due to past or present experiences." A nurse gave a typical response by saying:

> I'm not sure. I know that part of it is whether the medication works or not. If the meds don't do anything for them, then probably it's not that disorder. Sometimes the medication does help you diagnose. If you give Mylanta and it goes away, it's probably heartburn.

This comment came from a participant who had previously seemed quite sure that medical research supported and proved the existence of AD/HD.

There did not appear to be any doubt in these nurses' minds that these were scientific, factually supported positions. When asked

where she and other nurses had received information on AD/HD, most indicated workshops.

Educators' Voices

It might be expected that those schooled in medicine would tend to view AD/HD as having a biological etiology, but this was also true of educators who might be expected to understand behavior from a developmental and sociological view. Teacher preparation programs (particularly elementary education) and teacher inservice classes after employment have historically focused on child development and strategies for dealing with learning and/or social problems. Therefore, I was somewhat surprised at how readily the administrators and teachers expressed the medical model view of AD/HD.

An administrator shared the biological perspective of AD/HD by stating, "I would identify AD/HD as caused by the 'big man upstairs' who didn't give enough acid or too much acid and the synapses in the brain, the connector, is just not there." Another administrator offered a similar perspective:

> Kids are chemically imbalanced. That causes them to have attention problems. Or there's some kind of chemical thing going on so they can't focus on certain pieces. Whether it be because their Momma was on drugs or drank beer, I don't know.

His casual, off-handed reference to "Momma was on ..." struck me as a lack of understanding about the seriousness of the issue. Furthermore, I found it troubling that his comment seemed to border on a stereotypical view that AD/HD exists as a product of a lower socio-economic class family and the assumption that such families participate in the use of drugs. Both of these administrators professed the perception that AD/HD does exist as an intrinsic disorder in the child, and something the child cannot control.

When I interviewed an administrator of another school, I inquired if he could recommend any teachers who had experience with children diagnosed as ADHD. He suggested two who had 18 of 52 students, between the two classrooms, labeled as AD/HD. Both were middle-aged teachers with many years of experience. Each was very direct in her point of view and appeared confident in her expertise, knowledge, and ability to maintain an effective classroom environment. The teachers were interviewed separately but shared a common view of AD/HD as a biological disorder.

One of the teachers cited her interpretations of those in the medical community: "When I talk to doctors and nurses about it, they say it is a chemical imbalance in the brain and it depends on how

much of that is there." She could not say exactly what the chemical is or the part of the brain it affects.

The following comments from the other teacher were also representative of the perception that AD/HD is a biological disorder:

> A kid without Ritalin is like a diabetic without their insulin. It is a disorder. Research now has actual photographs of a brain of a person with ADD and one that doesn't, and the brain is different. So you cannot ignore it.

This teacher could not cite the specific research to which she was referring. It seemed to be something she had just heard somewhere, perhaps at a workshop, in the media, or in a discussion with peers.

It appears that these educators have not questioned the biological view of ADD from their rather simplistic answers. This suggests that the biological determinist perspective has been highly palatable to them. It is apparent that these teachers express a trust that the medical view of this disorder represents an accurate depiction of these children. Therefore, for them to ignore this disorder or to deny treatment to a child, would be considered as irresponsible as denying medication for any other medical affliction.

Parents' Voices

Parents interviewed in this study likewise expressed an understanding of AD/HD based on the medical model. This belief was exemplified in a parent's response, "Oh, I guess it is caused by some chemical imbalance in the brain. I had to come to grips with it [ADD], that it could be something she [the daughter] couldn't help." This parent had shared her feelings of frustration with her child's lack of success (particularly in math) in school, despite her [mother's] initial expectations. Because the child was reading prior to first grade and demonstrating advanced vocabulary skills, the mother expected high achievement from her daughter. With a chuckle of disappointment, she commented that she used to think, "Boyee, we've got a really bright one here." It is unfortunate that the mother equated the AD/HD diagnosis with lower ability in her child. I had observed this child in the classroom on two occasions and my impression was that the child is indeed bright and has a desire to learn.

