

1997

Attention deficit/hyperactivity disorder: Perspectives of participants involved in the identification and treatment process

Judy Davison
University of Northern Iowa

Let us know how access to this document benefits you

Copyright ©1997 Judy Davison

Follow this and additional works at: <https://scholarworks.uni.edu/etd>



Part of the [Special Education and Teaching Commons](#)

Recommended Citation

Davison, Judy, "Attention deficit/hyperactivity disorder: Perspectives of participants involved in the identification and treatment process" (1997). *Dissertations and Theses @ UNI*. 779.

<https://scholarworks.uni.edu/etd/779>

This Open Access Dissertation is brought to you for free and open access by the Student Work at UNI ScholarWorks. It has been accepted for inclusion in Dissertations and Theses @ UNI by an authorized administrator of UNI ScholarWorks. For more information, please contact scholarworks@uni.edu.

Offensive Materials Statement: Materials located in UNI ScholarWorks come from a broad range of sources and time periods. Some of these materials may contain offensive stereotypes, ideas, visuals, or language.

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA
313/761-4700 800/521-0600

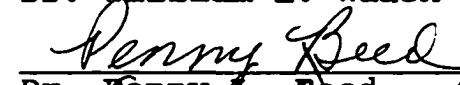
ATTENTION DEFICIT/HYPERACTIVITY DISORDER:
PERSPECTIVES OF PARTICIPANTS INVOLVED IN
THE IDENTIFICATION AND TREATMENT PROCESS

A Dissertation
Submitted
In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education


Approved:


Dr. Deborah J. Gallagher


Dr. William L. Waack


Dr. Penny L. Beed


Dr. Charles V. Dedrick


Dr. Mark A. Grey


Dr. Phyllis L. Baker

Judy Davison
University of Northern Iowa
December 1997

UMI Number: 9816934

**Copyright 1997 by
Davison, Judy Carol**

All rights reserved.

**UMI Microform 9816934
Copyright 1998, by UMI Company. All rights reserved.**

**This microform edition is protected against unauthorized
copying under Title 17, United States Code.**

UMI
300 North Zeeb Road
Ann Arbor, MI 48103

Copyright by
JUDY DAVISON
December 1997
All Rights Reserved

ACKNOWLEDGEMENTS

I extend my appreciation to the participants in this study who shared their time and candid views enabling a deeper understanding about this issue. Only through their cooperation was this study possible.

It is imperative that I acknowledge my committee chair, Deborah Gallagher. At the time, she was one, of few, who shared my passion for this topic. Her expertise in special education was invaluable to my deeper understanding of learning disabilities, and ADD in particular.

Likewise, other committee members were chosen for their expertise and support during my doctoral process: Phyllis Baker and Mark Grey shared their sociological perspectives, broadening my view of issues in education; Penny Beed provided encouragement and vision of opportunities for my future; and Charles Dedrick offered a broad knowledge of issues in education and a dry wit to sustain my efforts.

In addition to serving on my committee and providing careful editing of the manuscript, I offer my deepest respect and gratitude to William Waack who has faithfully supported my efforts through my graduate studies. His personal and intellectual integrity regarding the educational process has been a constant.

I also acknowledge my sons, Kevin and Joshua. They have developed into fine young men while sacrificing my time and attention during my work and studies.

PROLOGUE

Even though I was familiar with the label *Attention Deficit Disorder*, I had not thought about it very deliberately until one of my middle school students was diagnosed as being ADHD. Suddenly, the issue of labeling and treating children for ADD/ADHD became personal. For that reason, it is important to begin this study with the story of how this issue became critically important to me both personally and professionally and to clarify my predisposition as I conducted this study.

TABLE OF CONTENTS


Chapter	Page
I. INTRODUCTION	1
Searching for a Definition	8
The Growing Phenomenon	12
Criteria for Identification-- Who Is Involved?	16
II. REVIEW OF LITERATURE	19
Historical Review.	19
Summary of Historical Review	35
Current Conceptualization/Justifications and Counterpoints.	38
ADD Has a Biological/Neurological Etiology and Therefore Is Intrinsic to the Individual Child	38
Stimulant Medication Has an Effect Only on ADD Children.	42
Medication Is as Justified and Safe for ADD as for Any Other Illness	43
Identification Tools Are Objective	45
Medication Results in Academic Improvement	46
Other Arguments Against Conceptualizing and Treating ADD as an Intrinsic/Neurobiological Disorder	50
Drug Company Involvement and Economic Gains.	50
Moral Question of Personality Alteration	53
Changes in School Policies	53
III. DESIGN OF THE STUDY.	57
Problem Statement.	57
Purpose and Significance of the Study.	58
Preliminary Research Questions	60
Interpretivist Paradigm/Perspective.	60
Objectivity Versus Subjectivity.	63
Site/Participant Selection	65
Procedure for Data Collection and Analysis	66
IV. IN THE EYES OF THE BEHOLDER.	70
Incongruencies of Accounts	72
Etiological Understandings	73
Biological Etiology.	73
Nurses' voices	74
Educators' voices.	76
Parents' voices.	79

Chapter	Page
Sociological Etiology.	83
School environment	84
Home environment	88
Societal problems.	91
Rationale for Identification--Who Benefits?.	92
Identification Procedures.	97
Conclusion	107
 V. IMPLICATIONS OF THE STUDY.	 110
Received Knowledge: A Key Factor	111
Realist/Positivist Assumptions	114
Incompatibility of Realist/Constructivist Paradigms.	118
Lack of Conceptual Thinking.	121
Conclusion	126
Examination of Beliefs Needed.	126
Altered Practices Needed	128
 REFERENCES	 133
 APPENDIX A: Diagnostic Criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)	 143
APPENDIX B: Production of Methylphenidate.	146
APPENDIX C: Production of Ritalin.	148
APPENDIX D: Age-Gender Mean Scores on Conners' Rating Scale	150
APPENDIX E: Conners' Rating Scales	152
APPENDIX F: Historical Diagnostic Terminology.	155
APPENDIX G: Participant Consent Form	157
APPENDIX H: Interview Protocol	159

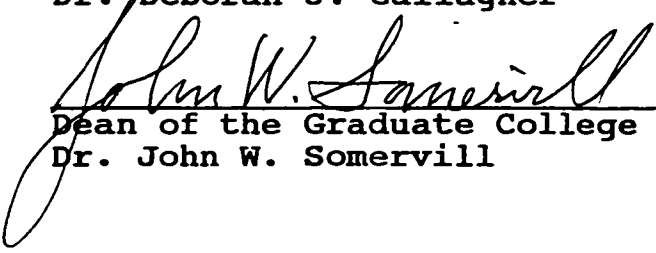
**ATTENTION DEFICIT/HYPERACTIVITY DISORDER:
PERSPECTIVES OF PARTICIPANTS INVOLVED IN
THE IDENTIFICATION AND TREATMENT PROCESS**

**An Abstract of a Dissertation
Submitted
In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education**

Approved:



Faculty Advisor
Dr. Deborah J. Gallagher



Dean of the Graduate College
Dr. John W. Somervill

**Judy Davison
University of Northern Iowa
December 1997**

ABSTRACT

The purpose of this study was to investigate the viewpoints, the perspectives, and the understandings about Attention Deficit Disorder (ADD) which are held by parents, teachers, other school personnel, and physicians who are regularly involved in the process of identifying and/or treating students for ADD. A qualitative inquiry approach was initiated in a middle class community in a Midwestern metropolitan area and included individual interviews and classroom observations.

The researcher offered her understanding of the meaning and intentions behind the expressions/behaviors/decisions of individuals who work or interact with children labeled as ADD. An examination of the data revealed incongruencies in participants' understandings of ADD in three distinct areas: first, the etiology of ADD; second, the benefits of diagnosis and treatment for ADD; and third, the procedures for diagnosis and treatment.

This study provides an alternative perspective in an area that has been primarily approached from a realist/quantitative methodology. It also provides input for thought-provoking dialogue and increased insight among educators concerning the decision to label children as ADD and subsequently to use medication to control behavior and attention within our schools.

CHAPTER I

INTRODUCTION

As a teacher of middle school TAG (talented and gifted) students, it was not uncommon to receive a request to fill out forms relating to school practices. On this particular day, my mailbox held a two-page form, the "Conners' Behavior Rating Scale," containing questions regarding student behavior. My first impression was that the form was to gather my general perceptions of middle school students. However, the following note was attached: "Fill out on Jason and return to me ASAP. Larry."

Larry was a school counselor with whom I normally had little contact. Because I had never thought of Jason needing any special testing, I was confused by the message. Therefore, I decided to go to Larry's office and request an explanation. He informed me that the parents and other teachers had requested that Jason be tested for ADHD (Attention-Deficit and Hyperactivity Disorder). I questioned the need for the testing because, from my perspective, Jason was doing very well in my class.

Larry seemed disinterested in my response. He looked up from his desk only briefly and continued organizing papers into various folders and placing them in a drawer of a filing cabinet. After a few moments he replied, "Just

fill it out as you see it and return it ASAP as they are anxious to get the results."

Larry's disinterest prompted questions in my mind. Had a decision already been made and was the completion of the form merely a formality to be disregarded if my answers were not consistent with other teachers? Was my input not valued because I worked only part-time within the building, was relatively new to the school system, and tended to have a view of my role as teacher not always compatible with other teachers in the building?

I read through the questions more carefully and felt they were so general that they could apply to any middle school student. One question asked, "Does he have a short attention span?" Presuming that "short" meant less than the majority of students, I wondered how responses to this question could be helpful. After all, different teachers have different senses about what constitutes short or even adequate attention. I did not find him all that different, so I answered, "No." As I continued through the questionnaire, I was troubled by its vagueness and the possibility that this one inventory might be very influential in deciding whether a child would be placed in special education programming. Something inside me cringed at the thought. My instincts told me that something was wrong.

I completed the questionnaire and returned it to Larry. He did not seem particularly relieved to receive it as he made no comments regarding the compilation of the data and the setting of a meeting to discuss strategies to meet Jason's needs. He simply accepted the form and placed it on his desk. I again wondered if the decision had already been made and if the form was merely a matter of formality.

Over the next 6 weeks I became aware of the fact that Jason had become increasingly quiet in my classroom. I commented to him that we had not heard his ideas for some time and missed his contributions. He responded, "I know, Ms. Davison. It's just that this medicine [Ritalin] they have me on makes me so tired."

I had a sinking, sad feeling. When I had filled out the form, it did not occur to me that my answers also would influence whether he would be medicated. I actually had forgotten the questionnaire and had not been contacted about the final decision. I was angry that such a decision could be made without my knowledge. Somehow I felt I had personally betrayed Jason even if my responses to the inventory had indicated that he did not have problems in my particular class. After all, I had passively participated in the process. Upon reflection, I felt I should have realized the seriousness of the situation even if no one had

contacted me. Jason trusted me--more than he seemed to trust most adults. Had I let him down?

I was familiar with Jason's adoptive mother. She was a sensitive and intelligent person, a professional who had adopted three siblings between the ages of 4 and 12 within the past 2 years. We always talked candidly during parent teacher conferences and when we would run into each other from time to time. I recalled seeing her in tears in the school hallway after a conference with Jason's other teachers earlier that spring semester. During our conversation on that occasion, she shared some of her frustrations in her new parenting role. That she was under stress was apparent in her swollen eyes and slightly slumped posture as she walked down the hall toward me. It was apparent, from our conversation, that she was under great stress and felt she was failing as a parent. She divulged that each evening brought a struggle over homework and conflict among Jason, his father, and herself. She indicated that my class was the only one that Jason was not failing. According to her, the counselor and other teachers had suggested that he should be pulled out of my class, which was an elective, to have study hall where he could work on missed homework from other classes. She disagreed, feeling that he needed my support and would probably waste his time in study hall anyway. I agreed with her and found

it odd that I had not been included in the meetings with other teachers.

The process through which Jason was identified as ADD and subsequently medicated left me perplexed. I started to be more cognizant about decisions being made within the district, especially those which were not compatible with my philosophy of education. I began to question the general process by which all children are placed in special programming and/or on stimulant medications. The unsettling experience with Jason prompted a time of contemplation about issues I had never seriously considered in my prior years of teaching.

The following fall I left the district to pursue graduate studies. As I began graduate coursework, I found myself becoming even more reflective about educational practices. In particular, I came to suspect that education has created a system whereby we sometimes dehumanize the individual student for the convenience of the adults working within the system despite our stated intent to enhance the learning and development of each student. I realize that this suspicion may strike the reader as unwarranted, particularly in its bluntness. Nevertheless, it represents an honest account of my professional musing at that point.

Despite my involvement in coursework and distance from the school district, the incidents surrounding Jason

continued to haunt me. I wondered how his teachers would view him this year and how he was currently viewing himself. As it turned out, he would not be the only student whose diagnosis of ADHD I would find disturbing.

During the first year of my graduate studies, I accepted a part-time K-4 talented and gifted teacher position in a school district near the university. At midyear, a third grade teacher approached me inquiring how I felt about IQ testing. One of her student's parents had requested an IQ test and that the talented and gifted teacher work with their son. The parents were concerned that his performance in school may not be reflective of his intelligence. Through my subsequent conversations with this teacher about this student's needs, I found myself confronted with another case of a child being "treated" for attention deficit disorder. Ritalin was also the treatment of choice for this child whom I will call Daniel.

The classroom teacher complained that Daniel did not stay on task and displayed "arrogance" in his interactions with other children. She also indicated that a special education consultant had completed a time study on him and had found that he was on task 50% of the time as opposed to an average student's rate of 85%. I asked her how much of his work he completed during that time. She responded that he usually completed his work even though he was slow to

begin. She said he had unusual interests for an 8-year-old boy and that I might find him interesting to observe.

During my first observation of Daniel I noticed that he squinted his eyes and wrinkled his forehead as though he were intently concentrating. I inquired if this were typical. The teacher said that it was. In our succeeding conversations, she also indicated that he had been placed on Ritalin before entering the second grade so she had not observed his behavior without the drug. I wondered how she could possibly know if Ritalin was "helping" him if she had no comparison with his behavior when not on the medication. At the request of the parents, Daniel took a low dosage at school (2.5 mg) during the day but received a heavy dosage (10 mg) toward the end of the day to ease the transition to home. According to the teacher, the parents had expressed concern that, on occasion, he would get lost walking home from school. Once again, this did not feel right to me, but I did not have the knowledge base regarding the use of Ritalin to make an informed judgment about the appropriateness of this use of medication for a child. I just knew that Dan really did not seem all that different from the other boys in class.

A few weeks later, I overheard a faculty member in the same school comment that another teacher had a class in which 25% of the students were placed on Ritalin. The

impression given by other teachers in this conversation was that this teacher had a difficult group of children. It seemed to me that most classrooms had at least one child on the drug. The inferences I received from these teachers were that these were really "bad" kids who would be impossible to handle without the intervention of Ritalin.

I inquired about how common it was to have students taking Ritalin. The teachers indicated that they had more and more each year. I was disturbed by this perception and felt compelled to discover what exactly ADD/ADHD was and if it were indeed true that the use of medication was commonly accepted.

Searching for a Definition

As a result of my reflections and subsequent questioning of these diagnoses and treatments, I initiated a search for a definition of ADD. I found that the diagnosis and administration of medication to ADD children are generally based on a definition established by the American Psychiatric Association.

The American Psychiatric Association first established this official definition of ADD in their 1980 Diagnostic and Statistical Manual of Mental Disorders-III (DSM-III). After years of revisions, the most recent DSM-IV (1994) stated that Attention-Deficit/Hyperactivity Disorder "is a persistent pattern of inattention and/or hyperactivity-

impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development." (See Appendix A for more complete diagnostic criteria.) However, as Breggin and Breggin (1994) suggested, these standards are set with reliance on subjective impressions and are controversial even within the field of psychiatry. Even so, they are used consistently in setting clinical and research trends and ultimately influence how millions of caregivers define and view the behavior of children.

Breggin and Breggin (1994) contended that the list of criteria for ADD listed in the DSM-IV actually "identifies children who have lost respect and trust for the adults around them" (p. 74) and that these characteristics should serve as an indicator that the adults should alter their interaction with children rather than seeking to alter the children. Furthermore, Breggin and Breggin stated that "it is quite possible that children have every reason to be angry in the context of their interactions with the environment adults arrange for them" (p. 74).

Examining these definitions led me to consider the possibility that Jason was an angry child. He and two siblings were abandoned by their biological mother and were then adopted by a professional couple. Is it possible that these new parents were well-intentioned but perhaps ill-

prepared for coping with the needs of an adolescent and two siblings? This must have been a difficult situation, and I can appreciate why it would not be easy for Jason to trust. He had made statements to me indicating he did not believe his mother loved him. Obviously, he also felt school to be a place of rejection. That the school had evaluated him and subsequently found him deficient (benevolent intentions notwithstanding) appears to have substantiated his mistrust.

As I read the list of "symptoms" in the DSM-IV, I did not see Jason as having a "persistent pattern of inattention." It varied. At times he would fail to follow through on an assignment; but if I monitored him closely, he usually would finish. It was not unusual for my TAG students, particularly males, to "wiggle" and be more physical than other children, so Jason did not stand out as being that different from the "norm."

I also did not see the persistent inattention stated in the DSM-IV during my observations of Daniel. As with Jason, his inattention seemed to vary. When I worked with him one-to-one, he consistently stayed on task. In fact, he needed to be coaxed to go back to the regular classroom and to stop the activity chosen for our session.

In my subsequent research on ADD I found that ADD children appear to perform just like other children on all tasks in which they are in control of the situation, but

they fail to do well in tasks controlled by someone else (Sykes, Douglas, & Morgenstern, 1973). This behavior would appear to be a lack of amenability to adult control rather than a lack of attention. The formal definition of ADHD as cited in the DSM-IV (see Appendix A) characterizes students with this disorder as those who cannot control the allocation of their attention. However, the observation made by Sykes et al. (1973) depicted these children as very much in control of their attentional allocations but not in ways that are particularly pleasing to teachers. I wondered how Daniel felt about the work assigned by his teacher.

As a result of this reflective process, I questioned my long-held belief that children's best interests are served in the schools. Was it possible that the focus of the decision about Jason seemed to be more for the benefit of teachers and parents than for his educational and personal needs? Could it be, as I speculated earlier, that the decision to label and even medicate him for ADD may have been decided long before my evaluation forms were returned to the counselor's office? The only sense I could make out of my current perspective was that either I had become too critical and/or less naive or that schools had undergone some fundamental changes.

As I reflected on the diagnosis and treatments of Jason and Daniel, as well as the definitions from my initial

literature search, more questions emerged. Consequently, I became increasingly convinced that this issue was worthy of study and began the process which led to a more extensive examination of this issue.

In the following two sections I discuss how the ADD diagnosis has grown into a national phenomenon and identify those who play a key role in this process of labeling and treatment. For the sake of consistency, I use "ADD" throughout this study in reference to attention deficit disorder with or without hyperactivity.

The Growing Phenomenon

That the diagnosis of ADD has become a national phenomenon can hardly be called an exaggeration. A generally well-informed person knows what ADD is--whether he/she is an educator or not. It has become a rare week that one has not seen a report on ADD/ADHD 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 ADD/ADHD but, in 1987, it was most frequently estimated that 3-5% of children in the United States had been diagnosed as having ADD (DuPaul, Guevrenont, & 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 cited

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%. It is considered an affliction of males as they predominate 6:1 in diagnosed cases and some studies have indicated 33% of elementary aged males have been diagnosed as ADD. (p. 61)

Armstrong (1996), on the other hand, suggested that the prevalence rate could even be over 40%. Is it possible that the real story is told in terms of the production of Ritalin, the most popular brand name for the drug methylphenidate, used to treat ADD?

The United Nations International Narcotics Control Board (INCB) requested data concerning trends in the use of methylphenidate from the U.S. 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 (see Appendices B and C).