Another parent who has been a strong advocate for her children and indicated that she has done a substantial amount of reading and talking to medical doctors stated her understanding that, "It [ADD] is related to neurotransmitter stuff. It's what happens in the brain and is manifested in behavior."" She indicated that this belief was based upon information received from a neurologist. In response to

my questioning about how the neurologist makes this determination, she stated, in a convincing voice, "Studies have been done with ultra sound and MRIs and compared to other people." I found it interesting that she followed that comment with, "However, those test results depend on who's reading them and what their philosophy is and whether they're in a research project stating they have proof that they can prove it using these tools." This statement seems to contradict her earlier assertion that it is a proven biological condition. Even with this candid admission of a serious flaw in the research or diagnostic process, she did not appear to hear incongruency in this line of thinking.

The tautological thinking in research on AD/HD has existed for decades. It remains problematic by the fact that the researchers cannot know whether their experimental groups are made up of subjects who have the disorder and their control groups composed of those who do not. Therefore, I believe the scientific research remains very questionable.

As I progressed through these interviewing experiences, I continually noted discrepancies between the initial statements of participants defining AD/HD in biological terms, while, almost in their next breath, offering sociological reasons for problematic behavior and lack of academic success. Although there is an appearance of fact to the participants in the process, their support of the AD/HD diagnosis is contradicted by their conflicting comments from the social constructivist perspective. The next section shows how, when questioned further regarding the etiology of AD/HD, the constructivist view was repeatedly expressed

Sociological Etiology

Finlan (1994), who viewed labeling as a socially constructed phenomenon rather than a medical condition, would suggest that a child really becomes AD/HD when declared AD/HD by adults who use the realist perspectives. One of the most insightful interviews that alluded to this was with a pharmacist [whom I will refer to as Lee] who has worked with schools, medical personnel, and parents. In his work Lee has the opportunity to talk with many individuals involved in the process of labeling and treating AD/HD. Even though his profession is scientifically grounded and hence more amenable to the biological view of AD/HD, he expressed concerns about over-diagnosis and misunderstandings about the safety of stimulant drugs for children. Some teachers had suggested that his own child may "have AD/HD." Lee indicated that during some years his child did just fine in class, but in other years struggled. He elaborated on that

experience in his discussion of how adults interact with a child. He had witnessed examples of how "one teacher may know how to deal with the child in the class, but the parents say they need the child to take the meds at noon and late afternoon cause they couldn't deal with it." The opposite may happen, as in his situation, where he could accept and channel the child's activity level at home; but the teacher could not at school. Therefore, it is the situation that seems to determine whether or not the child has a problem. His reasoning was that if the child's problem were biologically-based, he or she would demonstrate a consistent pattern of behavior across settings. That this is not the case clearly raises the social context as the operative factor. If this possibility were taken seriously, an examination of the school and home environments would be instructive.

School Environment

A school administrator expressed one simple observation of how classroom environment can play a role in a child's behavior:

> I have been in this room where nearly half the kids are on meds. At one point the kid's desks were in pods. If you have a kid who's sitting there and has trouble concentrating, and you have 3 other bodies right there, it's almost asking them to do something that is not possible for them.

In this particular case it seems apparent that a simple rearranging of the room might prove beneficial to those students who have difficulty concentrating. It occurred to me that, even as a normal adult, I would find sitting in such close proximity all day a distraction to my work.

A parent expressed another example of a participant's perception of the school environment as having an effect on the child's performance.

> I think my children [two of which had been diagnosed as ADD] probably did better in structured school environments as a whole. But they also responded very positively to respect, I think. If they felt the teacher really cared, then they would do almost anything for that teacher.

This view was interesting, as this parent had previously stated that she felt medication to be the key to her child's success. The message now appears to be that the relationship between the teacher and student is as important, perhaps even more so, as the perceived benefit of medication.