A 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 has occurred in the past 5 years, representing an increase of nearly 600% from 1990 to 1995 (Drug and

Chemical Evaluation Section, 1995). Out of the estimated 2 million children who are receiving labels of and treatment for ADD, there are at least 4 times more boys diagnosed with the "disorder" than girls (Hancock, 1996; McGuinness, 1989). Some researchers, such as Barkley (1990) and Armstrong (1995), indicated the figure may be higher. Currently, approximately one-third of all elementary-school boys are labeled as an abnormal population because they are fidgety, inattentive, and inalienable to adult control (McGuinness, 1989; see Appendix D).

McGuinness (1989) also indicated that, even with such a dramatic increase in numbers of children diagnosed and medically treated for ADD, attempts to discover neurological and physiological indices of hyperactivity have been largely sidestepped. Subsequently, the diagnosis has come to depend exclusively on questionnaire data. Armstrong (1996) suggested that relying on subjective judgments by teachers and parents who do have an emotional investment in the outcome may be one contributing factor in this increase. James Carrier (1986) stated that, by attaching labels such as LD or ADD to students, teachers can justify the student's lack of academic achievement. It is apparent that the perceptions of those individuals completing the questionnaires have a definitive influence on whether the

child in question will be labeled and possibly medicated for having the disorder.

A variety of rating scale instruments are used for the ADD diagnosis. Some of these are: Attention Deficit Disorders Evaluation Scale (ADDES)--Home Version (McCarney & Bauer, 1989), ADD-H Comprehensive Teacher's Rating Scale (ACTeRS; Ullmann, Sleator, & Sprague, 1991), Children's Attention and Adjustment Survey (CAAS)--Home Form (Lambert, Hartsough, & Sandoval, 1990), and Conners' Parent and Teacher Rating Scales (CPRS/CTRS)--28 (Conners, 1989a/b). Of this group, the Conners' scale is the most frequently used and is shown in Appendix E (Breggin & Breggin, 1994; Kramer & Conoley, 1992). Again, these instruments are completed by parents, teachers, and/or other school personnel who interact with these children daily.

The purpose of this study was to examine the perspectives held by these individuals in the lives of children in this growing phenomenon of ADD. 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 ADD, I believed it was imperative that we take a closer look at the ramifications of this issue.

Criteria for Identification--Who Is Involved?

In discerning who are the identifying individuals, one must determine how the children are characterized as ADD. Typically, the identification process is initiated by the child's classroom teacher in a conference with the parent/s. The classroom teacher usually begins by informing the parent/s that he or she has tried various strategies to assist the child in paying attention and getting assignments completed to no avail and now suggests that an evaluation for ADD be initiated through *school personnel, a child psychologist, or a medical doctor* (Divoky, 1989;, Granat, 1995). Any of these individuals may then request that an evaluation instrument be completed by an individual/s who is in a position to observe the child's behavior at school and/or at home.

Various observation rating scale instruments are available for use, such as the ACTeRS (Ullman et al., 1991), ADDES (McCarney & Bauer, 1989), CAAS (Lambert et al., 1990), and the CPRS (Conners, 1989a). Breggin and Breggin (1994) reported that the most popular rating scale employed is the Revised Conners' Questionnaire (CPRS). This scale contains a checklist similar to the one in the DSM-IV definition of ADD (see Appendix A). Even though each of these scales is widely criticized as containing no operational definitions and thus no means of establishing objective data in a

scientific sense, the information derived from administration is apparently believed to be objective in a practical sense by those using it (Breggin & Breggin, 1994).

Once the questionnaire of choice is completed, the parent/s frequently contact a physician or psychiatrist who subsequently prescribes medication. Along with the medication, behavioral modification strategies may be continued and monitored by the teacher and other school personnel depending on the system and available resources (McGuinness, 1985).

It is apparent that the parents, teachers, psychologists, and medical personnel involved in the evaluation interact and influence the process by which children are labeled and treated for having ADD. Therefore, it becomes critical to examine how the perceptions of these individuals affect the labeling process. Each person's perceptions are affected by his/her personal experiences and the personal knowledge base obtained through various sources such as courses of study, inservice, literature, and media.

Given the increasing interest on ADD in current popular and professional literature, many may believe ADD is a relatively new "illness." However, a closer examination of the literature finds reports of children diagnosed as having "symptoms" of ADD as early as the late 1800s and early 1900s. The terminology used through the years may vary, but

the references are obviously to the same behaviors (Barkley, 1981; see Appendix F).

To better understand a phenomenon, it is important to examine its history. As Popkewitz (1992) stated, "the reason of the present should be seen in relation to its past" (p. 50). There is always a link between the present and the past. An examination of the historical background of attention deficit disorder can offer possible explanations for assumptions found in the present.

A closer review of the literature demonstrates that there has always been disagreement among researchers when they attempt to define and treat children with these "symptoms." To begin to cast a light on differing contextualizations of ADD, I further examine the history of its definition and diagnosis in Chapter II.

CHAPTER II
REVIEW OF LITERATURE

Historical Review

Attention deficit disorder has been a cause for debate since its inception. The debate among researchers has been marked by dissent in the areas of etiology and diagnosis. The opinions have ranged from those of scholars such as Still (1902), Strauss and Lehtinen (1947), Zametkin et al. (1990), and Barkley (1995) who have viewed the etiology from a biological deterministic perspective (in other words, they considered ADD a neurological disorder) to others such as Armstrong (1995), Whalen and Henker (1976), McGuinness (1985), and Pellegrini and Horvat (1995) who viewed ADD as a social construction and questioned whether it even exists as a disorder (Bateman, 1992; Fisher & Greenberg, 1989; Pellegrini & Horvat, 1995; Walters & Barrett, 1993). Put differently, ADD was thought by the former group to be a discovered condition (one which existed before we conceived of it). The latter group of scholars insisted that ADD was not "discovered" but rather "made" or "constructed." That is, it did not exist until we conceived it.

Efforts to define a syndrome of ADD have followed a progression outlined by Achenbach (1988) with reference to the evolution of childhood psycho pathology paradigms--from mental disorders viewed as brain diseases to multivariate

descriptions of symptoms or signs (Matson, 1993). Thus, terms used for this "disorder" have ranged from "brain damage" in the earliest references to the more current "attention deficit disorder" (see Appendix F).

The earliest behavioral description most closely corresponding to ADD is generally attributed to George Still. In his 1902 publication, he postulated that "there are certain children who show so marked a deficiency of mental and moral control that . . . they can be picked out at once as different in this respect from all the others" (Still, 1902, p. 1079, as cited in Matson, 1993). Still perceived the behavior pattern as a medical problem which was "probably hereditary . . . or due to pre- or postbirth injury" (Armstrong, 1995). According to Ross and Ross (1982):

In one fell swoop Still laid the groundwork for the three major diagnostic categories--brain damage, minimal brain dysfunction, and hyperactivity--and for the place of learning disabilities as a cross-category phenomenon. (p. 11)

Murphy (1992) added that "underlying the learning disabilities movement has been the belief that there exists a 'true' form of learning disability that is not only neurogenic, but also is independent of any other disability or learning circumstance" (p. 2).

It is not apparent why nearly 3 decades lapsed before there was a renewed interest in studying hyperactive

children (Ross & Ross, 1982). However, as a result of Hitler's rise to power in Europe in the 1930s, several scholars, who would later prove influential in the field of learning disabilities, emigrated to the United States. Two of these were Alfred Strauss, a neuropsychiatrist and associate professor at the University of Heidelberg, and Heinz Werner, a developmental psychologist and associate professor at the University of Hamburg. References to attention deficit emerged out of work done by Strauss and Werner in the 1930s. During their studies of individuals labeled mentally retarded, Strauss and Werner postulated the notion of central nervous system (CNS) problems as being associated with hyperactivity. They hypothesized that "brain injury in the mentally retarded leads to distractibility--an inability to focus on the task at hand" (Hallahan, Kauffman, & Lloyd, 1985, p. 109). This comorbidity view of hyperactivity and learning disability persists into the 1990s.

Strauss's and Werner's studies were unique for the time because they applied this pathological concept to normally intelligent children who exhibited distractibility behavioral characteristics. They speculated that these children with distractibility problems must have a brain injury similar to the subjects in their current studies even though there was no proven medical test for diagnosis. This

tautological thinking would be challenged later by Cruickshank and Hallahan in the 1970s when they used a behavioral modification frame rather than a medical frame to "treat" children with similar behaviors.

A 1947 work of Strauss and Lehtinen included the following excerpt on "Psychopathy and education of the brain-injured child":

The response of the brain-injured child to the school situation is frequently inadequate, conspicuously disturbing, and persistently troublesome. The following quotes from a teacher's reports are illustrative.

J. M., 7 years old: " . . . doesn't pay attention to any directions. He is unaware of anything said, yet at times he surprises me by noticing things that others don't."

D. J., 7 years old: " . . . attention and to hold. Asks constantly: 'When can I go? Can I go now?' etcetera. No initiative. Little self-control. Seems high strung and nervous . . . "

D. H., 8 years old: " . . . has proven quite a serious problem in behavior. Has acquired the habit of throwing himself into tantrums at the slightest provocation . . . "

J. K., 8 years old: " . . . has made scarcely any social adjustments in relationships with other children, he loses all self-control, becoming wild and uncontrollable; he is extremely nervous and excitable; his attention span is very short and he is unable to concentrate for more than a few minutes. During work periods he jumps from one activity to another . . . " (p. 127)

One can note that these comments could have been made by teachers of the 1990s about children labeled as ADD in today's classroom.

James Carrier (1986) summarized Strauss and Lehtinen's model as follows:

1) some neural injury occurs to the child; 2) this leads to a disruption of normal brain function and development; 3) this disruption reduces the child's ability to perceive the invariant reality of objects and situations, leaving him to be distracted instead by insignificant surface appearances; 4) this relative inability manifests itself in mental and behavioral irregularities, which reduce the ability to learn. (p. 36)

Like Cruickshank and Hallahan (1981), Carrier pointed out the circularity of this reasoning in Strauss's conclusion that behavioral traits are due to neurological abnormalities.

Strauss's belief was in opposition to the view that behavioral problems (such as distractibility) have an emotional, much less a cultural, cause. Thus, he offered an alternate diagnosis for children who had been previously ascribed more negative labels such as *lazy, stupid, or emotionally disturbed*. This medical framework was welcomed by parents of the 1930s and 1940s as it freed them of blame, gave them what appeared to be a logical analysis, and also gave them more hope for treatment (Lerner, 1989). Once again, this statement might well apply to parents today.

However, the Strauss and Lehtinen (1947) study was criticized by other researchers as based on impressions rather than on controlled scientific research because individuals could be classified as brain injured based on

behavior alone. Even if no indication of a lesion through neurological tests or in the medical history existed, the child could be labeled *brain injured* if he or she displayed behavior observed in brain-damaged individuals (Franklin, 1987; Hallahan et al., 1985; Ross & Ross, 1976).

Goodman's (1983) criticism of Strauss's brain injured diagnosis used an analogy to the effects of a drought.

A drought can kill vegetation. If, however, we find dead vegetation, we cannot assume that drought was the cause. The vegetation could have been destroyed by any number of causes including a non-biological one such as lumbering. (p. 114)

This is a good example of how Strauss's tautological thinking came to be considered as flawed during the 1940s. It is evident that the debate between those who conceptualize ADD from an empiricist versus constructivist philosophical perspective is not just a current phenomenon.

A further milestone in the development of the ADD diagnosis was achieved in the late 1940s when several researchers at the Wayne County Training School in Northville, Michigan, studied the psychological effects of brain injury in a group of mentally retarded children. This Oxford International Study Group on Child Neurology, influenced by Still's and Strauss's work, ultimately recommended that the term *minimal brain dysfunction* replace *minimal brain damage*. The rationale for the change was that *damage* could not be inferred from behavior alone (Ross &

Ross, 1976). In fact, this would be the first of several name changes in reference to what has come to be called ADD (see chart in Appendix F).

From the beginning, the assumption that behavior problems of normally intelligent children are of neurological origin appears to have been problematic (Franklin, 1987). However, this assumption continues to be used today by those who see the response to stimulant medications as proof of a biological cause for ADD (Matson, 1993).

The earliest references to the paradoxical effect of stimulant medications on children were reported by Bradley in 1937. He prescribed an amphetamine (Benzedrine) for emotionally disturbed children in an effort to treat their severe headaches by raising blood pressure. To his surprise, a side effect of the medication was that the children had reduced motor activity and restlessness and, as a result, better behavior and work habits.

However, the Bradley (1937) report had very little impact on practices and attitudes at the time. Ross and Ross (1982) speculated that this lack of interest may have been due to the common practice of simply requiring children to stay at home if they could not conform to the demands of the classroom. They also suggested that our society was not as oriented to technology and drug treatments as we are now

and may have been less receptive to the use of medications in general.

The field of psycho pharmacology accelerated in the middle 1950s, with the accepted use of tranquilizers and antidepressants for adults. This precipitated a moderate interest in the use of stimulant medication for behavioral problems in children. Consequently, the 1937 Bradley study resurfaced, and pharmaceutical companies produced intensive advertising and professional literature which resulted in a greater acceptance of the use of stimulant medications for treatment during this period (Ross & Ross, 1976).

From the mid-1950s to mid-1960s, another group of researchers with backgrounds in neurology, psychiatry, or pediatrics, generally developed their studies based on an empiricist model. Considering their training, it was logical for them to look for a physiological cause for these disorders.

Laufer, Denhoff, and Solomons (1957) were among this group and were credited with the use of the term *hyperkinetic behavior syndrome* rather than *minimal brain dysfunction*. They also advocated a favorable response to amphetamine as the criterion for diagnosing *hyperactivity*. This is another example of tautological thinking similar to Strauss's thinking of the 1930s. Their work played a major role in the acceptance of stimulants to "treat" those

labeled as *hyperactive*. Parents also were influenced by the presentation of stimulants as a safe and effective "treatment" in media coverage and brochures published by drug manufacturers after the Laufer et al. publication (McGuinness, 1989).

There were others who chose a different approach toward treatment for attention/hyperactivity problems in children. Cruickshank and Haring were well known for conducting research, the results of which indicated the benefits of using behavioral approaches for the control of children described as emotionally or behaviorally disordered (Kauffman, 1993).

The behavior modification framework, which was based on the work of B. F. Skinner (1953), was used by Cruickshank in Montgomery City, Maryland, in an experimental public school program for brain injured and hyperactive children. Cruickshank's contention was that these children needed a minimal stimulation environment that was stable and consistent in demands and consequences (Ross & Ross, 1982).

Other significant studies conducted during the 1950s included Haring and Phillips (1962), Patterson (1965), and Zimmerman and Zimmerman (1962) all of whom described highly structured programs and consistent consequences for behavior as effective methods in modifying behavioral problems of hyperactive children rather than using medication to modify

behavior. Using a phenomenological/interactionist frame of reference, Haring and Phillips indicated that an effective structured environment should consist of three elements: clear directions; firm expectations that the child will perform as directed; and consistent follow-through in applying consequences for the behavior. This research and that of others created a wave of publications and differing concepts of these "disorders" and types of intervention.

According to Ross and Ross (1976), the composite picture of hyperactivity that emerged in the early 1960s was "that of a brain damage syndrome to be treated with stimulant drugs, a minimal stimulation classroom, and possibly psychotherapy, having a favorable prognosis for the adolescent years" (p. 19). In the early 1960s, increased attention was paid to low achieving children, and parents began a more organized effort to secure services for these children whom they felt were taught ineffectively.

The term *learning disabilities*, as suggested by Samuel Kirk in his 1963 speech to parents and professionals at the Fund for the Perceptually Handicapped Conference in Chicago was readily accepted (Murphy, 1992). *Learning disability* was an umbrella term which encompassed many types of learning disabilities including the *minimal brain dysfunction* label. Until that time, parents were confused by the number of terms used by professionals to describe

their children (e.g., dyslexia, reading disabilities, minimal brain dysfunction) so the "learning disability" term was desirable because it disassociated them from the area of mental retardation while still creating an advocacy group (Association for Children with Learning Disabilities) for their children.

Ultimately, this advocacy group became increasingly influential in establishment of policies. In fact, they were instrumental in establishing the Education of All Handicapped Children Act (Public Law 94-142) in 1975 which was designed to meet the needs of all handicapped and learning-disabled children (Hallahan et al., 1985). The organization has continued to be extremely effective in bringing learning disability issues to the attention of the legislature, school personnel, and parents of LD children during the last 30 years. Ultimately, parent advocacy groups were key players in having ADD included under the Public Law 94-142.

Like *learning disability*, ADD had been seen by some individuals as a real physiological handicap and by others as a vehicle to legitimize teachers' or parents' inadequacies (Bateman, 1992; Murphy, 1992). Skeptics from a constructivist view tended to see good teaching and good parenting as resolutions to all but a small percentage of cases, whereas those advocating from an empiricist frame saw

ADD as a true disability for which there was no cure (Kauffman, 1993). This is no different today.

The American Psychiatric Association's official designation of *hyperactivity* as a disorder in 1968 provided validation for this physiological frame; and by the mid-1960s, Ritalin (the brand name for the stimulant, methylphenidate) was well established as the treatment of choice for hyperactive children (Werry & Sprague, 1970).

In the early 1970s, some researchers (Schrag & Divoky, 1975; Whalen & Henker, 1976) began questioning this presumption of medical etiology. Ritalin use had become more common, and accusations of overprescribing the medication surfaced. For example, the Church of Scientology crusaded against the use of psychiatric drugs which led to a drop in the use of Ritalin for a few years (Drug and Chemical Evaluation Section, 1995). However, as Granat (1995) contended, Ciba-Geigy, the drug company that produces Ritalin, instituted concentrated marketing efforts late in the decade which resulted in reviving the use of Ritalin for ADD.

Subsequently, psychologists and psychiatrists focused much research on the study of attention and behavioral problems of children. Virginia Douglas, a Canadian researcher, was instrumental in fostering much of this research by presenting her view at the Canadian

Psychological Association Conference that "deficits in attention were more likely to be the real culprit in many children's behavioral difficulties rather than hyperactivity" (Armstrong, 1995, p. 7).

By the end of the 1970s over 2000 articles had been published (Armstrong, 1995). This surge of research continued into the 1980s. With the continued interest by psychiatrists, the American Psychiatric Association sanctioned this new "disease" by changing its listing of *hyperactivity to learning disabilities/ADD* in the 1980 Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III).

The Diagnostic and Statistical Manual (DSM) became widely accepted as a source in setting criteria for diagnosing ADD and has since become considered the official definition of the disorder. Because there continued to be no scientific/medical test for this determination, the diagnosis came to depend exclusively on questionnaire data. The DSM criteria for ADD became the basis for most of these diagnostic questionnaires; and, subsequently, it has been criticized on several accounts.

According to McGuinness (1985), the first criticism is that the definition and criteria have been changed in each edition, with the most recent including ADD without hyperactivity. These frequent revisions indicate that this

"condition" is being "made up over time," thus lending credence to the notion that ADD is socially constructed. The second criticism is that parents and educators who have no training in diagnosing behavior disorders are expected to rate children. Despite the spurious scientific aura surrounding this condition, the impressions of parents can hardly be seen as objective. Finally, many suspect that parents and educators are implicated as part of the cause because the characteristic behaviors "are rarely exhibited in a one-to-one situation, such as in a clinic" which would lead one to suspect that these "disorders" are situational in nature (p. 189). Therefore, we might blame the situation rather than the child. With the DSM legitimizing *Hyperactivity/ADD* in children, Armstrong (1995) contended that ADD has been the single most common condition for which the DSM has been consulted for diagnosis during these last 2 decades.

In the 1980s and 1990s, scholars such as Zametkin et al. (1990), Russell Barkley (1990), and Larry Silver (1990), who had been schooled in the medical sciences, were vocal in their views that ADD is grounded physiologically. In 1990, a National Institute of Health (NIMH) study was conducted by Zametkin and others which received much media attention and appeared, at least for a time, to vindicate those who had long insisted that ADD was physiologically based. Zametkin

et al. reported a link between hyperactivity in adults with an insufficient rate of glucose metabolism in the brain which reassured many that there was an empirical study to prove the biological connection suspected by many through the years. Even though the study was later criticized by scholars, and even though Zametkin et al. (1993) subsequently could not replicate the earlier findings, the original report maintained its impact, because the rebuttal had minimal press coverage (Armstrong, 1996; Breggin & Breggin, 1994).

Two researchers, Barkley and Silver, produced many publications, conducted workshops on ADD for parents and educators, received recognition across the United States, and influenced the decision making of professionals in children's lives (Breggin & Breggin, 1994). Barkley commented, in a keynote address to CH.A.A.D. (Children and Adults with Attention Deficit Disorder) members, "although these children do not look physically disabled, they are neurologically handicapped nonetheless. . . . Remember, this is a disabled child" (Armstrong, 1995, p. 19). He also stated that "present knowledge strongly points to a biological predisposition to the disorder" (Barkley, 1989). Walters and Barrett (1993) noted that Barkley's conclusions are similar to the observations of Still (1902), who originally speculated that the "disorder" was attributable

to brain damage. Likewise, Silver (1990), in a booklet written for classroom teachers, stated that there are two different types of hyperactivity: "One caused by a particular situation . . . and an other caused by neurological differences in the child's brain" (p. 6).

Even though there continues to be no substantial conclusive evidence that children and adults labeled as ADD have a physiological disease, research continues in search of the elusive cause of these behaviors while a philosophy of biological determinism, undergirded by the empiricist framework, continues to gain ascendancy.

Since 1987, and continuing to the present, support and advisory groups have played an important role in the distribution of information regarding the etiology of ADD and its treatment and hence have been a primary source of information to teachers and parents. CH.A.A.D., the largest advocacy group, has grown from 29 chapters in 1988 to over 600 chapters in 1994. The group has been very active at the local, state, and national levels sponsoring support groups, meetings, workshops for schools, and newsletters (U.S. Department of Education, 1991).

CH.A.A.D. membership continues to grow and play a vital role in assuring parents, teachers, and legislators that children labeled as ADD can be helped with medication along with other classroom strategies. With over 600 chapters

across the country, they have become a powerful support group for those who have children identified as ADD.

An example of this organization's pervasive influence would be CH.A.A.D.'s successful lobby of Congress in 1990 to have ADD officially declared a handicapping condition eligible for special services under Public Law 101-476. Initially Congress refused to certify it under the new law. However, in 1991 the U.S. Department of Education wrote to individual state schools outlining three criteria which would enable children labeled ADD to qualify for special education services. Thus, it could be said that ADD came quietly through the back door.

Summary of Historical Review

From its inception in the early 1900s, ADD (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.

ADD continues to be commonly considered organic in nature and as intrinsic to the child (Pellegrini and 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)

Goodman and Poillion (1992) stated that, 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)

It also appears that ADD 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).

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

It is apparent that parents, teachers, psychologists, and medical personnel all interact and influence the process by which children are labeled and treated as having ADD.

This process typically requires three individuals to be involved in the diagnosis. Therefore, it is critical that these participants in this process understand the compelling incongruities in the literature regarding the labeling and treatment of these children.

In the following section, I provide a sample of differing opinions to illustrate further the incongruities found in the literature of the last decade. Five general areas of disagreement are presented:

1. ADD has a biological/neurological etiology and therefore is intrinsic to the individual child.

2. Stimulant medication has an effect only on ADD children.

3. Medication is as justified and safe for ADD as for any other illness.

4. Identification tools are objective.

5. Medication results in academic improvement.

It is noted that all of these areas are interrelated and are supported by empiricist assumptions, whereas those coming from an interpretivist perspective challenge the realist arguments for a problem which appears to be socially constructed.

Current Conceptualization/Justifications
and Counterpoints

ADD Has a Biological/Neurological Etiology and
Therefore Is Intrinsic to the Individual Child

First, the belief that ADD is *intrinsic to the individual child (biological/neurological etiology)* is manifested in various research and popular publications. The National Institute of Mental Health (NIMH) supported Zametkin et al.'s 1990 study which linked hyperactivity in adults with an insufficient rate of glucose metabolism in the brain. These results received much media coverage, and parents were relieved that "finally, we have an answer to skeptics who pass this off as bratty behavior caused by poor parenting" (Armstrong, 1996, p. 427). As Smelter, Rasch, Fleming, Nazos, and Baranowski (1996) stated, "The child now has a 'medical condition' that has nothing to do with the child's upbringing" (p. 430). Viewing the inattention and/or hyperactivity from a neurological etiology also gives hope for finding a "cure."

The literature indicates that there is a general consensus among physicians that medication is useful in the treatment of ADD. Russell Barkley (1990), a strong supporter of the ADD diagnosis, is quoted by many parents and educators as he also views ADD as a medical problem rather than a byproduct of poor parenting or teaching or

other contextual factors. His comment that "there is something wrong with these children" (p. 4) tended to be very consoling to frustrated parents and teachers.

CH.A.D.D. also supports the position that these children have a neurological impairment and reassures parents and teachers that the disorder is not caused by environment. Their publications assert that the child's "disability" is the factor which causes the high stress within the family and classroom rather than that the family and/or classroom structure contributes to the child's behavioral/attention problems.

Ciba-Geigy, the primary drug company which manufactures Ritalin, produced a brochure which states: "The medication . . . appears to help the nervous system compensate for the deficits resulting in a decrease in motor behavior, a decrease in distractibility, or an increase in attention span" (Silver, 1990). Barkley (1981) also asserted that ADD is a physical disorder because the stimulant medication slows "these" kids down.

According to Breggin and Breggin (1994), well-respected, biologically-oriented professionals such as Barkley, Silver, and Conners, who have been instrumental in providing workshops and writing literature for parents and teachers, have affected policies practiced by schools. Because they profess the side effects of medication to be

minimal in comparison to the positive effects of Ritalin, teachers are more comfortable suggesting the evaluation process.

On the other hand, the belief that *ADD is intrinsic to the individual child* is questioned by others in the field. For example, the Zametkin et al. (1990) study is challenged on several accounts. In fact, Zametkin himself refuted his initial research in follow-up studies--one examining the original data and another using different experimental groups (Zametkin et al., 1993). When, in the reexamination of the original data, the sexes were compared separately, there was no significant difference between the control group and the ADHD adults in the experimental group. To achieve the statistically significant difference, the data were lumped together, thus including a disproportionate number of women in the control group. Also, when individual areas of brains of ADHD adults were compared to those adults in the control group, no differences were found (Breggin & Breggin, 1994).

In addition, when Zametkin and others replicated the original 1990 study in 1993 with adolescents, they found no significant differences between the "normal" group and the "hyperactive" group. Interestingly, the media did not cover this study as they had the previous one (Armstrong, 1996).

Armstrong (1995) argued that attention deficit disorder has been inaccurately defined as a medical disorder. He questioned why, unlike other medical diseases, it "pops up in one setting, only to disappear in another." He posited that if the symptoms of ADD disappear when the child is participating in activities of interest or in certain settings, then it would seem logical to look at those settings and activities rather than assuming the child has a medical problem preventing him/her from maintaining attention. Up to 80% of these children do not display the symptoms of ADD in the physician's office or other unfamiliar settings where there is a one-to-one interaction with an adult. These children are also indistinguishable from other "normal" children when in a learning environment where they can choose their own learning activities and pace themselves (Armstrong, 1996). This raises the obvious question of how these children can control, in some contexts, symptoms that are neurological in origin.

Some researchers, including Breggin and Breggin (1994) and Armstrong (1995), caution that we are jumping into the medical model much too quickly in order to explain why some individuals have more difficulty learning than others without asking what role the environment and culture is contributing that may be exacerbating this situation. As a society, we continue to look for a quick fix or blame others

(or genetics) for our problems instead of looking at ourselves and our interconnectedness to each other.

Stimulant Medication Has an Effect

Only on ADD Children

Another justification for adhering to the medical model and subsequently using medication as a "treatment" is the belief that *stimulant medication has an effect only on ADD children*. For example, DuPaul and Stoner (1994) stated that "medications can lead to improvements in on-task behavior, impulsivity, social behavior, compliance, and academic productivity in as many as 70%-80% of children with ADHD" (p. 16), thus conveying the strong impression that it does not have the same effect on other children.

However, others question this assumption. McGuinness (1985) referred to a study done by Dykman, Ackerman, and Oglesby in 1979 in which he used placebos and psycho stimulant drugs. Dykman and colleagues found the psycho stimulant drug had profound effects on all children, not just those diagnosed as hyperactive (p. 288).

Golden (1991) concurred that "the response to the drug cannot be used to validate the diagnosis. Normal boys as well as those with ADHD show similar changes when given a single dose of a psycho stimulant" (p. 40). Thus, we must conclude that Ritalin affects all children in the same way-- not just those labeled hyperactive. Within a half hour

after taking a dose, any child will become more obedient and willing to concentrate on tasks and instructions (Breggin & Breggin, 1994). Thus, a response to Ritalin or similar medication does not seem to substantiate the presence of neurological pathology or irregularity.

Medication Is as Justified and Safe
for ADD as for Any Other Illness

A third explanation is that *medication is as justified and safe for ADD as is medication for any other illness.* Advocates representing CH.A.A.D. and other grassroots groups offer an analogy such as the following: You would not deprive the diabetic child of insulin or another drug. Thus, assuming the physiological etiology of ADD, you would not deprive the ADD child of Ritalin. The prescription of medication for any physical illness has been construed as a responsible act on the part of concerned parents and educators. This is no different (McGuinness, 1989).

Dissenters consider this a weak defense and a poor analogy because there are medical tests for illnesses such as diabetes which can be detected through a blood analysis. However, there is no such medical test for ADD, and diagnosis is determined by subjective observations and assessments. They add that Ritalin is not risk free as represented by CH.A.A.D. and other supporters of this approach to the problem.

According to the Physicians Desk Reference (Medical Economics Data Production Company, 1995), Ritalin is a central nervous system stimulant and should be monitored very carefully to prevent side effects such as weight gain or loss, growth impairment, depression, fatigue, and overactivity. In fact, the DEA has classified Ritalin as a Schedule II controlled substance, the most potent category of drugs that can be prescribed (Divoky, 1989; Drug and Chemical Evaluation Section, 1995). According to the Armstrong (1996), central nervous system stimulants such as Ritalin help the teachers and parents but do little for the children.

Breggin and Breggin (1994) took the position that parents are uninformed about the potential health risks of Ritalin. Like any addictive stimulant, Ritalin can cause withdrawal symptoms. Since parents are not aware of this, they may misinterpret the withdrawal symptoms as an indication that their child needs to be on more of the medication. Even though studies have found no consistent brain abnormalities in children, one study has found brain shrinkage in adults who have taken Ritalin for years (Breggin, 1990, 1993). Despite more recent research which disproves previous studies attributing ADD to a biological/neurological disorder, we continue to increase the use of medication to treat children with ADD "symptoms."

Identification Tools Are Objective

The fourth justification for treating ADHD as a medical condition is that *identification tools and processes are construed as being objective*. The literature suggests that the evaluations be done by professionals who have experience with ADD children (Barkley, 1990; Silver, 1990). Scholars such as Russell Barkley and Larry Silver, who have medical backgrounds and cast ADD as a pathological medical condition, brought the perceived scientific objective view to the discourse. They have many publications which have been cited by parents, teachers, and CH.A.D.D. (e.g., Silver, 1990, ADHD, Attention Deficit-Hyperactivity Disorder and Learning Disabilities: Booklet for the Classroom Teacher; Barkley, 1995, Taking Charge of ADHD: The Complete, Authoritative Guide for Parents).

Dissenters, those raising questions about ADD, challenge the perception that *identification tools and processes are objective* as the checklists used for diagnosis depend upon the "subjective judgments by teachers and parents who may have an . . . emotional investment in the outcome" (Armstrong, 1996, p. 425).

McGuinness (1985) also supported this view. She pointed out that even though parents and teachers typically have no clinical training, they are asked to rate a particular child on a subjective questionnaire as the

central part of the diagnosis for ADD which, more often than not, leads to the prescribing of stimulants. In a study using a behavior rating scale, parents and teachers agreed that the child was hyperactive only 24% of the time (McGuinness, 1985). Even professionals do not always agree. Meanwhile, in another study two psychiatrists were provided identical information and agreed in only 69% of the cases on an ADD diagnosis (Goyette, Conners, & Ulrich, 1978).

Many people, including members of CH.A.D.D., assert that ADHD must be a physical disorder because the medication (which is a stimulant) slows "these" kids down. This paradoxical effect, once accepted in the medical field, has now been discarded there, although it is still cited by many educators (Cooter, 1988).

Medication Results in Academic Improvement

Finally, substantial support for the current identification and medicating of children comes from those who might well be referred to as the secondary consumers of treatment: parents and teachers. This constituency has reported tremendous satisfaction with current diagnostic/treatment practices. *Parents, teachers, and students report improvement in the ADHD child's performance in school.* More often than not, teachers consider the use of drugs to have improved these children's academic ability (McGuinness, 1985).

Silver (1990) acknowledged that the medication will not cure learning disabilities, but he goes on to note that it will make your child more able to learn. Barkley (1981) concurred that, when children take medication, their behavior improves and they do attend to classroom tasks better and are less impulsive.

Because teachers are expected to meet the needs of a diverse population of students and often struggle in overcrowded classrooms, a child with ADD "symptoms" can create havoc within that environment and can disrupt the traditional education process for the entire group. At least the drug interventions enable teachers and parents to exert more control over the learning environment as the ADD child exhibits lowered activity levels and increased focus on academic tasks in the classroom settings.

Divoky (1989) stated that "defenders of the use of stimulants maintain that, once children begin taking such a drug, they stop viewing themselves as failures at school and begin seeing themselves as competent and successful. According to this view, children don't consider the drug to be a chemical crutch; in fact, they move from dependence on the drug to independence, with increased confidence in their own abilities" (p. 602).

Others counter that, even though therapists are prescribing drugs such as Ritalin for treatment of ADD, the

literature indicates that any positive effects in drug management are short term and do not translate into improved learning in most cases (Cooter, 1988). More specifically, even though stimulants seem to improve the child's ability to concentrate, there has been no proven increase in academic performance. Barkley and Cunningham (1978), for example, conducted a study on the impact of medication on learning and found that there was a significant discrepancy between objective measures and the subjective opinions of teachers and parents. The opinion was held that learning was improved; however, the assessment measures did not corroborate this expectation.

P. O. Quinn and J. L. Rapoport (1976), from the National Institute of Mental Health, drew the same conclusion when they studied hyperactive boys on and off drug regimens over a period of 2 years. They found no difference between the drug group and placebo group in tests of reading, spelling, or math.

In response to the claim that children/youth treated with medication feel better about themselves and become more independent, critics claim the opposite effect often occurs. Armstrong (1996) stated that when children receive medication they may attribute their improved behavior to the pills rather than to their own inner resources.

Furthermore, the interventions suggested in the majority of the literature are external control measures, including medication and behavior modification, rather than internally-based interventions. Even though these external approaches may appear to help many children, they neglect to address the underlying causes of the child's behavior or to assist the child in better understanding him/herself. According to Kohn (1993), these external interventions also can blunt creativity, discourage risk-taking, decrease intrinsic motivation, and even impair academic performance.

In 1976, Whalen and Henker published a research study using a qualitative or interpretivist approach which included interviewing children who had taken stimulant medications for several years. They found that these children viewed the drugs as a crutch and felt helpless in controlling their own behavior without them. Moreover, these children also believed that their normal off-drug behavior was not their fault.

In another response to those who are convinced that the drug helps build confidence, Divoky (1989) noted that

in many cases the children's talk doesn't bear out this untested theory. They talk about how 'good' Ritalin makes them, how 'bad' they are if they forget Ritalin, how the pill makes them accepted by teachers and parents, how it gets them through tests at school, how it makes them popular at social events. They sound very much like young drug addicts. (p. 602)

Other Arguments Against Conceptualizing and Treating
ADD as an Intrinsic/Neurobiological Disorder

The increase in use of Ritalin has begun to concern some individuals within the medical and education communities, but those voices have not been as well received at this point. Scholars such as McGuinness (1989), Breggin and Breggin (1994), and Armstrong (1996) are committed to examining the ramifications of increased labeling and medicating of children for ADD and hopefully will be heard by those making these decisions. Other arguments have been proposed, by those mentioned, which have not been addressed to any great extent by those supporting the labeling and treating of children for ADD.

Drug Company Involvement and Economic Gains

The growth of ADD also has been strengthened by industry and governmental support. As we examine the drastic increase in the number of students identified as ADD in the past 5 years, we must also consider that there are economic gains to this increase. Armstrong (1995) noted that this list of financial benefactors would include pharmaceutical companies, physicians, psychologists, and learning specialists. The usual cost to obtain medical diagnosis alone is \$1200. To that figure add the cost of prescriptions, and it becomes apparent that monetary gains exist for many in the medical community.

The DEA's Office of Diversion Control, Drug and Chemical Evaluation Section, published a background paper in 1995 which questions the ties between Ciba-Geigy (the manufacturer of Ritalin) and CH.A.A.D. Ciba-Geigy contributed \$748,000 to CH.A.A.D. from 1991-1994 which helped fund the publication cost of literature. In this document, it was also indicated that, when Ciba-Geigy warned the public of an impending shortage of Ritalin, CH.A.A.D was instrumental in advertising the shortage to all members. CH.A.A.D members, who rely upon the organization for guidance on diagnosing and treating their children, had not been informed about this relationship.

Even if CH.A.A.D. was established as an advocacy group for those diagnosed as ADD, it is quite possible that Ciba-Geigy could be instrumental in promoting the use of their product (Ritalin). Thus, the motives of CH.A.A.D. have been questioned, and the literature they publish reveals little information about liability, abuse, or serious side effects of the medication (Drug and Chemical Evaluation Section, 1995).

According to the Office of Diversion Control (Drug and Chemical Evaluation Section, 1995), most of the ADD literature prepared by CH.A.A.D. or Ciba-Geigy does not discuss the potential or actual abuse of Ritalin. Instead, it is presented as a "benign, mild substance that is not

associated with abuse or side effects" (p. 4). As a consequence, parents of children and adult patients may not be fully informed. The United Nations International Narcotics Control Board (INCB) has expressed concern about parent associations actively lobbying for the use of methylphenidate for children despite the fact that it still is not scientifically proven that ADD is caused by a neurobiological disorder (Drug and Chemical Evaluation Section, 1995).

Meanwhile, the use of Ritalin has increased 600% in the United States since 1990. In fact, the United States consumes more than 80% of the total world supply. CH.A.A.D. has petitioned their Congressional Representative to reschedule methylphenidate from Schedule II to Schedule III drug schedule classification and thus release quotas which had been established. This rescheduling would allow an increase in production. Schedule II is the highest class and also includes morphine, cocaine, and amphetamine (Drug and Chemical Evaluation Section, 1995). Clearly, one might expect further increases of consumption if it is reclassified, because restriction levels on its production rate as well as its criteria for prescription will be correspondingly decreased.

Moral Question of Personality Alteration

Medication takes away the very spark of creativity that may very well be the child's greatest asset. According to Hartmann (1993), numerous ADD-diagnosed writers, artists, and public speakers indicate that, although their "lives became more organized and their workdays easier when taking the drug, their creativity seemed to dry up" (p. 60). Schrag and Divoky (1975) stated that the idea that the behavior of children should be chemically managed represents a "dangerous extension of authority and most pervasive imposition on personal liberty" (p. 107). It also defines them as a disabled person who must lean on medication instead of internal devices to succeed. In the words of Armstrong (1995), are we giving them the message that "to be successful--to be an okay person--they need to take a drug" (p. 44)?