Another example of parents viewing the teacher/student relationship as instrumental in how the student is perceived (as normal or disabled) was evidenced in the following statement:

> Some teachers saw her [the child] produce at erratic times and do most of the work ineffectively. They came from a different place than the ones that saw her as having some potential but lazy cause she wouldn't learn to spell. The art teacher thought she was delightful.

Two aspects of the school environment are expressed in this comment. First, the relationship and perceptions by individual teachers can vary. Second, and in a related vein, the child may behave quite differently depending on subject matter, teaching strategies, and perhaps most importantly, on the teacher's judgment of the child's competency.

Yet, another expression of the importance of matching teaching strategies to the individual child was found in an interview with another parent. This parent, who also was convinced that the use of stimulant medication was helpful to her child, relayed a discussion she had with her son's teacher. The teacher had told the parent that she thought her son had a learning problem because he "just couldn't keep up." She also suggested that he could not keep up because of this "medical problem [ADD]." Despite the teacher's perception that it was not possible for him to do the work, she did add that "if it was a subject that he really liked, like experiments, hands on, he does OK; but he loses interest in work sheets real fast." This very important observation notwithstanding, the central problem was still attributed to the child's physical condition.

An administrator who indicated that simple boredom could sometimes be an issue with a child's behavior and ability to learn also expressed these concerns about the ability of teachers to motivate all children:

> If you're in class and the teacher is talking to you in a monotone voice and he or she is not doing anything to capture the kids' attention or keep their attention, they [the students] start looking around. Something has to connect up here to say that you need to pay attention and get this information.

This may seem to be an indictment of some teachers, but later in the interview she also shared her view that the home environment may also provoke AD/HD behaviors.

Home Environment

As noted in the previous section, the administrator who mentioned the possibility of unmotivating teachers contributing to a lack of focus on the part of some students also indicated that the home environment can be problematic:

> My experience has been that a lot of kids get labeled ADD because they have a behavior problem that's environmental, that they grew up with – no sense of organization, so when they come to school they don't know how to organize. That desk doesn't mean anything to you.

The belief that the home lives of these children is often disorganized was evidenced in an interview with a school nurse. When I questioned her as to why there has been an increase in the numbers of children diagnosed as AD/HD, she responded:

> There are a lot of different reasons why – environmentally. Life for a lot of these kids is so disjointed with having two parents work, no schedules for meals, no family time. I don't think anybody really knows that there's an exact cause.

Once again, the reasons given for what she had previously depicted as a biological disorder lie in the context of the societal/environmental.

A participant who is actively involved with support groups for parents of children labeled as AD/HD also discussed some of the common problematic home situations. She is in a position to hear about these from other parents as well as sharing some of her personal experiences. Her tone was not accusatory; instead it was rather compassionate as she spoke of family struggles:

> So many [parents of ADD children] are single parents or operating as single parent families. Fathers have a difficult time accepting it. Men deny the situation and responsibility, don't attend parent meetings. Then the Moms end up covering up for the kids as Dads tend to be very punitive.

These were her impressions derived from her involvement with the support groups, but she also added examples from her personal experience. She shared, "I think my husband had the idea that if his sons weren't perfect he didn't want to admit it or even deal with it. Whenever I would try to talk about it, he could not tolerate to listen." Another parent spoke of her husband's reaction to the behavior of their child. She viewed his reactions to be common to many fathers, particularly fathers from homes with a history of a "hyperactive" temperament. For example, she explained:

> I think that happens in so many families when you're dealing with ADHD adults and children. His [her son's] father had no tolerance for his hyperness when he was little and his [father's] frustration level was so low and mine is so high. I would have to make sure they were in separate rooms sometimes because I knew he [father] wouldn't tolerate some of this. I was the peacemaker. Sometimes he would get on the verge of verbal abuse in what he didn't tolerate. I always wanted to explain but they're hyperactive, but they're learning disabled.