Changes in School Policies

Changes in school policies through the years have reinforced the support for labeling children. Bennison (1988) noted that special classes for "defectives" were a result of a need for order in classrooms that were chaotic and/or overcrowded in the early 1900s (p. 13). The rationale provided was that these children who were "deficient" could receive more individual attention while the "normal" students could proceed.

A study of the School for Exceptional Children in Milwaukee during the early 1900s cited numerous examples of children who were labeled as "feeble minded" in their regular school resulting in transfer to this special school. Upon examination, the researchers found that a range of social factors such as ethnicity, family structure, academic norms, and so forth were considered in classifying these children and that it appeared a different "yardstick" was used to measure male and female "disability" as males outnumbered females (p. 26).

Is it possible that the logic behind labeling children today is not far removed? Bennison (1988) argued that these terms of identification are socially constructed and have multiple interpretations. She suggested that it is time to re-examine the notion of biological determinism and its consequence for social justice. We may no longer send these children to a separate school for control, but we seem to be using our medical technology to "take care of the problem" while allowing the student to stay in class.

Hancock (1996) proposed that with the enactment of compulsory education laws and with the institution of inclusion policies, we may have created situations which are potentially valuable for students but which have not addressed the issue of how well prepared teachers are to accommodate these varying needs. Furthermore, we have not

offered adequate support and education to teachers in those necessary areas. Hancock added that as teachers begin to feel overwhelmed with increasing demands, some may perceive the labeling and medicating of nonconforming children to be a viable option in their quest to maintain control of student behavior.

The inclusion (mainstreaming) movement of the last 2 decades has encouraged teachers to keep students in the regular classroom. Although some teachers have attempted to broaden their teaching strategies to accommodate a diverse class population, many have not modified their teaching procedures. Since the inception of learning disability categories, perceived deficits in children have been "treated" rather than changes made in the social structure and education system to meet the needs of the children (Sleeter, 1986).

By removing students physically or pharmacologically from the classroom, it becomes easy to ignore needed improvements in the classroom environment or problems from home that are affecting the student's performance within the classroom. If we say the problem is intrinsic to the child, it absolves the adults and society of responsibility.

Because diagnosis and treatment of ADD has grown so rapidly despite this incongruity, we must attempt to explain

why this has occurred. This study attempts to clarify how this process continues.

CHAPTER III

DESIGN OF THE STUDY

Problem Statement

According to the Drug Enforcement Administration (Drug and Chemical Evaluation Section, 1995), there has been a 600% increase in the production and use of methylphenidate to treat children diagnosed as ADD since 1990. This increase contrasts sharply with trends seen in the rest of the world. In fact, the United Nations International Narcotics Control Board (INCB) has written letters of concern to the DEA about this increase, requesting data concerning the drug use and abuse.

Even though cited prevalence figures for children treated with medication for ADD varies, 3% to 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). Furthermore, it is estimated that as many as one-third of American boys are now labeled and treated for ADD and are thus considered "abnormal" because they are fidgety, inattentive, and unalienable to adult control (McGuinness, 1989).

Considering the frequent use of stimulants to treat these boys and the lack of any conclusive medical test to diagnose ADD, it seems reasonable to suspect a problem of

overidentification, if not an indication that this disorder 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 ADD diagnosis and treatment, a closer examination of the circumstances of the diagnosis and use of medication in treatment of ADD/ADHD is needed.

To date, the majority of the 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. 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 ADD. Therefore, it is time to stop taking the practice of labeling and treatment for granted; it is time to examine more closely the perspectives of those who are part of this process.

Purpose and Significance of the Study

In this study, I investigated the viewpoints, perspectives, and understandings about ADD and its treatment which are held by teachers, parents, students, other school personnel, and physicians who are regularly involved in the

process of identifying and/or treating students for ADD. 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 ADD children. In Palmer's (1969) words, I sought to "understand deeply" (p. 215). 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 research recognizes as its underlying assumption that fact is not separate from values. Moral questions are fundamental to research.

This study provides a different perspective in an area that has been primarily approached from a realist/quantitative methodology. Its intended result is thought-provoking dialogue and increased insight among educators concerning the decision to label children as ADD and to use medication to control behavior and attention within our schools. Such dialogue, it is hoped, can provide an opportunity to reevaluate procedures used in prescribing medication and to consider the number of children placed on the drug before all other avenues of treatment have been addressed.

Once the assertion has been accepted that ADD is an intrinsic biological disorder and millions of children have

been medicated as a treatment, it is very difficult for professionals with academic reputations and years of funding to reevaluate the premise. The qualitative inquiry process makes the "familiar strange" (Spindler, 1982). It forces us to move out of our comfort zone and to become more aware of the epistemological decision-making which affects our children and society. I have attempted to synthesize the findings into a more lucid understanding of the common decision to label and treat for ADD.

Preliminary Research Questions

Specifically, this study was guided by the following preliminary questions:

1. What factors influence the decision to prescribe medication for children?
2. What are this study's participants' perceptions of the etiology of ADD/ADHD?
3. What are this study's participants' perceptions of children labeled as ADD?

Interpretivist Paradigm/Perspective

Researchers conduct inquiry via a particular paradigm because it "embodies assumptions about the world that we believe and values that we hold" (Schwandt, 1989, p. 399). Positivist researchers assume they can find reality "out there" by use of objective, empiricist, prescriptive methods. However, the interpretivist perspective assumes

that objectivity in the sense that one can separate the "truth" from his/her values, perspectives, intentions, or that one can separate what *is* from what *seems* to be, simply does not exist (MacIntyre, 1984). Qualitative inquiry acknowledges that no such separation between what we take to be facts and what we construe as values can be achieved.

Qualitative inquiry is the avenue through which interactions between the individuals can be best examined (Rorty, 1989; Smith, 1993; Sullivan, 1986). Thus, an examination of my topic by the use of interpretivist principles provides a rich understanding of the perceptions and interactions of the participants in the decision to label and treat children for ADD rather than to seek right or wrong answers or offer generalizations as a quantitative researcher would.

According to Clifford Geertz (1973) and Vygotsky (1986), meaning is socially constructed by human beings. We cannot uncover reality, but we can generate understandings based on the interpretations of people--how people experience and give meaning to their worlds. Our constructions of the world, our values, and our ideas about how to inquire into those constructions are mutually self-reinforcing.

Smith (1993) stated that there are two basic concepts that define the focus of social and educational inquiry--

human action and social action (individual choice vs. choice affected by understandings/interactions, motives of others). Meanings should evolve and become more evident "as a result of the continuing dialogical encounter between and among people" (p. 186). Gadamer's (1960/1994) concept of "fusion of horizons" refers to how one does not react from just one's own standpoint. A fusion of self to others occurs--an interaction to each person's own meanings, interpretations, and intentions. All individuals have reasons for their actions, and our actions are affected by our perceptions of others and our surrounding environment (Smith, 1993).

What information do these individuals use which feeds into the process of current trends in identification of students as ADD? In this study my interpretation of the "expressions of others" contributes to the understanding of the intentions and motivations behind those expressions.

Lincoln and Guba (1985) observed that so long as belief systems are widely shared within a culture, they appear holistic and internally consistent. Therefore, if the belief that ADD is an intrinsic biological disorder is commonly shared, it appears to have been reified by the culture. However, Lincoln also noted that once such belief systems begin to disintegrate, cultures become fragmented and at odds with themselves. Thus, it may be very disconcerting for individuals who have accepted ADD as a

legitimate disease and who have even participated in the "diagnostic" process to begin to question that practice.

Greenfield (1980) commented on Max Weber that "having spun a web of meaning to make sense of the world, man is caught in it. The world makes no sense without the web. Man must make it, yet the web both constrains his action and makes it possible" (p. 34). Heshusius (1989) commented that "the properties of the parts can only be understood from the dynamics of the whole" (p. 411) which also supported Weber's web view. She added that the synchronizing nature of mechanistic or empiricist thought also relates to Weber's web. The Newtonian mechanistic assumptions which have guided conceptions of the learner have dictated "the criteria we choose for problem selection and evaluation" (p. 404). This paradigm is questioned by Heshusius and others (e.g., Blatt, 1984; Poplin, 1985; Smith, 1986).

Objectivity Versus Subjectivity

I followed the lead of Heshusius (1994) and was less concerned about issues of objectivity and subjectivity. She argued that we cannot have an objective or a subjective relationship; we are a whole. Furthermore, she noted "that one can not actually distance oneself, and then regulate that distance in order to come to know, or understand" (p. 16). In fact, she referred to the effort to do so as an

alienated consciousness that has left us alienated from each other, from nature, and from ourselves. She added that, "inquiry through a participatory consciousness . . . requires an attitude of profound openness and receptivity leading to greater understanding" which is at the core of conducting interpretive inquiry (p. 16).

Smith (1992) explained the empiricist view of objectivity by stating that "to be objective means that the investigator is detached and faithful to the reality under consideration and to be subjective is to accuse the researcher of a failure to remain detached" (p. 101). However, if an interpretivist is to use the terms at all, objectivity is best thought of as an expression that denotes that agreement has been reached among inquirers or, possibly, as a compliment one pays to someone who agrees with one's interpretation. By contrast, subjectivity would denote disagreement or the concern that someone has introduced considerations that one thinks are beside the point (p. 101).

As researcher, one must embed oneself in what understanding is desired rather than concentrating on managing one's "privileged status" as researcher. This is an act of ethics because the participants or observees are not just subjects, but they are now those with whom you share this journey to seek understanding. We cannot

separate our personal selves from our researcher role. It is a connected consciousness--a holistic approach (Smith, 1985).

Site/Participant Selection

I conducted ethnographic research in a metropolitan area with a population of 112,000. The sites involved were varied: classroom settings and various locations for interviews. Observations were conducted in various classrooms, and interviews were conducted at locations convenient for each participant.

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.

Of the total 35 participants in this study, 19 were elementary school personnel, 6 were parents, and 10 were

associated with the medical community. The school personnel group included 10 teachers, 3 counselors, and 6 principals. Those participants associated with the medical community were: 2 physicians, 2 private practice nurses, 5 school nurses, and 1 pharmacist. It is worth noting that 4 of the professionals spoke from dual roles (professional and parental).

I chose to look at a broad number of participants rather than narrowing to a more limited number because I believe that to understand a part, one needs to understand the whole context. Furthermore, I believe that a wide range of participants take part in the process whereby children are identified as having ADD. These participants were located through referrals from individuals contacted who have been in contact with children labeled as ADD. As the interviews progressed, I anticipated that additional names of participants would surface. This approach in selecting participants offered flexibility and an opportunity to reach a broader group of interesting participants (Glesne & Peshkin, 1992; Taylor & Bogdan, 1984).

Procedure for Data Collection and Analysis

The strength of qualitative inquiry is its ability to get at the underlying meanings and make visible the complexity of a situation in a way not possible through quantitative research (Mead, 1934). One does not act/react

from just one's own standpoint. There is a fusion of self to others--an interaction to each person's own meaning and interpretations and intentions (Smith, 1993, p. 196).

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 (see participant consent form in Appendix G), (b) classroom observations, and (c) archival documents. 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, ADD testing instruments, and inservice materials also reaffirmed the emerging patterns. These patterns showed consistency of views or perceptions of participants and also reinforced inconsistencies.

As researcher, I was the main instrument as I observed, questioned, and interacted. In my reflective notes, I described the participants' interpretations of this social phenomenon of ADD, as well as my own interpretations. Semistructured interviews were conducted by combining an exploratory and structured approach. The interviews were

initially semistructured but became more structured or focused in any follow-up interviews as themes in areas of importance to the participants became evident (Berg, 1995). (Interview protocols are shown in Appendix H.)

The questions focused on the perceptions of individuals working with ADD children within the school, home, and other social settings. I anticipated incongruencies among the participants. Follow-up interviews were undertaken as necessary to clarify initial findings. The interviews were taped, transcribed, and then analyzed using a constant-comparative, emergent-theme approach. At the end of each interview and observation, I either taped or wrote reflections regarding the experience which became part of my data and also analysis. Once the interviews and reflections were transcribed, I noted emerging themes/categories in the wide margins of the transcripts. Ultimately, the major categories were medical views and sociological views. Subcategories were classified under benefits of diagnosis/treatment, identification process, and environmental influences on children. A file by categories of participants assisted in visualizing any common views/perceptions among the groups. Ultimately, these categories or themes became sections in the findings chapter of this work.

Data analysis was ongoing throughout the study. I anticipated that, as the study continued, unforeseen issues and leads would become evident. Important leads were identified in the early phases of data collection and pursued by asking new questions and/or interviewing additional individuals. In an emergent-research design, the sample composition itself may evolve during the study (Glesne & Peshkin, 1992).

As unforeseen issues emerged in the process of data gathering, I pursued and reflected on those issues. To gain an understanding of the interactions, I addressed the participants' values, beliefs, and expectations for children. I also kept a reflective journal throughout this process which encouraged self inquiry as I viewed my own intentions and meaning, my own reason and responses (Smith, 1992). As Krall (1988) indicated, one can learn much from self reflection on one's own motivations and reasons for actions and understanding interactions with others. Lincoln (1989) reiterated this approach when she stated that we must examine "how we behave, both as inquirers and toward our respondents and co-participants in the inquiry process" (pp. 27-28).

CHAPTER IV
IN THE EYES OF THE BEHOLDER

Gnat said, "What's the use of their having names if they won't answer to them?" Alice responded, "No use to them but it is useful to people who name them, I suppose. If not, why do things have names at all?"

Lewis Carroll, Through the Looking Glass.

So the question becomes, what is the rationale underlying the labeling of children as ADD? In this study I examined the perspectives of individuals involved in the process of identifying children as ADD. This chapter focuses on those findings which, by and large, reveal that most participants in the identification process hold incoherent, if not contradictory, perspectives about the nature of ADD. Later, in Chapter V, I discuss how those perspectives contribute to the continuing decision to label children as ADD and subsequently prescribe medication as a treatment.

These incongruencies of perspectives were expressed in three distinct areas:

1. Etiological understandings
2. Benefits of diagnosis and treatment
3. Identification procedures

These three areas of incongruencies are presented separately in this chapter. It becomes apparent how these

inconsistencies in perceptions emerged as the data are presented.

Shibutani (1955) and Becker and Ragin (1992) offered guiding definitions of perspectives. Shibutani defined perspectives as "an ordered view of one's world--what is taken for granted about the attributes of various objects, events, and human nature" (p. 564). Becker and Ragin referred to *perspectives* as a "co-ordinated set of ideas and actions person/s use in dealing with a problematic situation" (p. 34). Thus, Becker and Ragin included actions as well as ideas and beliefs within his definition. He went further than Shibutani in explaining the effect of beliefs on decision-making. He suggested that individual views are made evident when faced with situations in which a definitive choice must be made. Accordingly, actions on those choice points flow from the beliefs, and beliefs justify the actions.

When children demonstrate behaviors considered problematic, surrounding adults make choices about how to best address those behaviors. If a particular situation recurs frequently, the perspective on those behaviors and subsequent choices about intervention are likely to become an established part of a person's or group's way of dealing with those situations. Ultimately, Becker and Ragin (1992) stated, "it becomes such a common way to respond in the

situation that it calls for no thought at all; the situation is not problematic for them" (p. 35). The participants in this study found it to be so increasingly common to have children labeled as ADD that there appeared to be little critical questioning of that practice.

Incongruencies of Accounts

Despite the common practice to label for ADD, the picture which 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 offered by participants was that ADD exists as a biological disorder. Within this view was the guiding assumption that the etiology of ADD 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 ADD is a product of social consensus: that ADD is caused or influenced by sociological situations. The social constructivist perspective is one in which an idea (in this case ADD) becomes reified, not through biological testing but through social consensus. The biological determinist view suggests that we discover ADD in children, whereas the constructivist view is that ADD

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 goes on to note that many otherwise capable children may respond to a lack of academic success by withdrawing or behaving aggressively. In accordance with this belief, participants noted that recent changes in the American family structure, societal mores, and child-rearing practices have contributed to the development of ADD.

Etiological Understandings

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 ADD as a condition. Within the same interview they would explain ADD in biological terms but later explain the increased numbers of children diagnosed in sociological terms. First, I discuss the participants' views of ADD existing as a biological disorder.

Biological Etiology

Most participants in this study, including professional practitioners and parents, assumed that the ADD diagnosis is based on objective, scientific information and that such definitions/diagnosis operate in the best interests of

children. This biological determinist view was cited in the initial responses from most participants to a question about the etiology of ADD. 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 many participants as they shared their perspectives with me. I have organized the participant voices into three categories: nurses, educators, and parents. The categories were chosen to help illustrate that, despite differences in experiences, professional background, and sources of information, the common thread of the biological view of ADD exists.

Nurses' voices. I found the interviewed school nurses responded quickly and assuredly to my questions regarding the etiology of ADD. All nurses were interviewed in their school health offices. Typically, the offices were very small spaces with just one cot available for a sick child. Periodically a child would interrupt our interview for medication or a minor first aid treatment. Despite interruptions, the nurses were cordial and seemed to be glad to share their professional expertise. During the ensuing interviews, it occurred to me that they may have felt isolated and actually enjoyed having someone ask for and value their opinions. They appeared comfortable with my questions and open in their responses.

A representative 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." In other words, because ADD 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 more deeply into this issue I asked, "How do you tell the difference between the child who has ADD from one who just has no self control due to past or present experiences?" A nurse gave a response typical of others in this study 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 ADD.

There did not appear to be any doubt in the interviewed nurses' minds that these were scientific, factually supported positions. When asked where the school nurses have received information on ADD, most indicated workshops.

The next group to be interviewed were school administrators and teachers. Their voices expressed the same etiological understanding as that expressed by the nurses.

Educators' voices. It might be expected that those schooled in medicine would tend to view ADD as having a biological etiology, but such a viewpoint was also true of educators who might be expected to possess clear understanding of 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 frequently the administrators and teachers expressed the medical model view of ADD.

A principal reflected the biological perspective of ADD by stating, "I would identify ADD 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 principal 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 ADD exists as a product of a lower socioeconomic class family and the assumption that such families participate in the use of drugs. Both of these interviewed administrators professed the perception that ADD does exist as an intrinsic disorder in the child and something the child cannot control.

When I interviewed a principal of another school, I inquired if he could recommend any teachers who had experiences with children diagnosed as ADD. He suggested two who had 18 students out of 52 labeled as ADD. 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 two teachers were interviewed separately but shared a common view of ADD 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." When further questioned, 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 this perception that ADD 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 interviewed administrators and teachers 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 ADD based on the medical model. This belief was exemplified in one 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 ADD 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 made this determination, she stated in a convincing voice, "Studies have been done with ultrasound 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 be aware of any incongruency in this line of thinking.

The tautological thinking in research on ADD 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 are composed of those who do not. Therefore, the "scientific" research remains very questionable.

As I progressed through these interviewing experiences, I continually noted discrepancies between the initial statements of participants defining ADD 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 ADD diagnosis is contradicted by their conflicting comments from the social constructivist perspective.

As discussed in the literature review, the practice of labeling children as ADD has become a phenomenon within our American society. Finlan (1994) asserted that, "Labeling is a fact of life. Some labels will be helpful or complimentary while some will be destructive and hurtful. We cannot stop it. Labeling controls our thinking and perceptions" (p. 59). Therefore, the practice of labeling is the result of a judgment and produces a social reaction and reinforces common perceptions.

Finlan (1994) also indicated that labels force us to view the world as fixed and rational--one filled with facts, truth, and clear cut categories. He extended this observation, stating that, "by viewing the world from this perspective, we ignore the unusual, the human, the different, and the unpredictableness of life" (p. 62). Those with this realist point of view perceive ADD as a "true" anomaly intrinsic to the child with causal factors derived from a scientific, medical model. Most participants in this study considered ADD to exist as a real biological disorder. Finlan (1994), who viewed labeling as a socially constructed phenomenon rather than a medical condition,

suggested that a child really becomes ADD when declared ADD by adults who use the realist perspectives.