As she described this stressful situation in the home, I wondered how the child felt. Both parents loved their sons but their approaches to handling the behaviors seemed to be quite different. Perhaps this left the child confused by the inconsistency between the two parents. She did say, "her husband could get the boys to stop whatever activity they were doing faster than she could as she spent a lot of time reasoning with them." Each child is unique and a parenting or educational strategy that works for one may be less effective for another. It can take a great deal of time and energy for parents as they struggle to seek appropriate strategies for a difficult child. Coupled with parents' frustration is a society that many participants perceived as changed in ways that also contribute to these children's problems.

Societal Problems

An administrator who had been in the field of education for 15 years expressed concerns about how things have changed in general regarding how "most kids used to be able to take a reading assignment, sit and read. Not anymore, we have to do oral reading because kids just can't seem to concentrate any length of time." I asked how he explained this change in attention span through the years. He stated that he viewed the fact that "kids watch more TV and play a lot of Nintendo or computer games" as being a major contributor to the problem. Other participants expressed the suspicion that technology may have had a negative effect on the attention span of children. A teacher discussed her view of a technologically changed society in her response to my question about why more children are labeled as AD/HD: "I guess I personally feel that the change in the family, the introduction to TV and videos, that kind of technology where children are left to their own devices a lot of the time."

During this part of the interview, the teacher's voice grew louder and she became more animated. I felt that I had touched on an important concept with her. She further explained that:

> I don't know, it's just very different than the time when I was brought up. I remember it was the exception to the rule to find children fooling around with their things in their desks, not paying attention, and we had large classes back them. I mean there was a time when children, when there was an element of fear. I respected my parents and I knew there was a law. Now, parents say I don't want them to be mad at me; I just want to be their friend.

She seemed almost angry about this shift in parental authority, but also sad for the children when she added:

> Let's face it, there are a lot of kids that go home to an empty house. They [children] get up and get themselves off in the morning and in some ways that makes them more independent but others, they have nobody to model after. A parent will say [in a conference], 'Oh, I know I should make them do chores, but it is so much work and easier to just do it myself.'

These comments were reflective of the specific home environment as discussed earlier but also reflective of a wider societal change. It was very apparent that this teacher had strong feelings on this issue and seemed to think the situation was rather hopeless. It is also worth noting that this teacher taught in a classroom in which 46% of the students were identified as AD/HD.

Conclusion

As long as AD/HD is viewed as a biological illness, the participants in this study can support and rationalize the use of medication as being beneficial to the child. As the participants indicated, psychostimulant treatment appears to improve behavior and the ability to focus, conveying the message that the child's problems are biologically based. This explicit biological view of AD/HD persists despite no conclusive empirical evidence, perpetuating the acceptance of the disorder. Because neither the parent, teacher, nor child is perceived as causing the difficulties, none of these individuals can be expected to ameliorate them. At the same time, participants also expressed their understanding of the AD/HD diagnosis in implicit socially constructed terms. Most AD/HD proponents in this study were acutely aware of the non-biological factors possibly contributing to AD/HD type behaviors. However, they continued to operationalize the idea of AD/HD from the medical model rather than fully accepting AD/HD as a socially constructed disorder.

Mann (1992) indicated that Western societies (particularly American) perpetuate empiricist beliefs. He added that drugs are a compelling method to solve western societal problems and the ongoing process of diagnosing children as AD/HD is less prevalent in cultures with more relaxed behavioral standards for children and more stable home environments. The 1995 report from the DEA noted that methelpheniadate is rarely prescribed in other countries with the United States and Canada being by far the largest users. Breggin (1994) concurs and offers that European countries not only rarely prescribe stimulant drugs to children, they have not historically been allowed to do so by the National Health Service.

However, there are some doctors in Britain now who are proposing that they follow in America's footsteps on this issue (p. 87).

Another example of the pervasiveness of our societal views was expressed in the way participants focused on what professionals and parents do to handle the child rather than asking why this problem exists. The desired change is viewed as being within the student; yet others are imposing external controls. In the words of Swan (cited in Slee, 1995):

> Attention Deficit Disorder is not a disease; it's just a part of the spectrum of children's behavior. The issue is to find the line where abnormality stops and normality begins ... and the line moves according to who's drawing it. (p. 64)

Somewhere along this line of normality a decision is made to classify a group of children as defective.

Very, very few participants mentioned any concern about over-identification of children, which I interpreted as a lack of insight about the magnitude of this problem. Murphy (1992) discussed how people are likely to accept the first plausible explanation of a phenomenon and retain this initial causal attribution, even when later faced with better alternatives or new data. Once a child, his or her parents, and his or her teachers begin to ascribe positive behaviors to chemicals, it may be quite difficult to explain positive changes to such things as a child's developing competencies or changes in home or school environments. Good behavior may continue to be attributed to medication and bad behavior to lack of medication.

These participants appear to have based their decision to label children as AD/HD on received knowledge rather than to critically question the sources. Furthermore, the professionals who have been considered experts by most participants viewed AD/HD from a realist perspective, which is incompatible with meeting educational and personal needs of children. Despite good intentions to help children, the participants in the study struggled with a lack of conceptual thinking, which also leads to their confusion.

Examination of Beliefs Needed

As educators, we must begin to examine our beliefs/assumptions about AD/HD. Instead of accepting realist views without question, we must strive to think conceptually and examine the internal incoherence of our beliefs. What is done about a problem depends upon how it is defined and understood. Furthermore, these definitions are based on assumptions about the causes of the problem. Murphy (1992) discussed how definitions tend to

characterize problems indefinitely, to reflect existing sociocultural values and myths, and to influence the self-concepts, expectations, and behavior of people to whom the definitions are applied. It appears to me that, for as long as professionals continue to define AD/HD from a realist perspective and yet at the same time identify the behavior from a social contextual perspective, the phenomenon of AD/HD will continue to grow.

Murphy (1992) added that the social contextual interpretations refer to the interrelation of a variety of structural settings in our immediate environment, such as the family unit, agencies of education, health, recreation, law enforcement, and business. He went on to say that, "critics have charged that situation or context centered causal factors are often excluded from consideration as causes of learning disabilities," or more specifically ADD (p. 10). Perhaps this is because context-centered causal factors are more intractable – more difficult to remedy.

This consistent process of identifying AD/HD depends upon the meanings school professionals and parents attach to such behaviors and the context surrounding student behaviors. Professionals give the appearance of relying on facets of reality, but ultimately they rely on opinions and beliefs. Skrtic (1986) stated that researchers and practitioners perpetuate the narrow scope of medical treatment by failing to assess, address, alter, or circumvent the social, political, and cultural causes and contexts of disabilities. Gallagher (personal communication, July 1, 1997), Gould (1982), and Mehan et al. (1986) concurred that disabilities are social constructions. In other words, they are something we have created rather than something we have discovered. To this day, there remains no neurological test that can, in itself, determine learning disabilities.

We need to accept and address differences among students instead of equating those differences with defects or as a burden. Perhaps such children have trouble learning in traditional ways and become restless, inattentive, and disruptive. Others may be particularly bright or creative and are just bored (Webb & Latimer, 1993). Still others may be struggling with stresses in the home environment. We need to visualize the larger picture, that the individually constructed realities of AD/HD are part of a larger social context of learning problems.

Labeling and medicating will not force schools to create inclusive classrooms in which all children feel valued. Mara Sapon-Shevin (1996) said that removing the problem via medication obviates the need to make appropriate improvements in classrooms even if scholars acknowledge that medication is just one of several

suggested strategies. Educators, medical personnel, and parents must take a holistic view of each child with a serious examination of the wide range of causation for attentional and behavioral problems. As difficult as this may be, we must broaden our views to include historical, sociocultural, cognitive, educational, developmental, and psycho-affective domains as we meet the cognitive and affective needs of these children in our society.

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