One of the most insightful interviews which 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 opportunities to talk with many individuals involved in the process of labeling and treating ADD. Even though his profession is scientifically grounded and hence more amenable to the biological view of ADD, he expressed concerns about overdiagnosis and misunderstandings about the safety of stimulant drugs for children. As were all other participants, he was very willing to talk about these issues. In an interview he shared information from his professional experience as well as his experience as a parent of a child who was viewed by a teacher as hyperactive.

Lee indicated that during some years his own child did just fine in class, but in other years he 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 accomplish the same kind of control at school. Therefore, he concluded that it is the situation which seems to determine whether or not the child has a "problem." His reasoning, of course, 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 social context as the operative factor. If this possibility is taken seriously, an examination of the school and home environments, as well as the wider society, would be instructive.

Three themes emerged from the interviews that related to the sociological view of ADD: school environment, home environment, and societal problems. The next section presents participant comments related to each of those areas.

Sociological Etiology

The sociological view of ADD directly counters the biological determinist view. The social constructivist perspective asserts that the social situation or environment directly determines or at least influences the behavior of the child rather than a physiological abnormality. The first of three areas to be discussed is the environment at school.

School environment. One simple observation of how classroom environment can play a role in a child's behavior was expressed by a school administrator:

I have been in this room where nearly half the kids are on meds. At one point the kids' 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.

Another example of how a participant perceived the school environment as having an effect on the child's performance was expressed by a parent,

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 because this parent had previously stated that she felt medication was beneficial 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 of individual teachers can vary. Second, and in a related vein, the child may behave quite differently depending upon 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 mother, 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 mother that she thought the son had a learning problem because he "just couldn't keep up." The teacher 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, the mother did express her belief 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.

Another parent provided more evidence of this when she said, "These kids, they used to think they couldn't pay attention to anything. Well, that's not true. If it's something they are really interested in, they can become almost obsessive with it." Once again, it appears, performance may be affected by classroom strategies and subject matter.

I found it intriguing that so many parents, who had expressed the view that ADD is a biological disorder (something intrinsic to the child) and that medication was helpful to their children, could also be rather harsh in their reactions to teachers. A common perception was that teachers were not prepared to accommodate their children's needs. For example, one parent indicated that she believed there was a lack of knowledge in a lot of teachers, "especially older teachers. They don't believe in ADD and if they have kids that act different and are disruptive, they want them out of the room. Teachers are taught to teach the typical kid." Her inference was that the teachers

either wanted the children physically out of the room or perhaps "the problem" removed through medication.

On the other hand, some parents did acknowledge that some teachers were more adept than others at "dealing with" their children. Earlier in the section, the interviewed father had expressed this view when he discussed how his child had done better with some teachers than others.

Likewise, another parent stated that:

They [the school] changed his [her child's] label from LD to BD so he could have Mr. [name] who was better at dealing with him as a person as opposed to the LD teacher. Now, as I think about it, he was just dealing with ADHD symptoms.

This demonstrates that some parents and some schools will take whatever actions they believe necessary to address a child's needs even if it means manipulating the diagnosis.

It should be noted that in this situation, disabilities are viewed as interchangeable. The question that can and should be raised here is: If LD, BD, and ADD are distinct, intrinsic disabilities, can they also be viewed as interchangeable, depending upon situation specific contingencies? The fact that these participants accepted the application of varying labels to suit the present situation reveals at least a tacit belief that these disabilities, including ADD, are not at all intrinsic.

Concerns about the ability of teachers to motivate all children also were expressed by a principal who indicated

that simple boredom can sometimes be an issue with a child's behavior and ability to learn:

If you're in class and the teacher is talking to you and their voice is monotone and isn't 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 this same administrator shared her view that the home environment may also provoke these ADD behaviors.

Home environment. As just 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 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.

This belief that the home lives of these children is often disorganized also 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 ADD, 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 lay in the context of the societal/environmental.

A participant in this study who is actively involved with support groups for parents of children labeled as ADD 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." In her frustration, she initiated discussions with other parents who had children with similar difficulties. Understanding the frustrations personally, she felt she also could offer support to others in similar circumstances.

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 children felt. Both parents loved their sons but their approaches to handling the behaviors seemed to be quite different. Perhaps this left the children confused by the inconsistency between the two parents. She did say that her husband "could get the boys to stop whatever activity they were doing faster than I could as I 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.

There are many frustrated individuals in the education community and in the homes of these children labeled as ADD.

Coupled with their personal frustrations, they must face 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. 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 ADD:

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, its 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 then. 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. 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 not only of the specific home environment as discussed earlier but also 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 ADD.

Rationale for Identification--Who Benefits?

Despite the evidence that parents' and educators' needs are served in the diagnosis and treatment process, those interests are likely to be very unconscious and not deliberate. Most parents and educators cite the benefits

children derive from the treatment process as the overarching rationale for intervention.

The common belief on the part of school personnel, parents, and the medical community that children benefit from being diagnosed and treated for ADD was demonstrated by the following comments from school nurses. One said, "To some of these kids, it's been a life saver. They feel good about themselves and proud of what they accomplish." This expresses the perspective that children's interests are central in the diagnostic process and that the children accordingly benefit from medical treatment.

Not surprisingly, school nurses' views reflect their medical background, their experiences, and conversations with teachers. Many nurses agreed that children benefit from the use of medication and made common references to medication as a "miracle." In the words of one nurse, "Its effects [of medication] are miraculous." Another nurse recounted a conversation that she recently had with a teacher which seemed to exemplify this perception. She stated:

The meds are like a miracle. One of the teachers showed me a 3rd grade student's journal. He had run out of Ritalin, and there was a huge difference between when he was on and off. When he was on, he had nice sentence structure. Off, it was like he was schizophrenic or something. No ideas, no complete sentences, not on the lines. The writing was terrible.

This expression is illustrative of the view of most participants that medication has a marked positive effect on performance in school. Without the medication, the child's work is considered profoundly deficient. Therefore, it would appear that school nurses and teachers consider medication a wonder drug for these children.

One teacher provided the following statement which resonated in other teachers' testimonials about how the medication had produced a tremendously positive effect on a child:

All of a sudden they can focus, learn, be proud of themselves; turns them around, they go out and play where before they were in fights and would end up missing recess and end up in behavior programs every day.

The quick and dramatically visible effect of the medication appears to be refreshing for teachers who normally see slow progress in correcting social and learning problems. It would also seem logical that the child would be happier when not finding him/herself frequently underachieving and in trouble.

Time after time teachers embraced the conviction that students benefit from medication and demonstrated this in their comments. In making a comparison of behaviors when students were and were not taking medication during a trial period, a teacher offered the following example which she felt illustrated the positive effect of the medication:

Some of what I saw happening [without medication] in the classroom was silly behavior. Most of the time it was kind of a more lethargic, not focusing, kind of thing where before the child may have been very involved in class participation when on Ritalin.

I noted that the comments from this teacher and the one previously mentioned focused primarily on behavioral issues such as fighting with others, acting silly, and seeming lethargic.

It is also interesting that interviews with teachers and parents seemed to reveal that improvement in written work, which provided convincing evidence of the medication's effectiveness, did not translate into improved academic performance in terms of test scores or grades. In fact, when I asked a parent if she had noticed any improvement academically, she replied,

No. In fact her math is worse. None. The teacher says she [the daughter] seems less frustrated [belligerent] moving from one task to another but no improvement in her work. She [the teacher] just says to wait, that she still thinks it will make a difference.

Hence, in this case, the "improvement" was defined in behavioral terms. This parent's comment statement also was an example of how some participants expressed the idea that placing a child on medication made teaching or parenting easier but that relief was expressed only as a secondary issue. The children were the primary beneficiaries. I did find, however, that interviewed parents felt themselves to

be relieved of some real or perceived pressures from educators or perhaps others such as friends and family when they were told their child had a biological cause for what most consider inappropriate behavior.

An interviewed parent of three boys, "all diagnosed with something," expressed guilt concerning her sons' diagnosed disabilities. She lamented, "What did we do wrong, the guilt? I was a child development major and elementary teacher. How could I possibly raise children who were out of control?" She added, "I feel strongly about labels because it's such a relief to know you can point exactly to what your child has."

This parent also professed a belief that Ritalin had helped her son:

I think he was able to concentrate more, although I don't remember that we solved a lot of problems with that. I don't know, after that, how things got better for him. It seems like we saw some relief, but it wasn't things that I think Ritalin does for children.

Yet, in talking about how she would do things differently with another son, she said, "I really think if he had been placed on medication earlier he would have learned better." Once again I heard her expressed feelings of guilt or regret that she and the teachers did not make the "right" decision (to use medication) to help her son earlier in his life.

From the reported interviews, one can believe that parents and educators are not selfish, self-interested

victimizers of children. They genuinely have children's best interest at heart, and if there appears to be some self-interest motives operating, they are so tacit that the adults likely do not realize their existence. Most of these children do have behaviors which are extremely difficult to curtail or channel in more productive ways. Whether the responsible party is a parent or teacher, medication is considered a tool to assist, not hurt, children. I contend, rather, that the participants are not clear in their understanding of this phenomenon called ADD and the role each participant plays in the struggle to meet the needs of children with difficult temperaments.

Identification Procedures

Despite earlier comments that only a medical doctor can diagnose ADD, it is quite apparent that nonmedical personnel such as educators and parents are influential in the diagnosis. In this study, it became evident that teachers are the primary persons who initiate the contact with medical personnel. Excerpts from interviews with parents, teachers, administrators, and school nurses provided evidence that it is, indeed, usually the teacher who initiates the process of identification and subsequent treatment. This supports the views of Divoky (1989) and Granat (1995) that the identification process for ADHD, and

all of the other disabilities as well, is most often initiated by classroom teachers.

In this study, a parent (who also has strong ties to the medical and education community) told me how he responded to a teacher's suggestion that his child could benefit from medication for ADD/ADHD. In an agitated tone, he said he told her that:

If you can't challenge my son, then don't put him on Ritalin. . . . Don't try to tell me my son needs Ritalin. He is all boy, but I can see it as a reflection of you as much or more than him.

I heard, in this comment, his resentment that teachers play such a strong role in the diagnosis and subsequent medical treatment of children. His view also revealed his suspicion that teachers' needs are primarily being served in the process.

The parent went on to add that he heard that a school policy supposedly says teachers cannot make the suggestion. His vehement response to those who present this policy as fact was:

That's baloney. What's really happening is that the teacher picks up a phone or in a conference with the parents and says, "We need something to control this kid 'cause he is ruining the classroom, himself, and everybody else." Then they say you should have an appointment with your doctor and rule out if he is hyperactive or not.

Even though teachers and administrators may state, on one hand, that the diagnosis is a medical decision and not a

teacher decision, my interviews showed that evidence invariably arises which demonstrates that teachers play a major role in the process.

The following comment by an administrator also illustrates this point: "In the 1st grade we have a couple of kids who they [counselor and teacher] think could be on medication. One of them, we're really working on. . . . But they [parents] locked the files on us." This statement seems to indicate that school personnel can bring pressure to bear on parents who are reluctant to accept diagnosis and treatment. They may do so because, in their view, the best interests of the child are being served. However, some believe that the school personnel's interests are also being served.

Even though school personnel believe it is in the best interest of the child, it may be difficult to convince parents. Consider the following comments from principals: "We've had some dealing trying to explain to parents about medication. When push comes to shove, we're going to lead them into the right decision to benefit their youngster."

Another principal demonstrated this view when he said:

We have kids in 1st grade that could be on medication. . . . I think they would benefit from medication. We're not quite sure they're [parents] going to say yes. We think right now they would benefit from medication, so we're on that path to talk with Mom, and our psychologist and strategist are talking about it and recommending a physician. It's real hard for

parents to understand that this is a medical, not a psychological, problem.

It appears that these educators are quite certain they are right, even before the official "diagnosis" is made by a doctor. They seem to view the parents as somewhat uninformed, and, thus, their [educators'] job is to inform the parents.

Hence, although the official policy forbids educators to take a direct hand in the diagnosis, subtle (or not so subtle) pressure to obtain the diagnosis is brought to bear through informal channels. A teacher of at-risk students also provided evidence of educators' informal influence. In her comments about an upcoming meeting with a parent, she stated quite candidly: "The conference I have at 4:00--we're talking about putting this particular 5th grader on medication. Most of my students are on medication."

Even though the teacher does not write out the prescription, the implication in this case seems to be that they are making a judgment that the child would benefit from treatment with stimulant medications. Again, it appears pressure is applied to have a child medicated. The administrators and teachers consistently make the point that they are not allowed to suggest that the child has ADD. However disingenuous this may appear to an outside observer, they believe they are helping.

Conscious of the understood school policy forbidding ADD diagnosis by educators, this teacher explained how she handles these situations:

We're not allowed to say. We're not doctors. We're not allowed to say there's any suspicion of ADD. We're not supposed to say that. So you say it in a gentle way, you know, that the child can't complete assignments, is having trouble concentrating, bothered by others. So we are supposed to be very careful about bringing up ADD. It is always a parental decision. Always.

In accordance with the view of ADD as a biological disorder, teachers typically insisted that only a medical doctor can diagnose ADD since it is a "disease." For example, this statement: "We [as opposed to doctors] are not supposed to be qualified to diagnose that [ADD]," was representative of this common view.

Similarly, another teacher commented as follows:

My judgment would be [that the child is ADD], but I'm not a doctor, and it has to come from a doctor or area agency person where the parents are really "told," you know, that we're sure that the child has ADD. We only report the symptoms we see.

In a way, she is saying, "We already can tell when a child has ADD--but we must formally have the authority to say as much from the doctor's report." Does this mask the teachers' role in identification process?

The parents of diagnosed children who are also educators contribute unique insight due to their dual roles. One parent who had a child diagnosed as ADD spoke from her

professional role as a teacher of at-risk students when she shared an experience with another teacher in her building. She stated, "The classroom teacher was difficult to work with. All she wanted to do was up his [a student's] medication. They upped it to a point where he became obsessive compulsive." Interestingly enough, this parent/teacher did not share the positive view of medication when it involved her child. What does that say about instances in which perhaps there are competing interests? Is it easier in a more detached professional role to encourage stimulant use than when one is referring to one's own child?

In general, if the teacher perceives a child as "ruining the classroom," is it possible to justify the "settling" of that child via medication as beneficial not only to that child but also the teacher and other students in the classroom? It seems safe to assume that teachers do benefit from having an unruly child become calmer after medication is prescribed. A typical response supporting this view was provided by a school nurse:

I have the feeling sometimes that in order for the teacher to feel like they can survive in their classroom with sometimes a wide variation of abilities that it would be nice to have everybody on drugs so you've got a captive audience all day long. . . . sometimes people look at the medicine as a dependency. You don't have to do any other things. You don't have to get them to behavioral mod. programs, create spaces

where kids can go off and be by themselves. That [medication] becomes their first choice.

Even though this nurse had appeared supportive of the use of stimulant medication for children labeled as ADD, she alluded to competing concerns. On one hand, she exemplified a compassion for teachers trying to meet the diverse needs present in their classrooms. Yet, she also seemed to express a concern that there may be some dependency on medication as an easier, more time efficient way to maintain a peaceful classroom.

The perception that the medical community also benefits from the ADD diagnosis was indicated in the interviews with a pharmacist and physician. The pharmacist noted, "Doctors are businessmen. They want to keep the customer happy. If I don't provide, they will just go somewhere else." A physician concurred: "Some parents will just come in and say the teacher has told me 'Johnny' needs meds, and if I say no, they will find someone else who will." These statements reflect a pressure applied from parents. This is especially interesting when one considers that parents also felt pressured by educators to use medication for their child.

It was very evident throughout all interviews that the ADD diagnosis does indeed fulfill a number of needs of teachers and parents, not just the child. Parents benefit or receive a sense of relief from the diagnosis. Perhaps

most significantly, the diagnosis offers an explanation for troublesome behaviors without assigning blame or responsibility to anyone.

One parent captured the sense of relief experienced upon receiving a diagnosis for her child: "It's such a relief to know you can pinpoint exactly what your child has." Another parent offered, "It got to the point that we couldn't have friends over in the evening 'cause Johnny would end up making a mess of the evening by being in trouble so much." Clearly, these parents experienced an intense sense of relief subsequent to their child's diagnosis.

In one interview, a school nurse expressed her contention that occasionally she feels a child has been placed on medication unnecessarily to benefit the parents:

We've got a kid right now that I don't think needs to be on Ritalin at all . . . 'cause he sometimes is playing on the playground and doesn't come in for it and the teacher says there is absolutely no difference in his behavior. His mother has him on it.

The clear implication is that the mother had sought the diagnosis for her own personal reasons. Once the child is on medication, adult needs also influence the dosage necessary to eliminate problematic behavior.

Decisions about dosage levels are direct outgrowths of parents' and teachers' perceptions of when it is most necessary for the child to be on his/her best behavior. If

one dosage does not correct the behavior, the parent or teacher (not the physician) often makes the decision to change the dosage on his or her own. Thus, parents and educators make a judgment call about when the medication is being effective enough for a given context. Under these conditions, one might reasonably suggest that parents' and/or educators' needs figure into this equation, at least to some extent.

The following statements from a pharmacist who finds that parents confide in him indicated that, "Parents decide, 'Are our goals at school, early evening with homework, or both?'" He went on to share concerns he has about the informality of monitoring by many physicians, thereby giving nonmedical individuals too much control:

Mom and Dad adjust the dosage according to when the child's behavior seems acceptable. There are a lot of people who come in and say that the doctor said, "If one doesn't help try two," and then we get into this idea of "If 2 doesn't help, try 3," etc., and pretty soon you've got a mess.

Given that Ritalin is a class III narcotic, this participant's concerns appear to be well-founded.

A parent who felt pressured to treat her daughter with medication felt that there was little help offered for her or her child other than the suggestion to use medication. "I feel like the only help I've received from the school so far is that they helped find someone outside to tutor her in

math. I'm not aware of any behavioral modification or strategies being used this year."

In response to a question concerning how medication has affected her daughter's attitude toward school, she said, "Well, she is starting to find excuses to not go to school--stomach aches, etc., in the last month. Even the smallest sniffle is enough for her. She's too sick for school."

As the interviews suggest, teachers often have difficulty, or even resentment about, spending extra time developing strategies and providing documentation. They feel understandably overwhelmed with all of their professional demands. If the use of medication appears to help the child, it would follow that teachers would accordingly make such recommendations. It is evident from the interviews that it is the teachers who are instrumental in encouraging the contact with a physician or starting what she or he views as a diagnostic process to identify ADD which she or he believes will benefit the child. In fact, according to a parent, the teacher of her son said, "I really don't think he can do it--he can't pay attention--focus in. He was okay in the front row until someone would distract him, and then he just couldn't do it." This perception that the child is not capable of paying attention by using his own devices leads down an inevitable path to medical intervention.

Conclusion

As long as ADD 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 ADD persists despite no conclusive empirical evidence, perpetuating the acceptance of the "disorder." Because neither the parent, teacher, or child are 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 ADD diagnosis in implicit socially constructed terms. Most ADD proponents in this study were acutely aware of the non-biological factors possibly contributing to ADD type behaviors. However, they continued to operationalize the idea of ADD from the medical model rather than fully accepting ADD as a socially constructed "disorder."

Mann (1992) indicated that Western societies (particularly American) perpetuate empiricist beliefs. Drugs are a compelling method to "solve" western societal problems. The ongoing process of diagnosing children as ADD

is less prevalent in cultures with more relaxed behavioral standards for children and more stable home environments.

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 (as 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 overidentification 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 feasible explanation of a phenomenon and retain this initial casual 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" to lack of medication.

In Chapter V, I provide a more extensive explanation of how these conflicting views have developed and how this phenomenon continues. This discussion focuses on how participants have based their decision to label children as ADD on received knowledge. Furthermore, the professionals who have been considered "experts" by most participants viewed ADD 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, a matter I discuss in the last chapter.

CHAPTER V
IMPLICATIONS OF THE STUDY

If they hadn't believed it, they wouldn't have seen it.

Foster, Yesseldyke, and Reese (1975, p. 469)

The purpose of this study was to examine the perspectives about ADD which are held by key individuals who are regularly involved in the process of identifying and/or treating students for ADD. As mentioned in Chapter IV, Becker and Ragin (1992) referred to perspectives as a "coordinated set of ideas and actions person/s use in dealing with a problematic situation" (p. 34).

To expand on this idea, Becker and Ragin (1992) commented that group perspectives are modes of thought and action developed by a group which faces the same issue. A group perspective gains strength in an individual's behavior by being held in common with others, "everybody knows and everybody does. As a consequence it becomes increasingly hard to resist, increasingly tempting to comply with, and increasingly difficult for the individual to even know exactly what is happening or why" (p. 36). It would follow, then, that customary ways of thinking and acting appear to group members as the natural and legitimate ones to use in such situations. Because the ADD label and subsequent treatment with stimulants have become so commonplace, most

participants did not question those practices even though their own account of ADD etiology, motives, and identification procedures were incongruent. This became increasingly evident throughout the interviews as participants readily answered my questions. Furthermore, very few of the participants indicated they thought that their views were different from any others'. Most seemed comfortable with their own explanations and unaware of any competing explanations for ADD.

In this chapter, I offer an explanation of how these common views developed and why the practice of labeling children as ADD perseveres, despite critical analysis in the literature and also despite the fact that there are incongruencies within the perspectives of most of the decision-makers in the identification process. I also present an account of the phenomenon which I hope might ameliorate the confusion. I believe one possible explanation may be found in the concept of received knowledge.

Received Knowledge: A Key Factor

For the most part, participants in this study were operating under received knowledge from individuals they referred to as "experts" in the interviews. So what is wrong with received knowledge from perceived experts? Received knowledge from experts can lead to unquestioned

assumptions which ultimately, in turn, lead to contradictions. Skrtic (1991) indicated that this is the transmission of factual as well as philosophically unquestioned and, perhaps, conceptually flawed knowledge. Not only that, the experts can themselves be misguided, if not downright wrong. For example, recall that Chapter 2 referred to a 1990 study in which Zametkin and colleagues reported a link between hyperactivity in adults with an insufficient rate of glucose metabolism in the brain, but they later could not reproduce those findings. In 1995, Armstrong pointed out that even when Zametkin and his colleagues corrected the original work, the public, and professionals, continued to refer to the first study, mainly because his original work was heavily covered in the popular press, whereas his subsequent work did not receive such attention.

Skrtic (1991) indicated that the unreflective acceptance of assumptions that lie behind social practices frequently should be evaluated and reappraised. Skrtic (1986) earlier pointed out that a paradigm is a particular way of seeing and that a paradigm shift occurs when we abandon one lens (or way of seeing) for a different one. It would be a major shift for key individuals in the lives of these ADD children to begin to question the philosophical assumptions/foundations brought to bear in the process of

ADD identification. As I discuss at length later in this chapter, the responses to those behaviors would be very different when the current dominant conceptual grounding is held up for scrutiny.

The participants in this study appeared to base their decisions to apply the ADD label on knowledge obtained from a few scholars with a shared empiricist point of view. The individuals referred to as "experts," those who conducted workshops or inservices for teachers and parent groups, were typically a limited number of medical personnel and employees of an education agency which uses educational materials produced primarily from sources such as Russell Barkley and CH.A.A.D. which subscribe to the medical model of ADD.

As I stated in the literature review, Russell Barkley has been very influential in promoting the acceptance of the ADD label and the use of stimulant medication as a treatment. CH.A.A.D. (the parent support group funded, in part, by Ciba Geigy) has likewise offered not only consolation to parents and teachers but also the acceptance of, if not encouragement to use, stimulant medications for ADD children. These medical approaches to problem solving come from the realist/positivist perspective which underlies empiricist research. It follows, then, that this realist/positivist approach the "experts" have taken to

solving behavioral or learning problems in education also leads to another explanation for the common practice of identifying and treating children for ADD.

Realist/Positivist Assumptions

Those who view ADD from the realist perspective believe ADD resides in the child, that it is a "true," factual physiological affliction. They assume the behavioral and/or learning problem is intrinsic rather than extrinsic to the child and, thus, they define ADD in physiogenic terms. If the problem is viewed as being intrinsic to the child, then it follows that the interventions chosen are primarily focused on the child rather than extrinsic factors.

As Popkewitz (1992) maintained, "positivism perseveres in American educational thought. . . . educators draw on medicine rather than education" (p. 11). It would follow, then, that they often use what they consider scientific knowledge to solve human problems with little thought of the possible sociocultural relationship to those problems. Certainly this is evident in the ease with which many of the interviewed teachers and administrators in this study recommended that children be evaluated by a physician to address learning/behavioral difficulties.

A typical example of this process was expressed by a teacher:

We think right now that they [first graders] would benefit from medication, so we're on that path to talk with Mom, and our psychologist and strategist are talking about it and recommending a physician.

This teacher seemed to believe it was her responsibility to facilitate the process which leads to a better understanding of the ADD diagnosis on the part of the parent. It would follow, then, that this fuller understanding would benefit the child.

Two administrators also shared this mechanistic view toward addressing children's behavioral difficulties:

We've had some dealing trying to explain to parents about medication. It's like a battery. Sometimes, if you have too much acid, the battery doesn't work so we have to neutralize it. That's with medication. . . . is why you have to fiddle with it a little bit.

I found the using an analogy of a battery to a child's behavior somewhat troubling. The idea of "neutralizing" a child until he/she "performs" to our expectations seems to dehumanize human concerns.

Positivist medical terms, such as *diagnosis*, *intervention*, *symptom*, *diagnostic and prescriptive teaching*, *referrals*, and so forth, tend to make professionals and parents assume that what we are talking about is, in reality, medical in nature. Csapo (1984) suggested that spicing our professional jargon with medical or pseudo-medical terms makes educators appear to have professional expertise, seems to appear scientific, and legitimizes the

label. Again, this is reflective of the medicalized thinking in education today.

So what is problematic with these realist assumptions of educators? They are assuming that we can know the reality of ADD if the correct research procedures are used. They believe that facts can be separated from values even though it has become quite apparent that the identification process is based on personal value systems. As mentioned earlier, Skrtic (1986) indicated that the assumption that a learning disability is a condition that people "have" is derived from the positivist theory of knowledge. I propose that this view permeates the consciousness of most in education, from those who teach in teacher preparation programs to those who are practicing K-12 classroom teachers and, indeed, in our modern society as a whole.

Popkewitz (1992) maintained that we cannot transfer medicinal ideas to education without recognizing differences in the fields. The rationalism of the medical approach has a hidden delusion that social life and individualism can be fitted into rational categories. However, a pathological/abnormal framework is ill-suited for the developmental framework that must be present in education. Decision-making without historical reasoning obscures--portrays a view of science as enhancing educational practice with

little consideration for the complexity of a child's experiences and environment.

Murphy (1992) proposed that we, as a society, tend to blame people in difficult situations for their own predicaments. It would follow, then, that as long as children are blamed for their behavior with little consideration for other factors which may contribute to such, the more time efficient approach (treatment with medication) may be used. Therefore, sociocultural and developmental issues will be essentially ignored in the decision-making process.

The realist perspective, despite its well-documented flaws, is enacted in the official name of diagnosis and treatment "for the benefit of the child." As a result, arbitrary institutional procedures, such as in the ADD labeling process, begin to look reasonable and thus the power to influence is immeasurably enhanced. Consequently, it is a gradual, subtle, and seductive process for professionals and parents to accept without question, but the social consequences are enormous.

The scientific language used in this process is an important instrument of power. The participants in this study apparently convince themselves that this is science talking with all of its attendant authority. It appears to me that they assume it is the natural order of things and

that the labeling and treating for ADD has nothing to do with the arbitrary decisions of school personnel.

Incompatibility of Realist/Constructivist Paradigms

Tied to this pervasive realist view of learning/behavioral problems is another explanation for the persistent practice of labeling. This explanation lies in the incompatible views of ADD: one from the realist perspective and one from a social constructivist perspective. This incompatibility results in conflicting core accounts of ADD. When we have difficulty defining something, we tend to have difficulty in addressing it.

Our American society, and Western culture in general, is so saturated with the realist assumptions that an alternative explanation, such as the social constructivist perspective, is very difficult to grasp. This is particularly the case because it is so diametrically opposed to the realist perspective.

Slee (1995) suggested that, "the medicalization of student behavior transforms others' perceptions of students" (p. 74). The ADD label transforms the child from being "bad" to being "sick." Gilman and Goodman (1985) explained that medicine, like other "human sciences" is a relatively powerful source of conventions because we do tend to see its semiotics as objective compared to the conventions of aesthetics. Therefore, a "cure" is sought rather than

viewing the child as being unique with strengths and weaknesses.

Out of this realist perspective, the medical model looks at what are supposed to be biological symptoms in a dichotomous fashion (i.e., divorced from social context) to determine disease. If symptoms are present, the subject is considered to be abnormal or diseased, and pathological symptoms are considered a result of biological conditions. Viewed this way--"you have it or you don't" (Finlan, 1994, p. 34). Sociocultural influences are not relevant.

Mehan et al. (1986) referred to this orientation as the realist perspective because learning disabilities are perceived as absolute facts. He noted that 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 subjected to treatment, and this has also led to the view that students have a "problem." In this manner, an abstract idea, such as intelligence, becomes reified as a thing--the idea becomes objectified. This "problem" is a disability perceived as residing in students, as their private, personal possession rather than a result of environment and interactions.

Becker (1963) took issue with applying the realist view to education and would most likely view ADD as being

incompatible with a social constructivist perspective. He underscored two ideas: "First, deviance is created by responses of people to different kinds of behavior, and second, rules created and maintained to label behavior as deviant are not universally agreed upon," therefore not being scientific in nature (p. 18). For example, looking back on how my interest first developed in this issue, I was perceiving the child very differently than were my colleagues. I interpreted my student's behavior as not all that different from any other bright, creative child; but other teachers interpreted the behavior as deviant from the norm. Therefore, one must ask if ADD is actually a consequence of the relationship between an individual and the person's conceived notions with whom he or she comes into contact.

One researcher who has considered this relationship is Csapo. In 1984, she suggested that children are often tested with devices "dressed in a cloak of professional respectability, but without a sound scientific, empirical basis. In fact, those devices merely reflect the social, cultural and political beliefs of the tester" (p. 215). The socioconstructivist view acknowledges nonmedical factors which contribute to the behaviors associated with ADD and thus views ADD as constructed through social consensus. It

is created, not discovered, as is the case with a biological illness.

Skrtic (1986) professed that "professional practitioners . . . are inducted into subcultures of conventional knowledge, which they receive on faith as the only way of unrandomizing the complexity of their practice" (p. 8). These practitioners can be so accepting of this view that they may not even be aware of contradictions or incongruities in their perceptions and responses to nonconforming children. They may have been comfortable in their familiar conceptual framework and, therefore, do not feel compelled to question or deal with conceptual aspects. This received knowledge underlies the problem with parents' and practitioners' beliefs, and their lack of conceptual thinking underlies the problem with how the "expert's" method of knowledge is generated.

Lack of Conceptual Thinking

My last explanation for this practice of labeling children as ADD is a lack of conceptual thinking on the part of participants in the lives of children. When teachers/parents are puzzled, they tend to seek the advice of persons they perceive as experts, individuals they believe to have more experience and knowledge than they do.

As mentioned previously, the individuals who participated in this study, and those who were viewed as

experts by these participants, hold a realist view of learning disabilities and, thus, of ADD, at least in the sense that the realist view dominated their decision-making with regard to ADD. Murphy (1992) proposed that "the neurogenic/realist view of LD appears to transcend any current theoretical positions within the field and is maintained despite dissenting voices. He added that critics have charged that educators and scholars who study ADD ignore the conceptual and empirical contradictions that confront them. This was demonstrated in Murphy's study by the way in which the participants cited the experts' realist views of ADD as a biological condition but went on to mention environmental/sociological reasons for the behaviors as well, at the same time remaining unaware of their own contradictions.

It was suggested by Algozzine and Ysseldyke (1987) that, as it has become increasingly more difficult to define learning disabilities, attempts to make LD more sophisticated have become popular, rather than questioning the concept itself. Similarly, the increased numbers of children diagnosed and medically treated for ADD have bolstered the acceptability of the label. Practitioners are not "with it" unless they are engaged in neuro-psychological assessment. Furthermore, when educators and parents use

medical terminology, an image of professionalism is conveyed.

Unfortunately, many (if not most) educators do not seem concerned about overlabeling of children. Finlan (1994) proposed that "labeling is the result of a judgment and produces a social creation and one result is that we unconsciously shape the people who are labeled" (p. 59). In other words, they tend to live up or down to whatever label is bestowed upon them.

Alfie Kohn (1996) proposed that every teacher (whether he/she realizes it or not) has a theory which "colors everything that happens in classrooms, from the texts that are assigned to the texture of casual interactions with students" (p. 1). These theories are rarely explicit but certainly implicit in decision making. Could this apply to ADD? One would not expect a teacher to say, "The reason I support the practice of medicating kids is because it is the only way I can control him/her and make the classroom environment more pleasant." Whereas this conveys a rather blunt and harsh rendition of the situation, Murphy (1992) suggested that, by considering ADD or LD to be an "intrinsic deficit, one not caused by (or perhaps exacerbated by) external factors such as poor teaching or parenting, parents and teachers are let off the hook" (p. 8). This argument is not meant to imply that all parents and all teachers have

only their own self interests at heart. It simply suggests that the view of ADD as an intrinsic disorder is easier to see.

Hargreaves (1980) theorized that teachers attach labels to students to explain their educational achievement. Armstrong (1995) seemed to support this view when he suggested that the ADD label serves as a neutral term which helps to organize all the contradictory elements in these children's lives without blaming anyone. He said, "Like its old cousin, learning disability, ADD comes to us dressed in the cloak of scientific respectability with no implication of neglect, emotional disturbance, or improper training or education on the part of the adults" (p. 23). Kleinman (1980) went even further when he proposed that, without a professed illness, no disorder and no guide for seeking a health professional who could diagnose an illness and thus prescribe medication for treatment, could be justified. The ADD diagnosis may have gained respectability among adults, but what statement does this make to the children diagnosed?

Because school nurses are in contact with these students regularly during the times in which they take the dosages of medication, I reasoned that they should have an excellent view of the children's attitudes toward what the medication does for them. When I inquired about this, it was evident that there was no overt stigma attached to

students on Ritalin. In response to my inquiry concerning any possible stigma attached to the use of medication, a school nurse responded, "No, it's [comments in regard to medication] just kind of matter of fact. It's never in a disparaging way or making fun. 'Why, you take those kind too,? I take 1/2 more than you are.' Any stigma? Not at all."

Another nurse said, "Some children have pet names for the medication. One child came into the office and announced, 'I need my chill pill.' You hear people joke-- 'Better give that kid some Ritalin.' You hear it lightly like that." She also added that, "I don't hear any teachers say they hear negative comments from students nor are negative towards medication themselves. I really don't hear much dialogue about it."

Most participants in this study demonstrated a lack of conceptual thought concerning the psychological/educational results of using medication as a method for gaining self control. In 1976, Whalen and Henker expressed concern that giving a child drugs to control restless or unruly behavior deprives him/her opportunities to use his/her own "executive powers" and develop effective modes of self-control. When a child refers to "needing his pill" for self-control, I interpret this statement to mean that he has little self-control without it. Few participants in this study

expressed this concern. Furthermore, Whalen and Henker noted that when a child begins to behave better, there may be a risk that attempts to deal with academic underachievement might be curtailed. "Reading failure is certainly less salient and less irritating than disruptive behavior, although the long-term consequences may be equally detrimental" (p. 40).

Skrtic (1991), stated, "Because its professional knowledge is grounded in scientific management, education administration presupposes explicitly that school organizations are rational and that implicitly school failure is pathological" (p. 152). It would follow, then, that if the students are incapable of controlling their own behavior, then they must have pathological problems. I question if this message is one that will enhance these students' self-esteem and willingness to take risks to succeed in life.

Conclusion

We do but do we know why?

Examination of Beliefs Needed

As educators, we must begin to examine our beliefs/assumptions about ADD. 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 ADD from a realist perspective and yet at the same time identify the behavior from a social contextual perspective, this phenomenon of ADD 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 ADD 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. Despite this, school personnel (as well as others) adhere to the existence of ADD as a biological condition.

Herbert (1997) proposed that biological determinism now colors all sorts of public policy debates. A belief in the power of genes necessarily diminishes the potency of such individual qualities as personal will, a capacity to choose, and the sense of responsibility for those choices--if it's in your genes, you are not accountable. This also absolves everyone else from his other responsibility. The moral and ethical implications of this philosophy are profound, indeed.

Altered Practices Needed

It is too common in education to view children as the source of the problem. The schools, teachers, curricula, and instruction are rarely considered as being at fault when

a child has a problem with learning or behavior. Likewise, parents may blame the lack of success of their child on the child or the school, taking little responsibility for it themselves. Any time that educators and parents frame the issue in terms of the need to change a child's behavior, they are unwittingly buying into a larger theory that excludes the child's thoughts, feelings, needs, motives, and values which are the very things that result in certain behaviors. Furthermore, a school psychologist is then employed to determine what is wrong with the child, not with the curricula and teaching techniques.

Societal changes have had an impact on the school setting (Armstrong, 1995). Teachers no longer have the unquestioned authority they once had in the classroom-- children are no longer intimidated by authority. Thus, is it a physical "disease" or a social problem? Is it possible that changes in the American family have resulted in fewer parents available who provide consistent guidance? Armstrong proposed that, with less support to deal with an increasing number of societal pressures, many children simply buckle under the stress. He stated that "Many who are hyperactive/inattentive are not ADD but anxious or depressed because of any number of family, school, or other problems" (p. 27). He also considered the possibility that the child "with ADD" is a product of a short attention span

culture; that today's child is a scanner. He expanded on this idea when he added that,

the child's experience with electronic media has taught him/her to scan life the way one's eye scans a TV set or from a radio. These fast paced kids may be labeled ADD by adults who live in the slow lane, especially in classrooms which these children may find boring. (p. 30)

This statement suggests that it may be important to examine the temperament of teachers and parents who are more receptive to using the ADD label. The interaction between these adults and children could play a major role in the number identified as ADD.

In 1994, Finlan concluded that LD children have difficulties in school similar to how one might have difficulty hitting a golf ball, riding a horse, and so forth. He proposed that, given time and proper instruction, the skill would improve. Parents and educators must be willing and able to provide that time and proper instruction.

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. We need to visualize the larger picture, that the individually constructed realities of ADD are part of a larger social context of learning problems.

We must also consider the concept of *self-fulfilling prophecy*. What one expects from a child is often what one gets as a result of those expectations. Children tend to modify behavior to a given or conveyed expectation. 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 obviates the need to make appropriate improvements in classrooms. If medication appears to remove the problem, then no other changes may be required by the teacher or parent. I would question if self-esteem/concept of the child really improves through a child's feeling that it is only through medication that he/she can maintain self-control.

It is my wish that this study will lead the reader to ask serious questions about the existence of ADD as a distinct medical disorder and also to reflect on the roles that each of us, as parents and educators, play in this process. There is no doubt that this is a complex issue. The symptoms may be the same, but the causes attributed to ADD are very different. Perhaps educators should be asking if ADD children are symptoms of problems within the education system in our Western society. It is time that this phenomenon of children "needing" medication to get through a school day warrants serious reflective attention

by parents and educators. I see the challenge offered by Diane McGuinness (1989) as one we must all take very seriously:

The past 25 years has led to a phenomenon almost unique in history. Methodologically rigorous research . . . indicates that ADD [attention deficit disorder] and hyperactivity as "syndromes" simply do not exist. We have invented a disease, given it medical sanction, and now must disown it. The major question is how we go about destroying the monster we have created. It is not easy to do this and still save face. (p. 151)

REFERENCES

- Achenbach, T. M. (1988). Integrating assessment and taxonomy. In M. Rutter, A. H. Ruma, & I. S. Lann (Eds.), Assessment and diagnosis in childhood psychopathology (pp. 300-343). New York: Guilford.
- Algozzine, B., & Ysseldyke, J. (1987). Learning disabilities as a subset of school failure: The oversophistication of a concept. Exceptional Children, 50(3), 242-246.
- Armstrong, T. (1995). The myth of the A.D.D. child. New York: Dutton.
- Armstrong, T. (1996). ADD: Does it really exist? Phi Delta Kappan, 77(6), 424-428.
- Barkley, R. A. (1981). Hyperactive children: A handbook for diagnosis and treatment. New York: Guilford.
- Barkley, R. A. (1989). Attention deficit-hyperactivity disorder. In E. J. Mash & R. A. Barkley (Eds.), Treatment of childhood disorders (pp. 39-72). New York: Guilford.
- Barkley, R. A. (1990). Attention deficit hyperactivity disorder: A handbook for diagnosis and treatment. New York: Guilford.
- Barkley, R. A. (1995). Taking charge of ADHD: The complete, authoritative guide for parents. New York: Guilford.
- Barkley, R. A., & Cunningham, C. E. (1978). Do stimulant drugs improve the academic performance of hyperkinetic children? Clinical Pediatrics, 17, 85-92.
- Barone, T. E. (1992). A narrative of enhanced professionalism: Educational researchers and popular storybooks about schoolpeople. Educational Researcher, 21(8), 15-24.
- Bateman, B. D. (1992). Learning disabilities: The changing landscape. Journal of Learning Disabilities, 25, 29-36.
- Becker, H. S. (1963). Outsiders: Studies in the sociology of deviance. London: Free Press of Glencoe.

- Becker, H. S., & Ragin, C. C. (Eds.). (1992). What is a case? Exploring the foundations of social inquiry. New York: Cambridge University Press.
- Bennison, E. A. (1988). Creating categories of competence: The education of exceptional children in the Milwaukee public schools, 1908-1917 (Wisconsin). Unpublished doctoral dissertation, University of Wisconsin, Madison.
- Berg, B. L. (1995). Qualitative research methods for the social sciences. Boston: Allyn and Bacon.
- Blatt, B. (1984). On distorting reality to comprehend distortion. Journal of Learning Disabilities, 17, 627-628.
- Bradley, C. (1937). The behavior of children receiving benzedrine. American Journal of Psychiatry, 94, 579-585.
- Breggin, P. (1990). Brain damage, dementia and persistent cognitive dysfunction associated with neuroleptic drugs: Evidence, etiology, implications. Journal of Mind Behavior, 11, 425-464.
- Breggin, P. (1993). Psychiatry's role in the holocaust. International Journal of Risk and Safety in Medicine, 4, 133-148.
- Breggin, P., & Breggin, G. R. (1994). The war against children. New York: St. Martin's Press.
- Carrier, J. G. (1986). Learning disability: Social class and the construction of inequality in American education. New York: Greenwood Press.
- Coles, G. (1987). The learning mystique: A critical look at "learning disabilities." New York: Pantheon Books.
- Conners, C. K. (1989a). Conners' parent rating scales. North Tonawanda, NY: Multi-Health Systems, Inc.
- Conners, C. K. (1989b). Conners' teacher rating scales. North Tonawanda, NY: Multi-Health Systems, Inc.
- Cooter, R. B. (1988, May). Effects of Ritalin on reading. Academic Therapy, 23(5), 461-467.

- Cruickshank, W. M., & Hallahan, D. P. (1981). Alfred A. Strauss: Pioneer in learning disabilities. In W. M. Cruickshank (Ed.), Concepts in special education: Selected writings (Vol. 1, pp. 268-280). Syracuse, NY: Syracuse University Press.
- Csapo, M. (1984). Segregation, integration and beyond: A sociological perspective of special education. B. C. Journal of Special Education, 8(3), 211-229.
- Divoky, D. (1989, April). Ritalin: Education's fix-it drug? Phi Delta Kappan, 70, 599-605.
- Drug and Chemical Evaluation Section. (1995, October). Methylphenidate: A background paper. Washington, DC: U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control.
- DuPaul, G. J., Guevrenont, D. C., & Barkley, R. A. (1991). Attention-deficit hyperactivity disorder. In T. Kratochwill & R. Morris (Eds.), The practice of child therapy (pp. 115-144). New York: Pergamon Press.
- DuPaul, G. J., & Stoner, G. (1994). ADHD in the schools: Assessment and intervention strategies. New York: Guilford.
- Dykman, R. A., Ackerman, P. T., & Oglesby, D. M. (1979). Selective and sustained attention in hyperactive, learning-disabled, and normal boys. Journal of Nervous and Mental Disease, 167, 288-297.
- Finlan, T. G. (1994). Learning disability: The imaginary disease. Westport, CT: Greenwood Publishing.
- Fisher, S., & Greenberg, R. P. (Eds.). (1989). The limits of biological treatments for psychological distress: Comparisons with psychotherapy and placebo. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Foster, G., Yesseldyke, J., & Reese, J. I. (1975). I never would have seen it if I hadn't believed it. Exceptional Children, 41, 469-473.
- Franklin, B. M. (1987). Learning disability: Dissenting essays. New York: Falmer.

- Gadamer, H. (1960/1994). Truth and method (2nd Rev. ed.). (J. Weinsheimer & D. Marshall, Trans.) New York: Continuum Publishing.
- Geertz, C. G. (1973). The interpretation of cultures. New York: Basic Books.
- Giddens, A. (1977). Studies in social and political theory. New York: Basic Books.
- Gilman, A., & Goodman, L. S. (1985). Goodman and Gilman's the pharmacological basis of therapeutics (7th ed.). New York: Macmillan.
- Glesne, C., & Peshkin, A. (1992). Becoming qualitative researchers: An introduction. White Plains, NY: Longman.
- Golden, G. S. (1991, March). Role of attention deficit hyperactivity disorder in learning disabilities. Seminars in Neurology, 11(1), 35-41.
- Goodman, J. F. (1983). Organicity as a construct in psychological diagnosis. In T. R. Kratochwill (Ed.), Advances in school psychology (Vol. 3, pp. 101-139). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Goodman, G., & Poillion, M. J. (1992, Spring). ADD: Acronym for any dysfunction or difficulty. Journal of Special Education, 26(1), 37-56.
- Gould, S. J. (1982). The mismeasure of man. New York: W. W. Norton.
- Goyette, C. H., Conners, C. K., & Ulrich, R. F. (1978). Normative data on revised Conners' parent and teacher rating scales. Journal of Abnormal Child Psychology, 6, 221-236.
- Granat, D. (1995, April). The young and the restless. The Washingtonian, 30(7), 60-114.
- Greene, J. C. (1993). The role of theory in qualitative program evaluation. In D. J. Flinders & G. E. Mills (Eds.), Theory and concepts in qualitative research (pp. 190-199). New York: Teachers College Press.

- Greenfield, T. B. (1980). The man who comes back through the door in the wall: Discovering truth, discovering self, discovering organizations. Educational Administration Quarterly, 16(3), 26-55.
- Hallahan, D. P., Kauffman, J. M., & Lloyd, J. W. (1985). Introduction to learning disabilities. Englewood Cliffs, NJ: Prentice-Hall.
- Hancock, L. (1996, March 18). Mother's little helper. Newsweek, 113(3), 51-56.
- Hargreaves, D. H. (1980, October). A sociological critique of individualism in education. British Journal of Educational Studies, 28(3), 187-198.
- Haring, N. G., & Phillips, E. L. (1962). Educating emotionally disturbed children. New York: McGraw-Hill.
- Hartmann, T. (1993). Attention deficit disorder: A different perception. Lancaster, PA: Underwood-Miller.
- Herbert, W. (1997, April 21). How the nature vs. nurture debate shapes public policy--and our view of ourselves: Politics of biology. U.S. News & World Report, 122(15), 72-80.
- Heshusius, L. (1989). The Newtonian mechanistic paradigm, special education, and contours of alternatives: An overview. Journal of Learning Disabilities, 22(7), 403-415.
- Heshusius, L. (1994). Freeing ourselves from objectivity: Managing subjectivity or turning toward a participatory mode of consciousness? Educational Researcher, 23(3), 15-22.
- Kauffman, J. M. (1993). Characteristics of emotional and behavioral disorders of children and youth. New York: Macmillan.
- Kleinman, A. (1980). Patients and healers in the context of culture: An exploration of the border land between anthropology, medicine, and psychiatry. Berkley: University of California Press.
- Kohn, A. (1993). Punished by rewards: The trouble with gold stars, incentive plans, A's, praise, and other bribes. New York: Houghton Mifflin.

- Kohn, A. (1996). Beyond discipline: From compliance to community. Alexandria, VA: Association for Supervision and Curriculum Development.
- Krall, F. (1988, Fall). From the inside out: Personal history as educational research. Educational Theory, 38(4), 467-479.
- Kramer, J. J., & Conoley, J. C. (Eds.). (1992). The eleventh mental measurements yearbook. Lincoln: University of Nebraska Press, The Buros Institute of Mental Measurements.
- Lambert, N., Hartsough, C., & Sandoval, J. (1990). Children's attention and adjustment survey. Circle Pines, MN: American Guidance Service.
- Laufer, M. W., Denhoff, E., & Solomons, G. (1957). Hyperkinetic impulse disorder in children's behavior problems. Psychosomatic Medicine, 19, 38-49.
- Lerner, J. (1989). Learning disabilities: Theories, diagnosis, and teaching strategies. Boston: Houghton Mifflin.
- Lincoln, Y. (1989, April). The making of a constructivist: A remembrance of things past. Paper presented at the International Conference on Alternative Paradigms for Inquiry, San Francisco, CA.
- Lincoln, Y., & Guba, E. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.
- MacIntyre, A. (1984). After virtue: A study in moral theory (2nd ed.). Notre Dame, IN: University of Notre Dame Press.
- Mann, E. M. (1992, November). Cross-cultural differences in rating hyper-disruptive behaviors in children. American Journal of Psychiatry, 149(11), 1539-1542.
- Matson, J. L. (Ed.). (1993). Handbook of hyperactivity in children. Needham Heights, MA: Allyn and Bacon.
- Maykut, P., & Morehouse, R. (1994). Beginning qualitative research: A philosophic and practical guide. Bristol, PA: Falmer Press.

- McCarney, S. B., & Bauer, A. M. (1989). Attention Deficit Disorders Evaluation Scale (ADDES)--Home Version. Columbia, MO: Hawthorne Educational Services.
- McGuinness, D. (1985). When children don't learn: Understanding the biology and psychology of learning disabilities. New York: Basic Books.
- McGuinness, D. (1989). Attention deficit disorder: The emperor's clothes, animal "pharm," and other fiction. In S. Fisher & R. P. Greenberg (Eds.), The limits of biological treatments for psychological distress: Comparisons with psychotherapy and placebo (pp. 151-187). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Mead, G. H. (1934). Mind, self, and society. Chicago: University of Chicago Press.
- Medical Economics Data Production Company. (1995). Physicians Desk Reference. Montvale, NJ: Author.
- Mehan, H., Hertweck, A., & Meihls, J. (1986). Handicapping the handicapped: Decision making in students' educational careers. Stanford, CA: Stanford University Press.
- Murphy, S. T. (1992). On being L.D. New York: Teachers College Press.
- Palmer, R. (1969). Hermeneutics. Evanston, IL: Northwestern University Press.
- Patterson, G. R. (1965). An application of conditioning techniques to the control of a hyperactive child. In L. Pullman & L. Krasner (Eds.), Case studies in behavior modification (pp. 370-375). New York: Holt, Rinehart, and Winston.
- Pellegrini, A. D., & Horvat, M. (1995). A developmental contextualist critique of attention deficit hyperactivity disorder. Educational Researcher, 24(1), 13-19.
- Popkewitz, T. S. (1992). Whose Future? Whose Past? Notes on critical theory and methodology. In E. Guba (Ed.), The paradigm dialogue (pp. 46-66). Newbury Park, CA: Sage.

- Poplin, M. (1985). Reductionism from the medical model to the classroom: The past, present and future of learning disabilities. Research Communications in Psychology, Psychiatry and Behavior, 10(1&2), 37-70.
- Quinn, P. O., & Rapoport, J. L. (1976) 2-year follow-up of 72 hyperactive boys. Journal of Nervous and Mental Diseases, 126, 126-134.
- Rorty, R. (1989). Contingency, irony, and solidarity. Cambridge, UK: Cambridge University Press.
- Ross, D. M., & Ross, S. A. (1976). Hyperactivity: Research, theory, and action. New York: Wiley-Interscience Publication.
- Ross, D. M., & Ross, S. A. (1982). Hyperactivity: Current issues, research, and theory. New York: Wiley-Interscience Publication.
- Sapon-Shevin, M. (1996). Including all students and their gifts within regular classrooms. In W. Stainback & S. Stainback (Eds.), Controversial issues confronting special education: Divergent perspectives (2nd ed, pp. 69-80). Boston, MA: Allyn & Bacon.
- Schrag, P., & Divoky, D. (1975). The myth of the hyperactive child and other means of child control. New York: Pantheon.
- Schwandt, T. (1989). Solutions to the paradigm conflict: Coping with uncertainty. Journal of Contemporary Ethnography, 17, 379-407.
- Silver, L. B. (1990). ADHD, attention deficit-hyperactivity disorder and learning disabilities: Booklet for the classroom teacher. Summit, NJ: CIBA-GEIGY.
- Shibutani, T. (1955, May). Reference groups as perspectives. American Journal of Sociology, 60, 564.
- Skinner, B. F. (1953). Science and human nature. New York: Free Press.
- Skrtic, T. M. (1986, March). The crisis in special education knowledge: A perspective on perspective. Focus on Exceptional Children, 18(7), 1-16.

- Skrtic, T. M. (1991, May). The special education paradox: Equity as the way to excellence. Harvard Educational Review, 61(2), 148-206.
- Slee, R. (1995). Changing theories and practices of discipline. Washington, DC: Falmer Press.
- Sleeter, C. E. (1986). Learning disabilities: The social construction of a special education category. Exceptional Children, 53, 46-54.
- Smelter, R. W., Rasch, B. W., Fleming, J., Nazos, P., & Baranowski, S. (1996). Is attention deficit disorder becoming a desired diagnosis? Phi Delta Kappan, 77(6), 429-432.
- Smith, F. (1986). Insult to intelligence. New York: Arbor House.
- Smith, J. K. (1985). Social reality as mind-dependent versus mind-independent and the interpretation of test validity. Journal of Research and Development in Education, 19(1), 1-8.
- Smith, J. K. (1992). Interpretive inquiry: A practical and moral activity. Theory Into Practice, 31(2), 100-106.
- Smith, J. K. (1993). Hermeneutics and qualitative inquiry. In D. J. Flinders & G. E. Mills (Eds.), Theory and concepts in qualitative research (pp. 1-9). New York: Teachers College Press.
- Spindler, G. (Ed.). (1982). Doing the ethnography of schooling: Educational anthropology in action. New York: Holt, Rinehart, and Winston.
- Still, G. F. (1902). The Coulstonian lectures on some abnormal psychical conditions in children. Lancet, 1, 1008-1168.
- Strauss, A. A., & Lehtinen, L. E. (1947). Psychopathology and education of the brain-injured child. Journal of Nervous and Mental Diseases, 96, 153-172.
- Sullivan, W. (1986). Reconstructing public philosophy. Berkeley: University of California Press.

- Sykes, D. H., Douglas, V. I., & Morgenstern, G. (1973). Sustained attention in hyperactive children. Journal of Child Psychology and Psychiatry, 14, 213-220.
- Taylor, S. J., & Bogdan, R. (1984). Introduction to qualitative research methods (2nd ed.). New York: John Wiley & Sons.
- Vygotsky, L. (1986). Thought and language (A. Kozulin, Trans.). Cambridge, MA: MIT Press.
- Ullman, R. K., Sleator, E. K., & Sprague, R. L. (1991). ADD-H Comprehensive Teacher's Rating Scale. Champaign, IL: MetriTech, Inc.
- U.S. Department of Education. (1991). A clarification of ADD: U.S. Department of Education clarifies continuing responsibility of schools toward children with ADD. (Publication Section 504). Washington, DC: Author.
- Walters, A. S., & Barrett, R. P. (1993). The history of hyperactivity. In J. L. Matson (Ed.), Handbook of hyperactivity in children (pp. 1-10). Needham Heights, MA: Allyn and Bacon.
- Werry, J., & Sprague, R. L. (1970). Hyperactivity. In C. G. Costello (Ed.), Symptoms of psychopathology (pp. 397-417). New York: John Wiley.
- Whalen, C. K., & Henker, G. (1976). Psycho stimulants and children: A review and analysis. Psychological Bulletin, 83, 1113-1130.
- Zametkin, A. J., Liebenauer, L. L., Fitzgerald, G. A., King, A. C., Minkunas, D. V., Herscovitch, P., Yamada, E. M., & Cohen, R. M. (1993). Brain metabolism in teenagers with attention-deficit hyperactivity disorder. Archives of General Psychiatry, 50, 333-340.
- Zametkin, A. J., Nordahl, T. E., Gross, M., King, A. C., Semple, W. E., Rumsey, J., Hamburger, S., & Cohen, R. M. (1990). Cerebral glucose metabolism in adults with hyperactivity of childhood onset. New England Journal of Medicine, 323, 1361-1366.
- Zimmerman, E. H., & Zimmerman, J. (1962). The alteration of behavior in a special classroom situation. Journal of Experimental Analysis of Behavior, 5, 59-60.

APPENDIX A
DIAGNOSTIC CRITERIA FROM THE
DIAGNOSTIC AND STATISTICAL MANUAL OF
MENTAL DISORDERS (DSM-IV)

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders, DSM-IV. Washington, DC: APA.

Attention-Deficit/Hyperactivity Disorder "is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development."

Diagnostic criteria for Attention-Deficit/Hyperactivity Disorder

A. Either (1) or (2):

(1) six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

- (a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
- (b) often has difficulty sustaining attention in tasks or play activities
- (c) often does not seem to listen when spoken to directly
- (d) often does not follow through on instruction and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instruction)
- (e) often has difficulty organizing tasks and activities
- (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- (h) is often easily distracted by extraneous stimuli
- (i) is often forgetful in daily activities

(2) six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

- (a) often fidgets with hands or feet or squirms in seat
- (b) often leaves seat in classroom or in other situations in which remaining seated is expected

- (c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subject feelings of restlessness)
- (d) often has difficulty playing or engaging in leisure activities quietly
- (e) is often "on the go" or often acts as if "driven by a motor"
- (f) often talks excessively

Impulsivity

- (g) often blurts out answers before questions have been completed
- (h) often has difficulty awaiting turn
- (i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulse or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings.

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. 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).

Code based on type:

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months

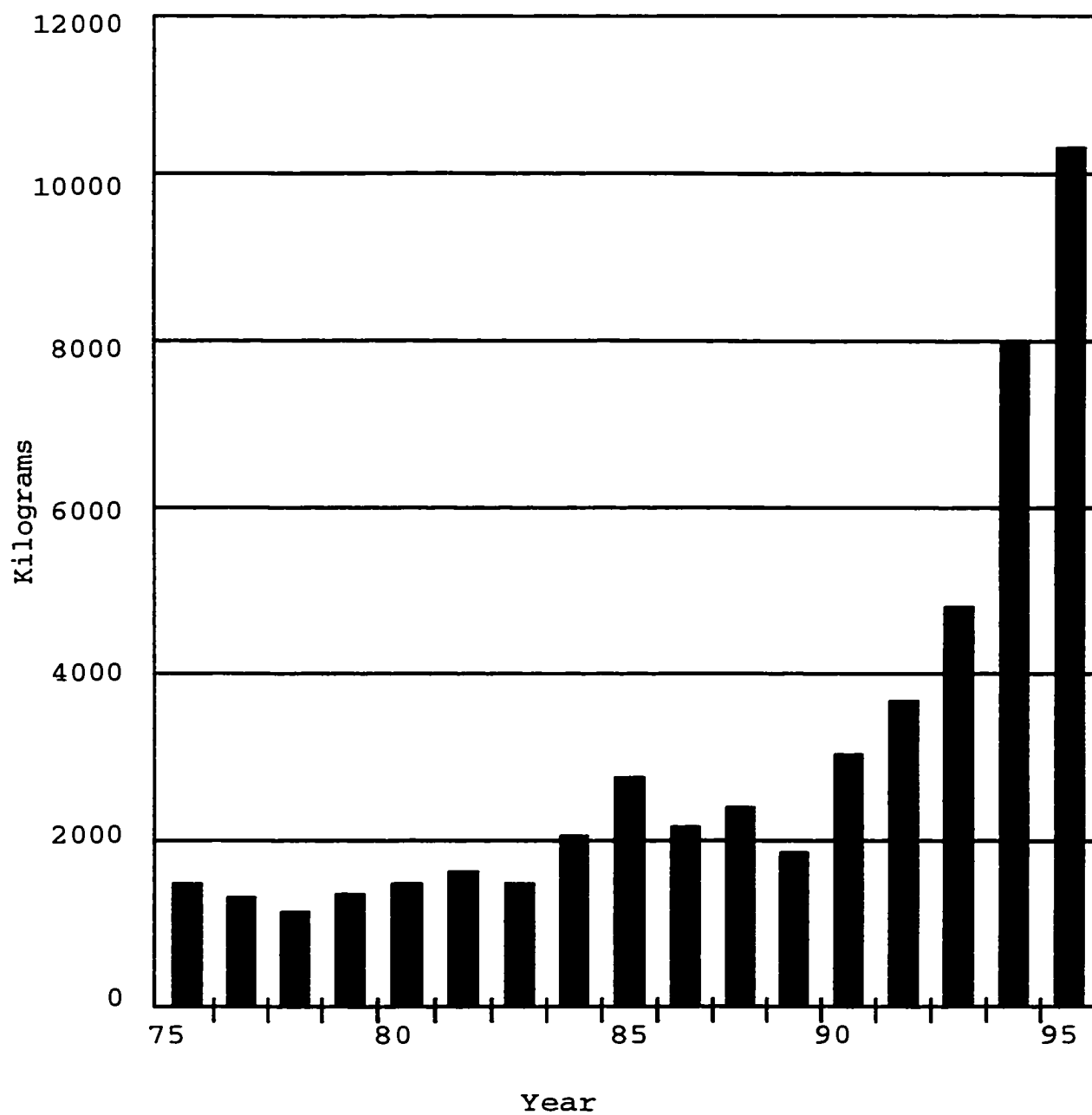
314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met by Criterion A2 is not met for the past 6 months

314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulse Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months

Coding Note: For individuals (especially adolescents and adults) who currently have symptoms that no longer meet full criteria, "In Partial Remission" should be specified.

APPENDIX B
PRODUCTION OF METHYLPHENIDATE

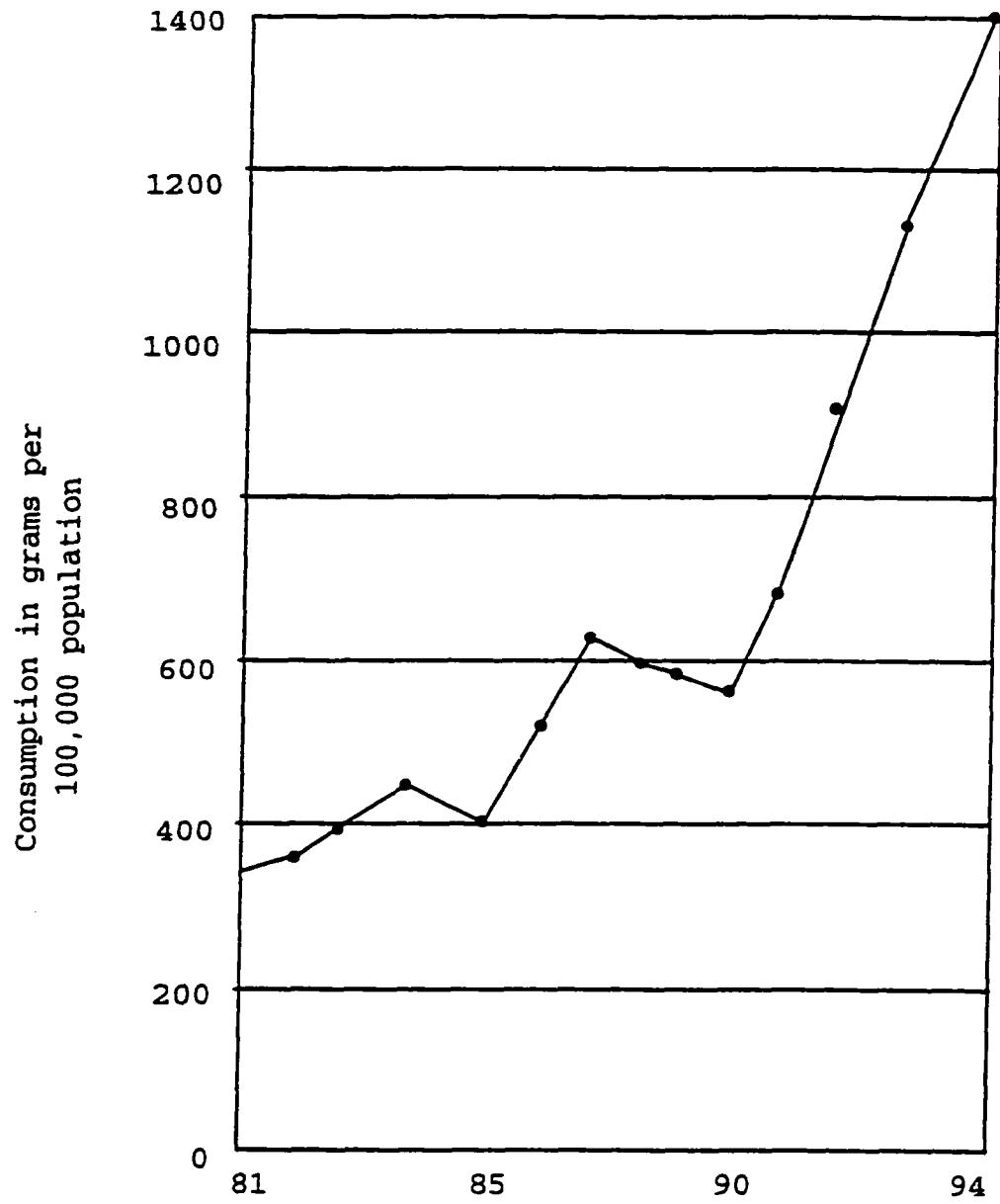
Annual U.S. Production
of Methylphenidate in Kilograms



Source: Drug Enforcement Administration: July 1996

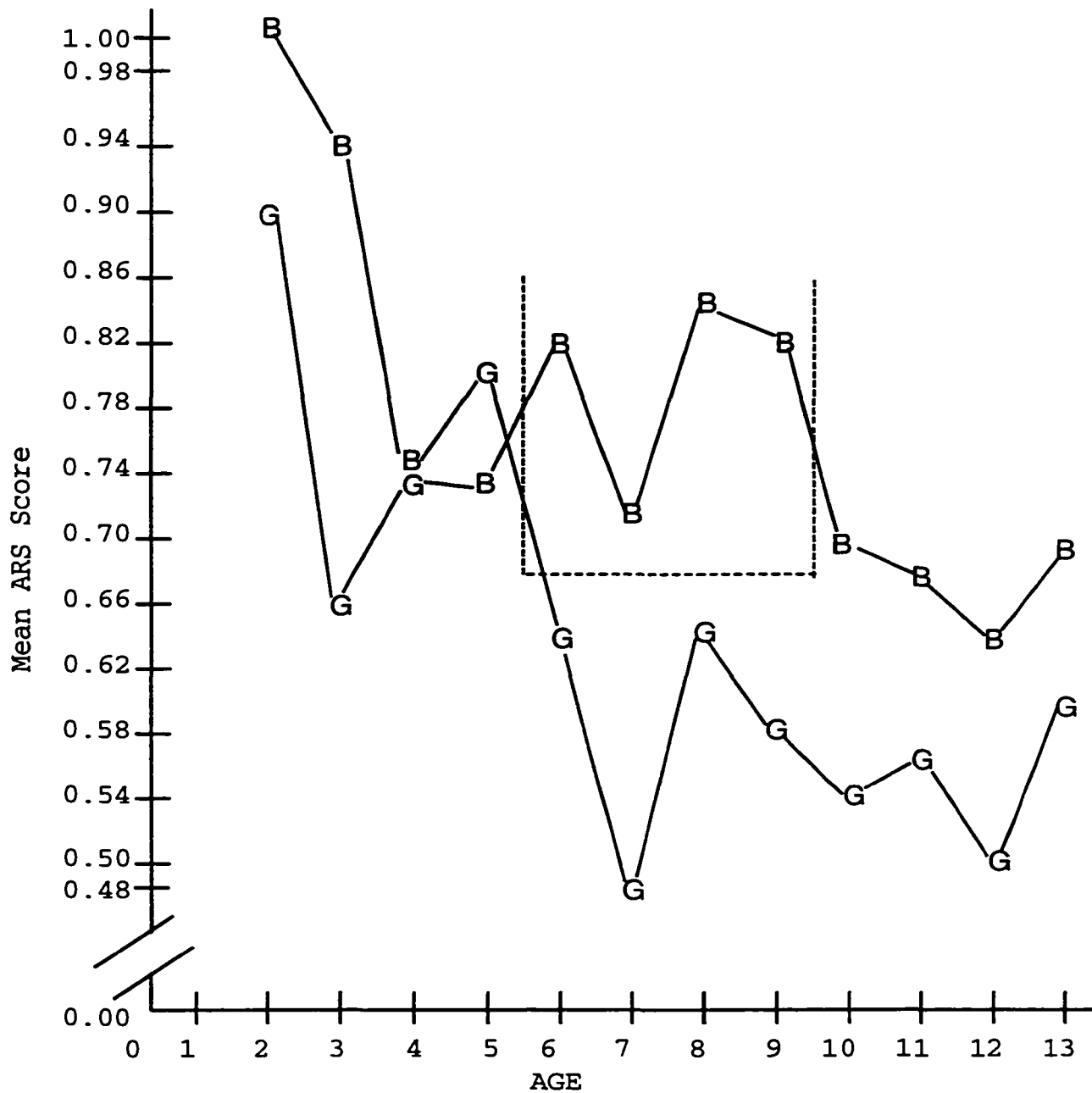
APPENDIX C
PRODUCTION OF RITALIN

Ritalin's Rise



Source: Drug Enforcement Administration

APPENDIX D
AGE-GENDER MEAN SCORES ON
CONNERS' RATING SCALE



NUMBER
 (G)irls=924: 72 66 71 80 71 70 73 88 85 87 70 91
 (B)oy =941: 69 81 79 71 76 83 59 76 110 70 91 76
 Total =1,865

STUDY POOL

Age-sex specific means on the Conners' Abbreviated Rating Scale. Reprinted with permission from Satin et al. (1985)

APPENDIX E
CONNERS' RATING SCALES

Exhibit 15-5

Conners Teacher Rating Scale

TEACHER'S QUESTIONNAIRE

Name of child _____ Date _____

Date of birth _____ Name of teacher _____

Age _____ Sex _____

Instructions: Please answer all questions. Beside each item below, indicate the degree of the problem with a checkmark (✓).

Observation	Degree of activity			
	Not at all	Just a little	Pretty much	Very much
Classroom Behavior				
1. Constantly fidgeting				
2. Hums and makes other odd noises				
3. Demands must be met immediately—easily frustrated				
4. Coordination poor				
5. Restless or overactive				
6. Excitable, impulsive				
7. Inattentive, easily distracted				
8. Fails to finish things he or she starts—short attention span				
9. Overly sensitive				
10. Overly serious or sad				
11. Daydreams				
12. Sullen or sulky				
13. Cries often and easily				
14. Disturbs other children				
15. Quarrelsome				
16. Mood changes quickly and drastically				
17. Acts "smart"				
18. Destructive				
19. Steals				
20. Lies				
21. Temper outbursts, explosive and unpredictable behavior				
Group Participation				
22. Isolates himself or herself from other children				
23. Appears to be unaccepted by group				
24. Appears to be easily led				
25. No sense of fair play				
26. Appears to lack leadership				
27. Does not get along with opposite sex				
28. Does not get along with same sex				
29. Teases other children or interferes with their activities				
Attitude Toward Authority				
30. Submissive				
31. Defiant				
32. Impudent				
33. Shy				

(Exhibit continues next page)

Exhibit 15-5 (cont.)

Observation	Degree of activity			
	Not at all	Just a little	Pretty much	Very much
34. Fearful				
35. Excessive demands for teacher's attention				
36. Stubborn				
37. Overly anxious to please				
38. Uncooperative				
39. Attendance problem				

Note. Scoring is on a 4-point scale: 0 (not at all), 1 (just a little), 2 (pretty much), 3 (very much). Table C-65 in Appendix C provides norms for the Conners Teacher Rating Scale for ages 4 through 12 years.
Source: Courtesy C. Keith Conners.

Exhibit 15-4

Conners Abbreviated Parent/Teacher Questionnaire

ABBREVIATED PARENT/TEACHER QUESTIONNAIRE

Name of child _____ Date _____

Date of birth _____ Name of parent/teacher _____

Age _____ Sex _____

Instructions: Please answer all questions. Beside each item below, indicate the degree of the problem with a checkmark (✓).

Observation	Degree of activity			
	Not at all	Just a little	Pretty much	Very much
1. Restless or overactive				
2. Excitable, impulsive				
3. Disturbs other children				
4. Fails to finish things he or she starts—short attention span				
5. Constantly fidgeting				
6. Inattentive, easily distracted				
7. Demands must be met immediately—easily frustrated				
8. Cries often and easily				
9. Mood changes quickly and drastically				
10. Temper outbursts, explosive and unpredictable behavior				

Comments: _____

Note. Scoring is on a 4-point scale: 0 (not at all), 1 (just a little), 2 (pretty much), 3 (very much). Tables C-64 and C-66 in Appendix C provide norms for ages 3 to 17 years for the Conners Abbreviated Parent Questionnaire and Conners Abbreviated Teacher Questionnaire, respectively.
Source: Courtesy C. Keith Conners.

APPENDIX F
HISTORICAL DIAGNOSTIC TERMINOLOGY

Historical Overview of Attention Deficit Disorder

Date	Diagnostic Terminology	Source	Characteristics
1941 1947	Brain damage syndrome	Werner & Strauss	Hyperactivity, distractibility, impulsivity, emotionality unstable perseveration.
1962	Minimal brain dysfunction (MBD)	Clements & Peters	Soft neurological indicators, specific learning deficits, hyperkinesia, impulsivity, short attention span.
1968	Hyperkinetic reaction of childhood	DSM II	Hyperactivity
1980	Attention deficit disorder with hyperactivity (ADHD)	DSM III	(a) Inattention, impulsivity, motor hyperactivity (b) Onset before age 7 (c) Duration of at least 6 months
	Attention deficit disorder without hyperactivity (ADD/noH)		Inattention, disorganization, difficulty completing tasks
1987	Attention-deficit hyperactivity disorder (ADHD)	DSM III-R	Any 8 of a set of 14 symptoms
	Undifferentiated attention deficit disorder (U-ADD)		Developmentally inappropriate and marked inattention
1991	Attention deficit disorder (ADD)	Policy Memorandum, U.S. Department of Education	IDEA, Part B-Other Health Impaired
In process		DSM IV	

Sources: *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed.; 3rd ed.; 3rd ed., rev.; 4th ed.) 1968; 1980; 1987; and in process. Washington, DC: American Psychiatric Association. "Minimal Brain Dysfunction in the School-Aged Child" by S.D. Clements and J.E. Peters, 1962, *Archives of General Psychiatry*, 6, pp. 185-187. *Psychopathology and Education in Brain-Injured Children* by A.S. Strauss and L.E. Lehtinen, 1947, New York: Grune & Stratton. "Pathology of the Figure-Background Relation in the Child" by H. Werner and A.S. Strauss. 1941, *Journal of Abnormal & Social Psychology*, 36, p. 234-248. U.S. Department of Education, Policy Memorandum, September 16, 1991.

APPENDIX G
PARTICIPANT CONSENT FORM

Informed Consent Form

Project Title: Labeling and Treating Children with ADD/ADHD

I understand that the purpose of this research is to determine how key players in the lives of children with ADD/ADHD perceive the disability and its relationship to themselves, others, and performance at school.

I further understand that my participation is voluntary and that I will not be paid for participating. I also understand that I may discontinue my participation at any time.

I understand I will be taped during this interview. My specific comments may be used as part of a dissertation and other writings but the researcher will assure confidentiality as deemed necessary by the interviewee. My name or specific place of employment will not be included in any presentations (oral or written) of data gathered.

If I have questions concerning this research and my rights as a research subject, I may contact the Human Subjects Coordinator, University of Northern Iowa at (319) 273-2748.

I am fully aware of the nature and extent of my participation in this project as stated above and hereby agree to participate in this project.

printed name

signature of participant

date

signature of researcher

date

APPENDIX H
INTERVIEW PROTOCOL

General Interview Questions
(for all participants)

Date _____ Participant _____

Introduce self, background, & research interest

Subject background:

- *Tell me about your professional background
- *Why did you choose this occupation?
- *How long have you been in this position?

-
1. How would you define ADD/ADHD (past & present)?
 2. How would you describe a child with ADD.
 3. How have you obtained information on ADD?
 4. When did you 1st become aware of the ADD/ADHD diagnosis?
--When/where did you 1st encounter ADD?
 5. Have you seen/heard the current media attention?
--If so, how do you account for it?
 6. Do you believe there has been increased numbers of children being diagnosed & treated for ADD as some do?
 7. How does it relate to what you see in your own school/profession?
 8. What is it like to have these ADD children within the classroom?
 9. Tell me about any school, district, or medical community guidelines or policies on diagnosis and/or treatment of ADD?
 10. Tell me about how students are tested for ADD.
 11. How does medication affect these children?
 12. How do think the children on medication and their classmates view taking medication for ADD?
 13. Tell me about your experiences with parents of ADD children.

14. In what ways, if any, have your perceptions of ADD/ADHD changed over time?

If so, what made them change?

Additional Questions for Parents and Teachers

Parents

1. When did you first suspect your child had ADD/ADHD?
2. Describe the social relationships of your child.
3. What aspects of your child's personality do you most enjoy?
4. What aspects of your child's personality do you find most frustrating?
5. How does your child feel about school?

Describe his/her school experiences since enrollment (pre-K on)

Teachers

1. How many children are labeled ADD/ADHD in your classroom?
Is this a typical number? Does it fluctuate within the yr.?
2. What special challenges does the ADD/ADHD child bring to the classroom?
3. What strategies seem to work best for ADD children?